SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part I
Covered California

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2020 Marketplace Plan Renewal Flowchart

Are you or your staff helping clients enroll or renew health care coverage for 2020? This guide provides a timeline for enrollment and renewals for 2020 coverage, and asks key questions to guide the renewal process. It explains that clients need to update their information in the Marketplace to ensure continued financial assistance and avoid gaps in coverage.

RWHAP staff can use this guide to:

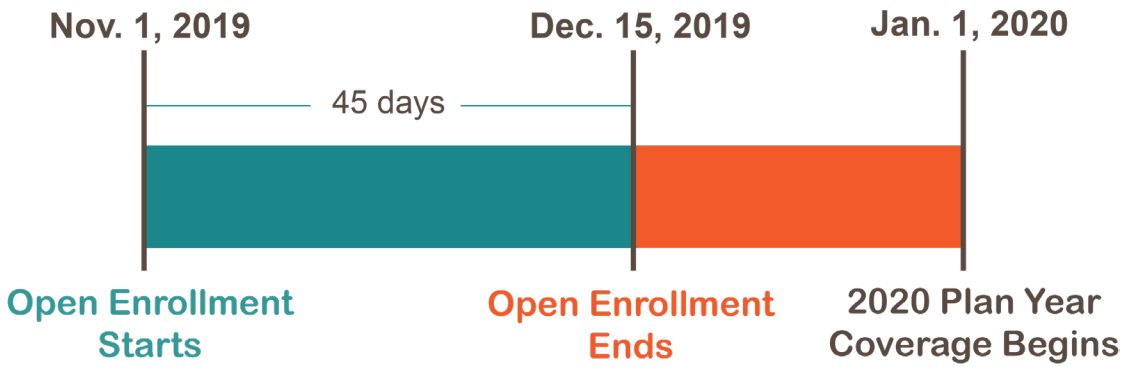
- Understand how to guide clients through the plan renewal process.
- Understand why enrolled clients need to update their Marketplace applications for coverage and financial assistance.

An important message about Open Enrollment and plan renewals:

- Clients who will change plans must enroll by December 15, 2019 in most states* to avoid a gap in coverage and ensure that their new plans begin on January 1, 2020.

Revised June 2019

Open Enrollment Timeline for 2020 Marketplace Coverage*



(includes all states using HealthCare.gov)

* In state-based and partnership Marketplace states, RWHAP providers and case managers should check with their Marketplace or regulating agency on the redetermination and renewal process, and to confirm the time period for Open Enrollment.

- Six-week enrollment period applies to both federally-facilitated marketplace states (FFMs) and state-based marketplaces (SBMs).

Marketplace Plan Renewal Flowchart for 2020 Coverage

1 Was your client enrolled in a qualified health plan (QHP) in 2019?

NO.
Eligible clients can choose and apply for a QHP during Open Enrollment.

YES.
Most clients will automatically be re-enrolled in coverage, with the exception of discontinued plans. Whether or not renewal is automatic, clients should log into their Marketplace application to compare plan options. Clients can select a new plan during Open Enrollment and update their income and household information.

Use the **ACE TA Center's Health Care Plan Selection Worksheet** to help clients find the best plan for them.

Use the **ACE TA Center's Pre-Enrollment Worksheet** to help clients prepare for their first visit with an enrollment assister.

TIP Even if the client is not eligible for as much financial help in 2020, s/he can review plans to compare costs and coverage for medications and services. RWHAP remains available to ensure coverage completion and may be able to help cover remaining premium and out-of-pocket expenses.

TIP Tell your clients that the Marketplace mails a *Health Insurance Marketplace Statement* each February with information they will need to complete Form 8962, which is a form that will get submitted with their tax return.

2 Is your client's QHP available in 2020?

NO.
If plan is discontinued at the end of 2019, the client may be auto-enrolled in a similar plan from the same insurer if one is available. If the insurer is leaving the Marketplace, the client may be auto-enrolled in a similar plan from another insurer. Encourage clients to examine **any new plan** carefully to ensure it still meets their needs. If a similar plan is not available, auto-renewal will not occur unless s/he actively chooses a new plan.

YES.
Even if your client's same plan is offered in 2020, encourage him/her to review new plan options to compare costs and coverage options, and see if s/he qualifies for financial help to lower the price of a new plan.

3 Did your client receive financial assistance, such as premium tax credits (PTCs) and/or cost-sharing reductions (CSRs), in 2019?

YES.
The Marketplace will use the client's tax information to calculate the amount of PTCs or CSRs the client is eligible for in 2020.

NO.
The client can apply for help paying for premiums and out-of-pocket expenses in 2020. Clients with incomes up to 400% FPL may be eligible for PTCs. Clients with incomes up to 250% FPL may also be eligible for CSRs.

4 Did the client file taxes this year?

YES.
Great! Clients who filed the previous years' taxes will have an automatic redetermination of their PTC/CSR in the new year.

See **Tax Credits and Cost Sharing: Federal Support for Health Insurance** for more information.

NO.
Clients must file a tax return for every year that they receive a PTC/CSR to continue to be eligible for future PTC/CSRs. Clients who were enrolled for the first time in 2018 and received a PTC/CSR will need to file their 2019 taxes in 2020.

5 Did the client authorize the collection of tax data from the IRS in 2019?

YES.
The Marketplace will use the client's tax information to calculate the amount of PTCs or CSRs the client is eligible for in 2020.

NO.
Tell your clients that without updated tax data, current financial help in the form of PTCs and CSRs will end on 12/31/19.

TERMS TO KNOW

QHP (QUALIFIED HEALTH PLAN)
A health insurance plan that is approved by and sold in the Marketplace.

PTC (PREMIUM TAX CREDIT)
Tax credit applied to premium costs of a QHP to help pay for health coverage.

CSR (COST SHARING REDUCTION)
A discount that lowers out-of-pocket costs for health insurance.

ELIGIBILITY DETERMINATION
When the Marketplace uses the client's tax information to calculate the client's financial assistance.

Marketplace Plan Renewal Flowchart

This resource is/was prepared by JSI Research & Training Institute, Inc., and supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30143: Building Ryan White HIV/AIDS Program Recipient Capacity to Engage People Living with HIV in Health Care Access. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government. **www.targethiv.org/ace**

ACE TA CENTER

What you'll need to enroll

The following is needed for every household member who will be covered:

- Proof of current household income*
- California ID or driver's license for adults
- Proof of citizenship or satisfactory immigration status (e.g., U.S. passport, legal resident card, certificate of citizenship or naturalization document)**
- Birth date
- Social Security number or Individual Taxpayer Identification number, if you have one
- Home ZIP Code

Sign up

Oct. 15, 2018 — Jan. 15, 2019

Sign up by Dec. 15 to be covered by Jan. 1

Medi-Cal enrollment is year round.

Even if you only need coverage for a just few months, look to Covered California throughout the year for your health insurance needs.

*Proof of current income of all members in the tax household such as a recent tax return, W-2, or pay stub. A dependent's income should only be included if their income level requires them to file a tax return. A household is defined as the person who files taxes as primary tax filer and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

**You can apply for your child even if you are not eligible. Households that include members who are not lawfully present can also apply.

You have options

Covered California offers four levels of coverage: Bronze, Silver, Gold and Platinum. Insurance companies pay a portion of covered services, and the benefits offered within each level are the same no matter which insurance company you choose.

COVERAGE LEVEL	ANNUAL DEDUCTIBLE	AVERAGE PAID BY INSURANCE COMPANY	AVERAGE PAID BY YOU
Bronze	YES	60%	40%
Silver	YES	70%	30%
Gold	NO	80%	20%
Platinum	NO	90%	10%

- **Choose Platinum or Gold** and you'll pay a higher monthly premium, but you'll pay less for medical services.
- **Choose Silver or Bronze** and you'll pay a lower monthly premium, but you'll pay more for medical services.
- **A minimum coverage plan** is available to those under 30 or those 30 and over who have received a hardship exemption from U.S. Department of Health and Human Services.

*Silver is the only level where your deductible and other costs may be lower based on your household income.

For more information or to find free, local, in-person help, please contact:

CoveredCA.com | 800.300.1506

Covered California Can Help You Get Affordable Health Coverage

What you need to know

COVERED CALIFORNIA

Welcome to Covered California

See if you can get help paying for your health insurance.

We've got you covered.

Covered California is where Californians can shop for and compare quality health plans among a variety of brand-name insurance companies. You may even get help paying for it.

We're here to help.

Covered California offers free, local, in-person enrollment help, online chat, and telephone assistance in thirteen languages as well as for the hearing-impaired.

Are you eligible? Find out here.

Maximum Annual Household Income to Qualify for Financial Help

FAMILY SIZE	MEDI-CAL	COVERED CALIFORNIA
1	$16,754	$48,560
2	$22,715	$65,840
3	$28,677	$83,120
4	$34,638	$100,400
5	$40,600	$117,680
6	$46,652	$134,960
	You may be eligible for low or no-cost Medi-Cal.	*You may be eligible for financial help through Covered California.*

All numbers listed above are estimates. For larger households, please visit the Shop and Compare tool at CoveredCA.com to find out if your family qualifies.

Shop and Compare

Visit CoveredCA.com and choose "Shop and Compare" to see which brand-name health plans are right for you.

More questions?

Watch our "Welcome to Answers" videos at **CoveredCA.com/find-help/FAQS**

COVERED CALIFORNIA

To get started, visit **CoveredCA.com** or call **800.300.1506.**

COVERED CALIFORNIA

A step-by-step guide to enrolling in quality health coverage

We've got you covered.

Covered California is where Californians can shop for and compare quality health plans among a variety of brand-name insurance companies. You may even get help paying for it.

This guide will help you better understand your coverage options so you can enroll in the health plan that best fits your needs.

We're here to help.

Covered California offers free, local, in-person enrollment help, online chat, and telephone assistance in 13 languages as well as for the hearing-impaired. For help at any point during the enrollment process, call **800.300.1506** or visit **CoveredCA.com**.

Step one:
See if you qualify for help paying for health coverage

Based on your annual household income, you may qualify for what's called an Advanced Premium Tax Credit (APTC) to help reduce your monthly premiums. Or you may qualify for low or no-cost coverage through Medi-Cal.

Coverage Year 2019

Maximum Annual Household Income to Qualify for Financial Help

FAMILY SIZE	MEDI-CAL	COVERED CALIFORNIA
1	$16,754	$48,560
2	$22,715	$65,840
3	$28,677	$83,120
4	$34,638	$100,400
5	$40,600	$117,680
6	$46,652	$134,960
	You may be eligible for low or no-cost Medi-Cal.	*You may be eligible for financial help through Covered California.*

All numbers listed above are estimates. For larger households, please visit the Shop and Compare tool at CoveredCA.com to find out if your family qualifies. Medi-Cal enrollment is year-round.

Sign up Oct. 15 – Jan. 15 | **To be covered by Jan. 1 sign up by Dec. 15**

Enrolling in quality health coverage

Step two:
Explore your coverage options

Covered California offers four levels of coverage: Bronze, Silver, Gold and Platinum. Insurance companies pay a portion of covered services, and the benefits offered within each level are the same no matter which insurance company you choose.

- **Choose Platinum or Gold** and you'll pay a higher monthly premium, but you'll pay less for medical services.
- **Choose Silver or Bronze** and you'll pay a lower monthly premium, but you'll pay more for medical services.
- **A minimum coverage plan** is available to those under 30 or those 30 and over who have received a hardship exemption from U.S. Department of Health and Human Services.

Shop and Compare

Visit CoveredCA.com and choose "Shop and Compare" to see which brand-name health plans are right for you.

Standard coverage benefits by level

KEY BENEFITS	BRONZE Covers 60% of average annual cost	SILVER Covers 70% of average annual cost	GOLD Covers 80% of average annual cost	PLATINUM Covers 90% of average annual cost
Individual/Family Deductible	$6,300/$12,600	$2,500/$5,000**	No deductible	No deductible
Annual Preventive Care Visit	No cost	No cost	No cost	No cost
Primary Care Visit Copay	$75*	$40	$30	$15
Urgent Care Visit Copay	$75*	$40	$30	$15
Emergency Room Copay	Full cost up to deductible	$350	$325	$150
Generic Medication Copay	Full cost up to $500 deductible	$15	$15	$5
Annual Out-of-Pocket Maximum for One	$7,550	$7,550	$7,200	$3,350
Annual Out-of-Pocket Maximum for Family**	$15,100	$15,100	$14,400	$6,700

Chart does not include all medical copays and coinsurance rates. For complete information, visit CoveredCA.com.

* For Bronze Plans, the deductible is waived for the first three primary care or urgent care visits. Additional visits are charged at full cost until deductible is met.

** Silver is the only level where your deductible and other costs may be lower based on your household income.

COVERED CALIFORNIA

Enrolling in quality health coverage

Step three:
What you need to enroll

The following is needed for every household member who is applying for coverage:

- ☐ Proof of current household income*
- ☐ California ID or driver's license for adults
- ☐ Social Security number or Individual Taxpayer Identification number, if you have one
- ☐ Birth date
- ☐ Home ZIP Code
- ☐ Proof of citizenship or satisfactory immigration status (e.g., U.S. passport, legal resident card, certificate of citizenship or naturalization document)**

The Affordable Care Act (ACA)

As part of the ACA, Covered California is a program where most legal residents of California and their families can compare quality health plans and choose the one that works best for their health needs and budget. The law requires that:

- Preexisting health conditions cannot prevent someone from being covered.
- Your plan cannot be canceled because you are sick or injured.
- Young adults can be covered under their parents' plan until the age of 26.
- All plans include free preventive care.

The ABCs of HMOs, PPOs and EPOs

Most insurance companies offer three types of plans:

HMOs
Health Maintenance Organizations only cover medical services inside the plan's network. HMOs often require members to get a referral from their primary care doctor to see a specialist.

PPOs
Preferred Provider Organizations pay for medical services both inside and outside the plan's network, but members pay a higher amount of the cost for out-of-network care. No referral is required to see a specialist.

EPOs
Exclusive Provider Organizations generally don't cover care outside the plan's network, but members may not need a referral to see an in-network specialist.

It's important to note that not all HMOs, PPOs and EPOs are the same. Before choosing a plan, use the Shop and Compare tool at CoveredCA.com to get details like what doctors and hospitals are covered and what it will cost to see a doctor out-of-network.

* Proof of current income of all members in the tax household, such as a recent tax return, W-2, or pay stub. A dependent's income should only be included if their income level requires them to file a tax return. A household is defined as the person who files taxes as the primary tax filer and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

** You can apply for your child even if you are not eligible. Households that include members who are not lawfully present can also apply.

Enrolling in quality health coverage

Step four:
Create an account and enroll

Enroll in your plan at CoveredCA.com. Simply create a user account and follow the enrollment process with the information in step three.

As always, we're here to help. If you have questions or to find free, local, in-person help, please visit **CoveredCA.com** or call **800.300.1506**.

Step five:
Save your info

Be sure to keep a record of key information regarding your application.

USERNAME

PASSWORD

APPLICATION ID NUMBER

ACCESS CODE

CASE NUMBER

HEALTH INSURANCE COMPANY'S NAME

INSURANCE PLAN INFORMATION (PLAN NUMBER, GROUP NUMBER, ETC.)

NAME AND CONTACT INFORMATION OF THE CERTIFIED ENROLLMENT COUNSELOR (CEC), CERTIFIED INSURANCE AGENT OR PLAN-BASED ENROLLER (PBE) WHO HELPED YOU ENROLL

Step six:
Pay your premium

Be sure to pay your monthly premium in full and on time to ensure that your coverage continues. Failing to pay your premium may disrupt or even cancel your health coverage.

For more information or to find free, local, in-person help, please contact:

Health Insurance Renewal Tracking Checklist

Use this checklist to track the key steps to support Ryan White HIV/AIDS Program (RWHAP) clients who are re-enrolling in health insurance.

Revised September 2017

Some renewal processes differ between states and health insurance programs. Please check with your local Marketplace or state agency about specific procedures.

Clients will require different levels of assistance during the renewal process. Clients changing health care plans or health insurance programs may need more help. Follow the checklist steps that are relevant to each client.

Enrollment Steps

Step 1: Get started.

- ☐ Describe the renewal process, the Open Enrollment time frame, how to submit renewal information, how long it will take, and when renewed benefits start.
- ☐ Describe how the Marketplace will automatically redetermine the client's eligibility for financial help.
- ☐ Discuss the importance of logging into the Marketplace to update information, such as income and household size, and the potential consequences of not reporting changes.

Step 2: Address client concerns, questions, and fears about health insurance.

- ☐ Discuss the client's concerns about renewal and/or insurance.
- ☐ Discuss any changes to the client's current health plan that will take effect in the next year.
- ☐ Talk to the client about his/her current health needs and whether his/her current plan meets those needs.
- ☐ Explain that RWHAP can still provide services not covered by insurance and may help pay some of the costs for health coverage, such as premiums and co-pays.
- ☐ Explain the importance of filing taxes to maintain financial assistance. Tell clients to reconcile their tax credits each year by completing tax Form 8962- using Form 1095-A.

Step 3: Fill-in application.

- ☐ If you do not provide renewal assistance, contact an enrollment assister to help. Help the client find assistance in another language, if necessary.
- ☐ Begin the renewal process, including updating the client's Marketplace or Medicaid information.
- ☐ Explain that to be eligible for tax credits, the client must allow the Marketplace to collect tax information.

Keep track of important dates, outcomes and notes.

Step 3: Fill-in application (continued)

- ☐ Review the client's current health care plan and discuss why and how to change health plans.
- ☐ Help the client select a health care plan. Check with your local ADAP to see if they recommend and/or provide financial support for certain health care plans.
- ☐ Keep track of important dates, outcomes and notes.
- ☐ Submit application.
- ☐ Follow-up on submitted application.

Step 4: Submit application.

- ☐ Explain what happens after the renewal information is submitted, including letters the client may receive.
- ☐ Copy the renewal information for the client and file it (if allowed/ applicable).
- ☐ Submit the renewal application and keep track of the application number, if applicable.

Step 5: Follow-up on submitted application.

- ☐ Support the client to check the status of their renewal application.
- ☐ Update other RWHAP programs, including ADAP, about the client's new enrollment status, including completing any required paperwork.
- ☐ Discuss the client's questions and concerns about his/her renewal status.

Step 6: Use benefits.

- ☐ Talk with the client about how to use insurance, including access to covered medications and services, such as primary and specialty care.
- ☐ Explain how ADAP and other RWHAP providers and services will work with the client's insurance.
- ☐ Discuss what costs the client may be responsible for, and the importance of paying premiums and other costs on time.
- ☐ If needed, help client find a doctor covered by his/her plan.

Step 7: Stay enrolled.

- ☐ Explain when and how to report life changes that may change the client's eligibility for insurance and/or ADAP and allow him/her to qualify for a Special Enrollment Period (SEP).
- ☐ Contact the client before open enrollment begins, or 60-90 days before the renewal date.
- ☐ Talk to the client about how and when to renew health insurance and ADAP eligibility, including the need for client to log into his/her Marketplace account each year to start the redetermination process, review health plan options, and/or pick a new plan.

Keep track of important dates, outcomes and notes.

Are you or your staff helping clients enroll or renew health care coverage for 2018?
Use the ACE TA Center Marketplace Plan Renewal Deadlines and Flowchart as a guide.

This tool was prepared by JSI Research & Training Institute, Inc. and supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Grant #UF2HA26520, Supporting the Continuum of Care: Building Ryan White Program Grantee Capacity to Enroll Eligible Clients in Affordable Care Act Health Coverage Programs. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

2020 Health Care Plan Selection Worksheet

Use this worksheet to help your client choose the best health care plan. The ACE TA Center's Plain Language Glossary of Health Care Enrollment Terms also provides easy to understand explanations of the health care terms in this worksheet. *Revised June 2019.*

Step 1: Get client's current information.

Current prescription medications			HIV-related medication?
1	Drug name		_____ Yes _____ No
2	Drug name		_____ Yes _____ No
3	Drug name		_____ Yes _____ No
4	Drug name		_____ Yes _____ No
5	Drug name		_____ Yes _____ No
6	Drug name		_____ Yes _____ No
7	Drug name		_____ Yes _____ No

Current sources of care

Primary care provider (PCP) _____

Clinic or hospital where PCP is seen _____

Is PCP also an HIV specialist? _____ Yes _____ No

Is PCP certified in specialty infectious disease? _____ Yes (If yes, specialty?) _____ _____ No

HIV specialist (if different than PCP) _____ Clinic or hospital where seen _____

Facility (clinic/hospital) where client goes when sick _____

Mental health provider _____ Clinic or office where seen _____

Substance use provider _____ Clinic or office where seen _____

The ACE TA Center helps RWHAP recipients and subrecipients enroll diverse clients, especially people of color, in health insurance. **www.targethiv.org/ace**

JSI ACE TA CENTER

Other specialist(s)

1. Provider name _____ Clinic or hospital where seen _____

2. Provider name _____ Clinic or hospital where seen _____

Income information

Client household income as a percentage of Federal Poverty Level (FPL)		
$	Percentage (%) FPL	Number of people in household
Note: Federal poverty guidelines change each year. To determine the percent FPL for your client's income, go to https://aspe.hhs.gov/poverty-guidelines		
With this income, can client get ADAP premium/cost-sharing assistance in your area? *Note: Eligibility guidelines and availability of assistance vary in different areas and may only be offered for certain health plans. Use the extra space to write any specific guidelines about the ADAP assistance.*		
Premium assistance	_____ Yes _____ No	Notes:
Co-pay assistance	_____ Yes _____ No	Notes:
Deductible assistance	_____ Yes _____ No	Notes:
Assistance purchasing medications	_____ Yes _____ No	Notes:
With this income, does client qualify for financial help with health insurance costs through the Marketplace? *Note: See Appendix A.*		
Premium tax credits to help lower monthly premium costs	_____ Yes _____ No	
Cost-sharing reductions to lower out-of-pocket costs for deductibles, copays, and coinsurance	_____ Yes _____ No	

Step 2: Compare plans.

	Plan 1 Name:	Plan 2 Name:	Plan 3 Name:
	Company offering plan:	**Company offering plan:**	**Company offering plan:**
Plan general information & cost			
Circle plan "metal" *To receive cost-sharing reductions through the Marketplace, eligible clients must select a Silver level plan.*	Bronze Silver Gold Platinum	Bronze Silver Gold Platinum	Bronze Silver Gold Platinum
Is plan eligible for ADAP premium or co-pay assistance in your area?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Premium client will pay Full premium minus advance premium tax credit or other premium assistance, including ADAP assistance *Note the amount of premium assistance provided by ADAP and the premium tax credit.*	Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount	Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount	Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount
Annual deductible The client may have a lower annual deductible if s/he qualifies for financial help through the Marketplace.	_____In-network _____Out-of-network	_____In-network _____Out-of-network	_____In-network _____Out-of-network

	Plan 1 **Name:**	Plan 2 **Name:**	Plan 3 **Name:**
Does the plan have a separate annual prescription drug deductible? **If yes, what is the amount?**	____No ____Yes $_____	____No ____Yes $_____	____No ____Yes $_____
What coinsurance is the client responsible for? The plan may have different coinsurance percentages for different services. If so, note the percentage for each service. *Note the amount of cost-sharing assistance provided.*			
Out-of-pocket maximum for plan The client may have a lower out-of-pocket maximum if s/he qualifies for financial help through the Marketplace (cost-sharing reductions).			
What is the co-pay for each health service? *If your client is receiving cost-sharing assistance, note the reduced co-pay.* **How many times does the client estimate they will use each health service in the next year?** *Specialty care could include routine HIV care if client's HIV provider is a specialist.*	Primary care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Primary care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Primary care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	Specialty care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Specialty care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*	Specialty care visits $_____ co-pay x _____ number of visits = *$_____estimated client cost*
	TOTAL ESTIMATED CO-PAYS/CO-INSURANCE *Add up total estimate client cost in each column.*		
	Plan 1 total co-pay costs:$_____	Plan 2 total co-pay costs:_____	Plan 3 total co-pay costs:_____

	Plan 1 **Name:**	Plan 2 **Name:**	Plan 3 **Name:**
How much will the client pay in co-pays? *This is only an estimation of co-pays for the client.*	Urgent care visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Urgent care visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Urgent care visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*
	Emergency room visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Emergency room visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Emergency room visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*
	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = $_____*estimated client cost*
	Lab work $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Lab work $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Lab work $_____ co-pay x _____ number of visits = $_____*estimated client cost*
	Mental health visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Mental health visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Mental health visits $_____ co-pay x _____ number of visits = $_____*estimated client cost*
	Substance use disorder visit $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Substance use disorder visit $_____ co-pay x _____ number of visits = $_____*estimated client cost*	Substance use disorder visit $_____ co-pay x _____ number of visits = $_____*estimated client cost*
	TOTAL ESTIMATED CO-PAYS/CO-INSURANCE *Add up total estimate client cost in each column.*		
	Plan 1 total co-pay costs:$_____	Plan 2 total co-pay costs:_____	Plan 3 total co-pay costs:_____

	Plan 1 **Name:**	Plan 2 **Name:**	Plan 3 **Name:**
What is the co-pay for each medication? *If your client is receiving cost-sharing assistance, note the reduced co-pay.* **How many refills does the client estimate in the next year?** **How much will the client pay for medication?** *If client has more than five medications use a blank page to calculate additional costs.*	Medication 1 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 1 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 1 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 2 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 2 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 2 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 4 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 4 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 4 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____*estimated client cost*
	TOTAL ANNUAL ESTIMATED MEDICATION COSTS *Add up total estimate client cost in each column.*		
	Plan 1 total medication costs:$_____	Plan 2 total medication costs:$_____	Plan 3 total medication costs:$_____

	Plan 1 **Name:**		Plan 2 **Name:**		Plan 3 **Name:**	
Provider network						
Are the client's current providers included in-network, out-of-network or both? (Circle)	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Does the plan consider the client's current HIV provider to be a primary care provider or a specialist?	_____ Primary care provider _____ Specialist		_____ Primary care provider _____ Specialist		_____ Primary care provider _____ Specialist	
If a specialist, would the client need a referral from a primary care provider to see his/her HIV specialist?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	
Are the client's preferred medical facilities, such as a specific hospital, included in the plan?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	
Is the client allowed to see out-of-network providers? If yes, what does the client have to do to get approval?	_____ Yes _____ No *If yes, note approval process:*		_____ Yes _____ No *If yes, note approval process:*		_____ Yes _____ No *If yes, note approval process:*	
Do out-of-network visits cost more? **Is yes, what is the additional cost?** Clients who plan to use out-of-network providers and/or facilities should note any additional costs in the estimated co-pay cost above.	_____ Yes _____ No $_____		_____ Yes _____ No $_____		_____ Yes _____ No $_____	
Are plan providers located conveniently for client?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	

	Plan 1 Name:	Plan 2 Name:	Plan 3 Name:
Pharmacy			
Does the plan allow use of ADAP pharmacy/ pharmacies?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Does the plan's drug formulary include the client's current HIV-related drugs? Plans must include at least one drug in each class of core ART medications for ADAP to help with costs.	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Are the client's current non-HIV drugs covered by the plan?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Are there restrictions on drug coverage? For example: Required use of specialty or mail-order pharmacy, prior authorization, step therapy.	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No

	Plan 1 **Name:**			Plan 2 **Name:**			Plan 3 **Name:**		
Access to additional services									
		Covered Service	Referral Required		Covered Service	Referral Required		Covered Service	Referral Required
What other needed services are covered by the plan? *Check all that apply.* **Would the client require a referral to access these services?** *Check all that apply.*	Mental/behavioral health			Mental/behavioral health			Mental/behavioral health		
	Substance use disorder			Substance use disorder			Substance use disorder		
	Vision			Vision			Vision		
	Oral health/dental			Oral health/dental			Oral health/dental		
	Chiropractic care			Chiropractic care			Chiropractic care		
	Laboratory services			Laboratory services			Laboratory services		
	X-ray/imaging services			X-ray/imaging services			X-ray/imaging services		
	Durable medical equipment			Durable medical equipment			Durable medical equipment		
	Home health services			Home health services			Home health services		
	Nutritional counseling/medical nutrition therapy			Nutritional counseling/medical nutrition therapy			Nutritional counseling/medical nutrition therapy		
	Case management			Case management			Case management		
	Other_____			Other_____			Other_____		
Does the plan limit the number of visits for specific services?	Mental health	Yes	No	Mental health	Yes	No	Mental health	Yes	No
	Substance use disorder	Yes	No	Substance use disorder	Yes	No	Substance use disorder	Yes	No
	Dental	Yes	No	Dental	Yes	No	Dental	Yes	No
	Other	Yes	No	Other	Yes	No	Other	Yes	No

Adapted from:

- Colorado Consumer Health Initiative CoveredU.org
  http://coveredu.org/shop/intro
- National Health Council Putting Patients First Estimate My Costs Calculator
  http://www.puttingpatientsfirst.net/calc
- Harvard Law School Center for Health Law & Policy Innovation's Marketplace Health Plans Assessment Workbook
  http://www.hivhealthreform.org/wp-content/uploads/2013/10/HLP-Market-Place-Health-Plan-Assesment-Tool-updated-10.23.pdf
- HIV Health Reform's Passport to Health Care
  http://www.hivhealthreform.org/wp-content/uploads/2013/10/ACA-Passport-how-I-get-my-care.pdf
- NASTAD's Health Reform Issue Brief: Plan Assessment Tools for Insurance
  http://www.nastad.org/Docs/045101_HCA-Brief-Plan%20Assessment-10.25.13.pdf

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Appendix A

Quick check chart: Do I qualify to save on health insurance coverage?

To learn if you qualify for lower costs on health coverage, find your estimated 2020 household income and household size on the chart below.

Choose the column for your household size.* The column on the left shows income levels that qualify for lower costs on premiums and out-of-pocket costs for private health insurance, and for low-cost health care through Medicaid. Remember to update your income and/or household size information if there are any changes throughout the year so that any financial assistance with premium and out-of-pocket costs is accurately calculated.

		Number of people in your household					
		1	2	3	4	5	6
Private Marketplace Health Plans	You may qualify for **lower premiums on a Marketplace insurance plan** (Premium Tax Credits) if your yearly income is between… *See next row if your income is at the lower end of this range*	$12,490-$49,960	$16,910-$67,640	$21,330-$85,320	$25,750-$103,000	$30,170-$120,680	$34,590-$138,360
	You may qualify **for lower premiums AND out-of-pocket costs for Marketplace insurance** (Premium Tax Credits and cost-sharing reductions) if your yearly income is between…	$12,490-$31,225	$16,910-$42,275	$21,330-$53,325	$25,750-$64,375	$30,170-$75,425	$34,590-$86,475
Medicaid Coverage	If your state has expanded Medicaid: You may qualify for **Medicaid coverage** if your yearly income is below…	$17,236	$22,335	$29,435	$35,535	$41,634	$47,734
	If your state isn't expanding Medicaid: **You may not qualify for any Marketplace savings programs** if your yearly income is below…	$12,490	$16,910	$21,330	$25,750	$30,170	$34,590

*Include in your household everyone you will claim as a dependent on your tax return and any children who live with you. To view instructions on calculating income, see: https://www.healthcare.gov/how-can-i-save-money-on-marketplace-coverage-chart/. Adapted from HealthCare.gov

COVERED CALIFORNIA™

2020 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **73%** average annual cost	Covers **87%** average annual cost	Covers **94%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	**$24,981 to $31,225 (>200% to ≤250% FPL)**	**$18,736 to $24,980 (>150% to ≤200% FPL)**	**up to $18,735 (100% to ≤150% FPL)**	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$40	$35	$15	$5	$30	$15
Urgent Care		$65*	$40	$35	$15	$5	$30	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$80	$75	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Laboratory Tests		$40	$40	$40	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$85	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$275 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$16**	$16**	$5 or less	$3 or less	$15 or less	$5 or less
Tier 2 (Preferred Drugs)		40% up to $500 after drug deductible is met	$60**	$55**	$25**	$10 or less	$55 or less	$15 or less
Tier 3 (Non-preferred Drugs)			$90**	$85**	$45**	$15 or less	$80 or less	$25 or less
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150** per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $4,000 Family: $8,000	Individual: $3,700 Family: $7,400	Individual: $1,400 Family: $2,800	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $300 Family: $600	Individual: $275 Family: $550	Individual: $100 Family: $200	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$8,150 individual only	$7,800 individual $15,600 family	$7,800 individual $15,600 family	$6,500 individual $13,000 family	$2,700 individual $5,400 family	$1,000 individual $2,000 family	$7,800 individual $15,600 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

Medical Networks:

Health Maintenance organization (HMO)

Upside of an HMO	Downside of an HMO
✓ You typically pay less premiums and co-pays	▪ You need to choose a PCP
✓ You typically have no or low deductibles	▪ You need a referral to see a specialist
✓ Your PCP manages your healthcare	▪ You typically pay the full amount in healthcare costs for out-of-network care
✓ HMOs emphasize preventative and routine care (physicals, screenings, and immunizations)	▪ You typically have a smaller network of doctors to chose from
✓ Coverage for emergency care, even if out-of-network	▪ Your PCP decides which specialist you see
	▪ Dependents must see in network doctors even if they live away from home

Medical Networks:

Preferred provider Organization (PPO)

Upside of a PPO	Downside of a PPO
✓ You don't need to choose a PCP ✓ You don't need a referral from a PCP to see a specialist ✓ You'll pay the least amount of costs if you stay in network ✓ You can visit any doctor at anytime ✓ You have a wider network of doctors to choose form	▪ You typically have to pay more in monthly premiums and out-of-pocket costs ▪ You find your own specialist and health care facilities ▪ You plan when you see a doctor for routine or specialized care ▪ Out-of-network services may be covered at a lower percentage, and you pay the difference.

Medical Networks:

Exclusive provider organization (EPO)

Upside of a EPO	Downside of a EPO
✓ Typically medium to low premium costs ✓ Copay costs are predetermined based on facility ✓ You don't need to choose a PCP ✓ You don't need a referral from a PCP to see a specialist ✓ You'll have a network of pre-approved doctors within the EPO network ✓ Emergency and Urgent care services are covered even if outside of network	▪ You are restricted to a limited network ▪ Any services or doctors you see outside of the network are not covered, (except emergency and urgent care) ▪ You find your own doctors and facilities within network lists.

Immigration Status and Eligibility

What You Need to Know

What if I'm from a Mixed Immigration Status Family?

If your family includes some noncitizens that are not lawfully present, you can still apply for health care through Covered California. When applying, remember that family members who are not lawfully present are not eligible for Covered California health plans, but may be eligible for Medi-Cal.

Interpreters are available for callers seeking help in other languages

CoveredCA.com
(800) 300-1506

Welcome to Covered California

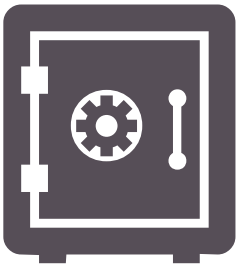
Covered California™ is a place where you can compare and shop for private health insurance plans, and get financial assistance to pay for health coverage if you qualify.

Who is Eligible for Covered California?

All U.S. citizens, U.S. nationals and noncitizens lawfully present in California may apply for health care through Covered California.

Who is Not Eligible for Covered California?

If you are not lawfully present in California, you are not eligible for a Covered California plan. However, you can still apply through Covered California to find out if you are eligible for Medi-Cal or to find coverage for family members who are lawfully present. For example, if your child is a U.S. citizen, you can apply on his or her behalf. You only need to provide information on immigrant status for family members applying for coverage.



Your Immigration Status Will Be Kept Confidential

All immigration information provided to Covered California will be kept private and secure. It will not be shared with or used by any immigration agency to enforce immigration laws.

Signing Up for Covered California Will Not Affect Your Immigrant Status

In general, receiving help to pay for a Covered California health plan or receiving coverage through Medi-Cal will not affect immigration status or the chances of becoming a citizen or lawful permanent resident of the U.S.

For more information or to find free, confidential local help, please contact:

El estado migratorio y la elegibilidad

Lo que debes saber

Bienvenido a Covered California

Covered California™ es un lugar donde puedes buscar y comparar planes de seguro de salud privados, y obtener asistencia financiera para pagar por tu cobertura de salud si calificas.

¿Quiénes califican para Covered California?

Todos los ciudadanos de los Estados Unidos, los nacionalizados y no ciudadanos con presencia legal en California pueden solicitar cobertura de salud a través de Covered California.

¿Quiénes no califican para Covered California?

Si no estás legalmente presente en California, no calificas para un plan de salud a través de Covered California. Sin embargo, puedes solicitar a través de Covered California para saber si calificas para Medi-Cal o para encontrar cobertura para los miembros de tu familia que sí están presentes legalmente. Por ejemplo, puedes solicitar en nombre de un hijo que es ciudadano de los Estados Unidos. Sólo tienes que proveer información del estado migratorio de los miembros de la familia que solicitan cobertura.

Tu estado migratorio permanecerá confidencial

Toda la información sobre tu estado migratorio que proveas a Covered California permanecerá privada y segura. No compartiremos información con agencias de inmigración ni será usada para ejercer leyes migratorias.

Inscribirte a través de Covered California no afectará tu estado migratorio

Por lo general, tu estado migratorio o tus posibilidades de convertirte en ciudadano o residente legal permanente de los Estados Unidos no se verán afectadas si recibes ayuda para pagar por un plan de salud a través de Covered California, o cobertura a través de Medi-Cal.

Para más información, o para encontrar ayuda gratis y confidencial, por favor comunícate con nosotros:

¿Qué pasa si el estado migratorio de mi familia es mixto?

Aun si tu familia incluye personas no ciudadanas y sin presencia legal, puedes solicitar cobertura de salud a través de Covered California. Cuando solicites, recuerda que los familiares que no están presentes legalmente no califican para planes de salud a través de Covered California, pero sí podrían calificar para Medi-Cal.

Tenemos intérpretes disponibles para los consumidores que quieran obtener ayuda en otros idiomas

CoveredCA.com/espanol
(800) 300-0213

PROGRAM ELIGIBILITY BY FEDERAL POVERTY LEVEL FOR 2019

Medi-Cal and Covered California have various programs with overlapping income limits.

COVERED CALIFORNIA

PREMIUM ASSISTANCE

AMERICAN INDIAN / ALASKA NATIVE PLANS

ENHANCED SILVER PLANS (100%-250%)

SILVER 94 (100%-150%) | SILVER 87 (>150%-200%) | SILVER 73 (>200%-250%)

HOUSEHOLD SIZE	% OF FPL	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%
	1	$12,140	$17,237	$18,210	$24,280	$26,604	$30,350	$33,224	$36,420	$40,218	$48,560
	2	$16,460	$23,336	$24,690	$32,920	$36,019	$41,150	$44,981	$49,380	$54,451	$65,840
	3	$20,780	$29,436	$31,170	$41,560	$45,433	$51,950	$56,738	$62,340	$68,683	$83,120
	4	$25,100	$35,535	$37,650	$50,200	$54,848	$62,750	$68,495	$75,300	$82,915	$100,400
	5	$29,420	$41,635	$44,130	$58,840	$64,263	$73,550	$80,253	$88,260	$97,148	$117,680
	6	$33,740	$47,735	$50,610	$67,480	$73,677	$84,350	$92,010	$101,220	$111,380	$134,960
	7	$38,060	$53,834	$57,090	$76,120	$83,092	$95,150	$103,767	$114,180	$125,613	$152,240
	8	$42,380	$59,934	$63,570	$84,760	$92,506	$105,950	$115,524	$127,140	$139,845	$169,520
	each additional person, add	$4,320	$6,100	$6,480	$8,640	$9,415	$10,800	$11,758	$12,960	$14,233	$17,280

DHCS California Department of HealthCareServices

MEDI-CAL FOR ADULTS | MEDI-CAL FOR PREGNANT WOMEN | MEDI-CAL ACCESS PROGRAM (FOR PREGNANT WOMEN)

MEDI-CAL FOR KIDS (0-18 yrs.) | COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

Medi-Cal uses FPL limits of the current year to determine eligibility for its programs. The column headings shaded in purple are associated with eligibility ranges for Medi-Cal programs:

- Medi-Cal for Adults up to 138% FPL
- Medi-Cal for Children up to 266% FPL
- Medi-Cal for Pregnant Women: up to 213% FPL
- MCAP: over 213% - 322% FPL
- CCHIP: over 266% - 322% FPL

The shaded columns display 2019 FPL values according to the Department of Health Care Services (see annual values on page 4) which administers the Medi-Cal program.

Covered California uses FPL limits from the prior year to determine eligibility for its programs as required by regulation. The unshaded columns are associated with Covered California eligibility ranges:

Premium Assistance **100% - 400% FPL**

Enhanced Silver Plans *100% - 250% FPL*

- Silver 94 100% - 150% FPL
- Silver 87 over 150% - 200% FPL
- Silver 73 over 200% - 250% FPL

American Indian/ Alaska Native Plans *100% - 300% FPL*

The unshaded columns display 2018 FPL values to determine eligibility for premium tax credits and cost sharing reductions for health plans effective in 2019. The unshaded columns, including the 100% column, display 2018 FPL values as published by the Department of Health and Human Services.

Qualified Dental Plan Application
Plan Year 2020
Covered California for Small Business
March 1, 2019

Table of Contents

1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Exchange) is accepting applications from eligible Dental Issuers[1] (Applicants) to submit proposals to offer, market, and sell qualified dental plans (QDPs) through the Exchange beginning in 2019, for coverage effective January 1, 2020. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for the 2020 Plan Year. QDP Issuers contracted for Plan Year 2019 will complete a simplified certification application since those issuers have a contract with the Exchange that imposes ongoing requirements that are similar to or satisfy the requirements in the certification application and consideration of this contract performance is included in the evaluation process. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange for Plan Year 2020. The Exchange reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 Background

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California enacted legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq). The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).
The Exchange offers a statewide health insurance exchange to make it easier for individuals to compare plans and buy health insurance in the private market. Although the focus of the Exchange is on individuals who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals. The vision of the Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.
The Exchange is guided by the following values:

- **Consumer-Focused**: At the center of the Exchange's efforts are the people it serves. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.
- **Affordability**: The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst**: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

- **Integrity**: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Transparency**: The Exchange will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.
- **Results**: The impact of the Exchange will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace is transforming from one that has prioritized profitability through a focus on risk selection to one that rewards better care, affordability, and prevention. The Exchange needs to address these issues for the millions of Californians who enroll through the Exchange to get coverage, but it is also part of broader efforts to improve care, improve health, and stabilize rising health care costs throughout the state.

The Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance operates in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans (QHPs) that will be offered in the Exchange.

The state legislation to establish the Exchange gave authority to the Exchange to selectively contract with issuers so as to provide health care coverage options that offer the optimal combination of choice, value, quality, and service and to establish and use a competitive process to select the participating health issuers.

These concepts, and the inherent trade-offs among the Exchange values, must be balanced in the evaluation and selection of the Qualified Health Plans that will be offered in Covered California for Small Business.

This application has been designed consistent with the policies and strategies of the Exchange Board which calls for the QHP selection to influence the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

1.3 Application Evaluation and Selection

The evaluation of QDP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health and dental plans for each region of California that best meet the needs of consumers in that region and the Exchange's goals. The Exchange wants to provide an appropriate range of high quality health plans to participants at the best available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications for 2020. These guidelines are:

Promote affordability for the consumer– both in terms of premium and at point of care

The Exchange seeks to offer health plans, plan designs and provider networks that are as affordable as possible to consumers both in premiums and cost sharing, while fostering competition and stable premiums. The Exchange will seek to offer health plans, products, and provider networks that will attract maximum enrollment as part of its effort to lower costs by spreading risk as broadly as possible.

Encourage "Value" Competition Based upon Quality, Service, and Price

While premium will be a key consideration, contracts will be awarded based on the determination of "best value" to the Exchange and its participants. The evaluation of Issuer QDP proposals will focus on quality and service components, including history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population. This commitment to serve the Exchange population is evidenced through general cooperation with the Exchange's operations and contractual requirements which include provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by the Exchange and used as part of the selection criteria to offer issuers' products on the Exchange for the 2020 plan year.

Encourage Competition Based upon Meaningful QDP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs[2]

The Exchange is committed to fostering competition by offering QDPs with features that present clear choice, product and provider network differentiation. QDP Applicants are required to adhere to the Exchange's standard benefit plan designs in each region for which they submit a proposal. The Exchange is interested in having HMO and PPO products offered statewide. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad

overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State
The Exchange must be statewide. Issuers must submit QDP proposals in all geographic service areas in which they are licensed and have an adequate network, and preference will be given to Issuers that develop QDP proposals that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state.

Encourage Alignment with Providers and Delivery Systems that Serve the Low-Income Population
Performing effective outreach, enrollment and retention of the low-income population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange is central to the Exchange's mission. Responses that demonstrate an ongoing commitment to the low-income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low income and uninsured populations beyond the minimum requirements adopted by the Exchange will receive additional consideration. Examples of demonstrated commitment include: having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution, having contracts with Federally Qualified Health Centers, and supporting or investing in providers and networks that have historically served these populations to improve service delivery and integration.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform
One of the values of the Exchange is to serve as a catalyst for the improvement of care, prevention and wellness to reduce costs. The Exchange wants QDP offerings that incorporate innovations in delivery system improvement, prevention and wellness, and/or payment reform that will help foster these broad goals. This will include models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention, or efforts to increase reporting transparency to provide relevant health care comparisons and to increase member engagement in decisions about their course of care.

Demonstrate Administrative Capability and Financial Solvency
The Exchange will review and consider Applicant's degree of financial risk to avoid potential threats of failure which would have negative implications for continuity of patient care and for the healthcare system. The Issuer's technology capability is a critical component for success on the Exchange, so Applicant's technology and associated resources are heavily scrutinized as this relates to long term sustainability for consumers. Additionally, in recognition of the significant investment that will continue to be needed in areas of quality reform and improvement programs, the Exchange offered a multi – year contract agreement through the 2017 application. Application responses that demonstrate a commitment to the long-term success of the Exchange's mission are strongly encouraged.

Encourage Robust Customer Service
The Exchange is committed to ensuring a positive consumer experience, which requires Issuers to maintain adequate resources to meet consumers' needs. To successfully serve Exchange consumers, Issuers must invest in and sustain adequate staffing, including hiring of bilingual and bicultural staff as appropriate and maintaining internal training as needed. Issuers demonstrating a commitment to dedicated administrative resources for Exchange consumers will receive additional consideration.

1.4 Availability

Applicant must be available immediately upon contingent certification of its plans as QDPs to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide dental plan services effective January 1, 2020. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange, including meeting data interface requirements of the system operated by Pinnacle HCMS. Successful Applicants must execute the QDP Issuer contract before public announcement of contingent certification. Failure to execute the QDP Issuer contract may preclude Applicant from offering QDPs through the Exchange. The successful Applicants must be ready and able to accept enrollment as of October 1, 2019.

1.5 Application Process

The application process shall consist of the following steps:

- Release of the Final Application;
- Submission of Applicant responses;
- Evaluation of Applicant responses;
- Discussion and negotiation of final contract terms, conditions and premium rates; and
- Execution of contracts with the selected QDP Issuers.

1.6 Intention to Submit a Response

Applicants interested in responding to this application must submit a non-binding Letter of Intent to Apply, identifying their proposed products and service areas. Only those Applicants who submit the Letter of Intent will continue to receive application-related correspondence throughout the application process.

Applicant's Letter of Intent must identify the contact person for the application process, along with contact information that includes an email address and a telephone number. On receipt of the Letter of Intent, the Exchange will issue instructions and a password to gain access to the online Application. A Letter of Intent will be considered confidential and not available to the public. However, the Exchange reserves the right to release aggregate information about all Applicants' responses. Final Applicant information is not expected to be released until the selected Issuers and QDPs are announced. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators.

The Exchange will correspond with only one (1) contact person per Application. It is Applicant's responsibility to immediately notify the Application Contact identified in this section, in writing, regarding any revision to the contact information. The Exchange is not responsible for application correspondence not received by Applicant if Applicant fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

Application Contact: Meiling Hunter
QHPCertification@covered.ca.gov
(916) 228-8696

1.7 Key Action Dates

Action	Date/Time
Release of Draft Application for Comment	December 2018
Letters of Intent due to the Exchange	February 15, 2019
Application Opens	March 1, 2019
Completed Applications Due (include 2020 Proposed Rates & Networks)	June 1, 2019
Negotiations between Applicants and Covered California	July 2019
Final QDP Contingent Certification Decisions	August 2019
QDP Contract Execution	September 2019
Final QDP Certification	October 2019

1.8 Preparation of Application Response

Application responses are completed in an electronic proposal software program. Applicants will have access to a Question and Answer function within the portal and may submit questions related to the Application through this mechanism.
Applicants must respond to each Application question as directed by the response type. Responses should be succinct and address all components of the question. Applicants may not submit documents in place of responding to individual questions in the space provided.

2 Administration and Attestation

Questions 2.1 and 2.3 are required for currently contracted Applicants. All questions required for new entrant Applicants.

2.1 Attestation

Applicant must complete the following:
No space for details provided.

Issuer Legal Name	*10 words.*
Entity name used in consumer-facing materials or communications	*10 words.*
NAIC Company Code	*10 words.*
NAIC Group Code	*10 words.*
Regulator(s)	*10 words.*
Federal Employer ID	*10 words.*
HIOS/Issuer ID	*10 words.*
Applicant tax status	*Single, Pull-down list.* 1: Not-for-profit, 2: For-profit
Year Applicant was founded	*10 words.*
Corporate Office Address	*10 words.*
City	*10 words.*
State	*10 words.*
Zip Code	*10 words.*
Primary Contact Name	*10 words.*
Contact Title	*10 words.*
Contact Phone Number	*10 words.*
Contact Email	*10 words.*
Applicant Eligibility	*Single, Pull-down list.* 1: Contracted in 2019, 2: New Entrant Applicant
Indicate if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.	*Single, Pull-down list.* 1: Yes, application will be completed, 2: No, application will not be completed

On behalf of Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that the Exchange may review the validity of my attestations and the information provided in response to this Application and if any Applicant is selected to offer Qualified Dental Plans, may decertify those Qualified Dental Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	*10 words.*
Signature	*10 words.*
Printed Name	*10 words.*
Title	*10 words.*

2.2 Applicant must attach a functional organizational chart of key personnel who will be assigned to the Exchange. The chart will identify key individual(s) who will have primary responsibility for servicing the Exchange account and flow of responsibilities. The functional organizational chart should include the following representatives with contact information:

- Chief Executive Officer
- Chief Finance Officer
- Chief Operations Officer
- Contracts
- Plan and Benefit Design
- Network and Quality
- Enrollment and Eligibility
- Legal
- Marketing and Communications
- Information Technology
- Information Security
- Policy
- Dedicated Liaison

No space for details provided.
Single, Pull-down list.
Answer and attachment required
1: Attached,
2: Not attached

2.3 Does Applicant anticipate making material changes in corporate structure in the next 24 months, including but not limited to:

- Mergers
- Acquisitions
- New venture capital
- Management team
- Location of corporate headquarters or tax domicile

- Stock issue
- Other

If yes, Applicant must describe the material changes.
Single, Radio group.
1: Yes, describe [200 words] ,
2: No

2.4 Attach a copy of Applicant's Certificate of Insurance to verify that it maintains the following insurance:

Commercial General Liability	Limit of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate
Comprehensive Business Automobile Liability	Limit of not less than 1,000,000 per accident
Employers Liability Insurance	Limits of not less than $1,000,000 per accident for bodily injury by accident and $1,000,000 per employee for bodily injury by disease and $1,000,000 disease policy limit.
Umbrella Policy	An amount not less than $10,000,000 per occurrence and in the aggregate
Crime Coverage	At such levels reasonably determined by Contractor to cover occurrences
Professional Liability or Errors and Omissions	Coverage of not less than $1,000,000 per claim/ $2,000,000 general aggregate.
Statutory CA's Workers' Compensation Coverage	Provide Proof of Coverage

If Applicant's organization does not carry the coverages or limits listed above, provide an explanation why Applicant has elected not to carry each coverage or limit.
Answer and attachment required
Single, Radio group.
1: Yes, attached,
2: No, attached, describe: [200 words]

2.5 Indicate any experience Applicant has participating in exchanges or marketplace environments
No space for details provided.

State-based Marketplace(s), specify state(s) and years of participation	*100 words.*
Federally-Facilitated Marketplace, specify state(s) and years of participation	*100 words.*

Private Exchange(s), specify exchange(s) and years of participation	*100 words.*

3 Licensed and Good Standing

Questions required only for new entrant Applicants.

3.1 Indicate Applicant license status below:
Single, Radio group.
1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a dental issuer as defined herein in the commercial small group market,
2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a dental issuer as defined herein in the commercial small group market,
3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a dental issuer as defined herein in the commercial small group market. If Yes, enter date application was filed: [To the day] ,
4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a dental issuer as defined herein in the commercial small group market. If yes, enter date application was filed: [To the day]

3.2 In addition to holding or pursuing all proper and required licenses to operate as a Dental Issuer, Applicant must confirm that it has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years (See Appendix A Definition of Good Standing). The Exchange, in its sole discretion and in consultation with the appropriate dental insurance regulator, determines what constitutes a material violation for the purpose of determining Good Standing. Applicant must check the appropriate box. If Applicant does not confirm, the Application will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed
Attached Document(s): Appendix A Definition of Good Standing.pdf

3.3 If not currently holding a license to operate in California, confirm that Applicant has had no material fines, no material penalties levied, and no material ongoing disputes with applicable licensing authorities in the last two years.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed,
3: Not applicable

4 Applicant Health Plan Proposal

Questions 4.3 - 4.6 are required for currently contracted Applicants. Questions 4.1 – 4.5 are required for new entrant Applicants.

Applicant must submit a dental plan proposal in accordance with all requirements outlined in this section.

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

Applicant may submit proposals to offer both a Children's Dental Plan and a Family Dental Plan. Applicant may submit DPPO and DHMO product proposals in its proposed rating regions. Applicant's proposal must include coverage of its entire licensed geographic service area for which it has adequate network. Applicant may not submit a proposal that includes a tiered network. Applicants must adhere to the Exchange's standard benefit plan designs and the requirements in this section without deviation unless approved by the Exchange.

4.1 Applicant must certify its proposal includes a dental product including the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Yes, proposal meets requirements,
2: No

4.2 Applicant must confirm it will adhere to Exchange naming conventions for on-Exchange plans and off-Exchange mirror products where applicable, pursuant to Government Code 100503(f).
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

4.3 Preliminary Premium Proposals: Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2020. Premium proposals are considered preliminary and may be subject to negotiation as part of QDP certification and selection. Premium proposals must be submitted with the Application. To submit premium proposals for Individual products, Applicant must complete and upload through System for Electronic Rate and Form

Filing (SERFF) the Rates Template available at: https://www.qhpcertification.cms.gov/s/QHP. Premium may vary only by geography (rating region), by age, and by actuarial value.

Dental plan premiums for adults 21 and over will be additive and calculated on a per member basis. The same rate must be charged for adults 19 years and older. The single adult rate will be assessed for each adult in the plan. The same rate must be charged for children age 0 – 18. The single child rate will be multiplied by two for a policy covering two children and by three for policies covering two or more children. Individuals ages 19 and 20 will be assessed the single adult rate, and only for purposes of summing total family premium will be considered as children when limiting the total family premium to no more than the three oldest covered children premiums together with covered adult premiums.

Applicant shall provide, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange-specific rate development process. This information may be necessary to support the assumptions made in forecasting and may be supported by information from Applicant's actuarial systems pertaining to the Exchange-specific account.
No space for details provided.
Single, Pull-down list.
1: Template Uploaded,
2: Template not Uploaded

4.4 Applicant must certify that for each rating region in which it submits a health plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. Complete Attachment A (Plan Type by Rating Region (Small Business Market)) to indicate the rating regions and number and type of plans for which Applicant is proposing a QHP in the Individual Exchange. To indicate which zip codes are within the licensed geographic service area by proposed Exchange product, complete and upload through SERFF the Service Area Template located at: https://www.qhpcertification.cms.gov/s/QHP.
No space for details provided.
Single, Pull-down list.
1: Yes, dental plan proposal covers entire licensed geographic service area; template uploaded, and attachment submitted,
2: No, dental plan proposal does not cover entire licensed geographic service area; template uploaded, and attachment submitted
Attached Document(s): Attachment A - Plan Type by Rating Region - Zip Code CCSB QDP.xlsx

4.5 Applicant must indicate if it is requesting changes to licensed geographic service area with the regulator, and if so, submit a copy of the applicable exhibit filed with regulator.
No space for details provided.
Single, Pull-down list.

1: Yes, filing service area expansion, exhibit attached,
2: Yes, filing service area withdrawal, exhibit attached,
3: No, no changes to service area

4.6 Applicant must complete and upload through SERFF the Plan ID Crosswalk located at: https://www.qhpcertification.cms.gov/s/QHP.
Single, Pull-down list.
1: Template completed and uploaded,
2: Template not completed and uploaded

5 Benefit Design

All questions are required for currently contracted Applicants and new entrant Applicants.

5.1 Applicant must certify its proposed dental products include the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Yes,
2: No

5.2 If applicable, Applicant must certify its proposed dental products include coverage of Diagnostic, Preventive, Restorative, Periodontics, Endodontics, Prosthodontics and Oral Surgery services for adults age 19 years and older comparable to those benefits found in Applicant's commercially available dental plan products for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.
No space for details provided.
Single, Pull-down list.
1: Yes,
2: No,
3: Not Applicable, only offering Children's Dental Plan

5.3 Applicant must comply with 2020 Patient-Centered Benefit Plans Designs. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Plans and Benefits template located at: https://www.qhpcertification.cms.gov/s/QHP.
No space for details provided.
Single, Pull-down list.
1: Confirmed, template submitted,
2: Not confirmed, template not submitted

5.4 Applicant must submit, as an attachment, draft Evidence of Coverage or Policy language and draft Schedules of Benefits describing proposed 2020 QDP benefits.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

5.5 Applicant must indicate how it provides plan enrollees with current information regarding annual out-of-pocket costs to date. Select all that apply.
Multi, Checkboxes.
1: Status of out-of-pocket costs provided through member login to the dental plan website,
2: Status of out-of-pocket costs provided by mailed document upon request,
3: Status of out-of-pocket costs available upon member request to customer service,
4: Other, describe: [20 words] ,
5: Status of out-of-pocket costs not provided

5.6 Applicant must indicate how it provides plan enrollees with current information regarding total oral health care services received to date. Select all that apply.
Multi, Checkboxes.
1: Status of oral health services received to date provided through member login to the dental plan website,
2: Status of oral health services received to date provided by mailed document upon request,
3: Status of oral health services received to date available upon member request to customer service,
4: Other, describe: [20 words] ,
5: Status of oral health services received to date not provided

5.7 If applicable, Applicant must indicate how it provides plan enrollees with current information regarding annual status of deductible and status of benefit limit. Select all that apply.
Multi, Checkboxes.
1: Status of deductible and benefit limit provided through member login to the dental plan website,
2: Status of deductible and benefit limit provided by mailed document upon request,
3: Status of deductible and benefit limit available upon member request to customer service,
4: Other, describe: [20 words] ,
5: Status of deductible and benefit limit not provided,
6: Not Applicable

5.8 Applicant must indicate if proposed QDPs will include coverage of non-emergent out-of-network services.
Single, Radio group.
1: Yes, proposed DPPO QDPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe the administration of out-of-network benefits including consumer communications, pricing methodology, and claims adjudication: [50 words] ,
2: No, proposed DPPO QDPs will not include coverage of non-emergent out-of-network services.,
3: No, offering a DHMO QDPs

6 Operational Capacity

6.1 Issuer Operations and Account Management Support

Questions 6.1.1 - 6.1.2 are required for currently contracted Applicants. All questions required for new entrant Applicants.

6.1.1 Applicant must complete Attachments C1 Current and Projected Enrollment and C2 California Off-Exchange Enrollment. Applicant must complete all data points for their lines of business (including Employer-Based coverage, Individual Market, and Government Payers) to provide current enrollment and enrollment projections. Failure to complete Attachments C1 and C2 will require a resubmission of the templates.
No space for details provided.
Single, Pull-down list.
Answer and attachment required
1: Attachments completed,
2: Attachments not completed
Attached Document(s): Attachments C1 C2 - CCSB QDP.xlsx

6.1.2 Applicant must provide a description of any initiatives over the next 24 months which may impact the delivery of services to Exchange enrollees including but not limited to: System changes or migrations, Call center openings, closings, or relocations, Network re-contracting, and vendor changes or other changes during the contract period. Applicant must include including a timeline, either current or planned.
200 words.

6.1.3 Does Applicant routinely subcontract any significant portion of its operations or partner with other companies to provide dental plan coverage? If yes, identify which operations are performed by subcontractor or partner and provide the name of the subcontractor.
No space for details provided.

	Response	Description	Conducted outside of the United States?
Billing, invoice, and collection activities	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Database and/or enrollment transactions	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Claims processing and invoicing	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No

Membership/customer service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Welcome package (ID cards, member communications, etc.)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No
Other (specify)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*	*Single, Pull-down list.* 1: Yes, 2: No

6.1.4 Applicant must provide a summary of its operational capabilities, including how long it has been a licensed dental issuer. For example, enrollment system, claims, provider services, sales, etc.
100 words.

6.2 Implementation Performance
Question 6.2.1 required for currently contracted Applicants. All questions are required for new entrant Applicants.
6.2.1 Applicant must complete Attachment F Implementation Organizational Chart and include a detailed implementation plan.
Answer and attachment required
Attached Document(s): Attachment F Implementation Organizational Chart.xlsx
Single, Radio group.
1: Yes attached, describe: [100 words] ,
2: No; Not attached,
3: No, Applicant is currently operating in the Exchange

6.2.2 Applicant must submit a Renewal and Open Enrollment Readiness Plan. Applicant must include in their plan a timeline (dates) for Communications (Regulated and Marketed), system and website updates and readiness, and trainings for staff and agents.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

6.2.3 Applicant must describe current or planned procedures for managing new enrollees. Address availability of customer service prior to coverage effective date, new member orientations, and describe what member communications regarding change in plans are provided to new enrollees.
200 words.

6.2.4 Identify the percentage increase of membership that will require adjustment to Applicant's current resources:
No space for details provided.

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	*Percent.*	*50 words.*	*50 words.*
Claims	*Percent.*	*50 words.*	*50 words.*
Account Management	*Percent.*	*50 words.*	*50 words.*
Clinical staff	*Percent.*	*50 words.*	*50 words.*
Disease Management staff	*Percent.*	*50 words.*	*50 words.*
Implementation	*Percent.*	*50 words.*	*50 words.*
Financial	*Percent.*	*50 words.*	*50 words.*
Administrative	*Percent.*	*50 words.*	*50 words.*
Actuarial	*Percent.*	*50 words.*	*50 words.*
Information Technology	*Percent.*	*50 words.*	*50 words.*
Other (List)	*Percent.*	*50 words.*	*50 words.*

7 Customer Service

Questions required only for new entrant Applicants.

7.1 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

7.2 If certified, Applicant will be required to meet certain member services performance standards. During Open Enrollment, Exchange operating hours are 8 am to 8 pm Monday through Friday (except holidays) and 8 a.m. to 6 p.m. Saturdays. Applicant must confirm it will match Exchange Open Enrollment Customer Service operating hours. Describe how Applicant will modify customer service center operations to meet Exchange-required operating hours if applicable. Describe how Applicant will modify current Interactive Voice Response (IVR) system to meet exchange required operating hours.
Single, Radio group.
1: Confirmed, explain: [100 words] ,
2: Not confirmed

7.3 Applicant must list internal daily monitored Service Center Statistics. What is the daily service level goal? For example, 80% of calls answered within 30 seconds.
50 words.

7.4 Applicant must provide the ratio of Customer Service Representatives to members for teams that support Exchange business.
10 words.

7.5 Applicant must indicate which of the following training modalities are used to train new Customer Service Representatives, check all that apply:
Multi, Checkboxes.
1: Instructor-Led Training Sessions,
2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment),
3: Video Training,
4: Web-Based training (not Instructor-Led),
5: Self-led Review of Training Resources,
6: Other, describe: [50 words]

7.6 Applicant must indicate which training tools and resources are used during Customer Service Representative training, check all that apply:
Multi, Checkboxes.
1: Case-Study,
2: Roleplaying,
3: Shadowing,
4: Observation,

5: Pre-tests,
6: Post-tests,
7: Training Evaluations,
8: Other, describe: [50 words]

7.7 What is the length of the entire training period for new Customer Service Representatives? Include total time from point of hire to completion of training and release to work independently.
50 words.

7.8 How frequently are refresher trainings provided to all Customer Service Representatives? Include trainings focused on skills improvement as well as training resulting from changes to policy and procedures.
50 words.

7.9 Applicant must indicate languages spoken by Customer Service Representatives, and the number of bilingual Representatives who speak each language. Do not include languages supported only by a language line.
Multi, Checkboxes.
1: Arabic: [Integer] ,
2: Armenian: [Integer] ,
3: Cantonese: [Integer] ,
4: English: [Integer] ,
5: Hmong: [Integer] ,
6: Korean: [Integer] ,
7: Mandarin: [Integer] ,
8: Farsi: [Integer] ,
9: Russian: [Integer] ,
10: Spanish: [Integer] ,
11: Tagalog: [Integer] ,
12: Vietnamese: [Integer] ,
13: Lao: [Integer] ,
14: Cambodian: [Integer] ,
15: Other, specify: [50 words]

7.10 Does Applicant use language line to support consumers that speak languages other than those spoken by Customer Service Representatives?
Single, Radio group.
1: Yes, specify vendor: [20 words] ,
2: No

7.11 Applicant must describe any modifications to equipment, technology, consumer self-service tools, staffing ratios, training content and procedures, quality assurance program (or any other items that may impact the customer experience) that may be necessary to provide quality service to Exchange consumers.
100 words.

7.12 Applicant must indicate what information and tools are utilized to monitor consumer experience, check all that apply:
Multi, Checkboxes.
1: Customer Satisfaction Surveys,
2: Monitoring Social Media,
3: Monitoring Call Drivers,
4: Common Problems Tracking,
5: Observation of Representative Calls,
6: Other, describe: [50 words]

7.13 List all Customer Service Representative Quality Assurance metrics used for scoring of monitored call.
50 words.

7.14 Applicant must identify how many calls per Representative, per week are scored.
20 words.

8 Financial Requirements

Questions required only for new entrant Applicants.

8.1 Applicant must confirm it can provide detailed documentation as defined by Covered California in the NOD 23 (Gross to Network Report) as specified in Appendix J Issuer Payment Discrepancy Resolution and Appendix K NOD 23 Report Glossary.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed
Attached Document(s): Appendix K NOD 23 Report Glossary.pdf, Appendix J Issuer Payment Discrepancy Resolution.pdf

8.2 Applicant must confirm and describe in detail it can perform financial reconciliation at a member and group level for each monthly coverage period. For example: list validation steps taken.
Single, Radio group.
1: Yes, confirmed: [200 words] ,
2: No, not confirmed: [200 words]

9 Fraud, Waste and Abuse Detection

Questions 9.2.6 and 9.2.11 are required for currently contracted Applicants. All questions required for new entrant Applicants.

The Exchange is committed to working with its QDP issuers to minimize fraud, waste and abuse. The framework for managing fraud risks is detailed in Appendix O (located on the Manage Documents page) U.S. Government Accountability Office circular GAO-15-593SP (available in Manage Documents). The Exchange expects QDP issuers to adopt leading practices outlined in the framework to the extent applicable. Fraud prevention is centered on integrity and expected behaviors from employees and others. All measures to detect, deter, and prevent fraud before it occurs are vital to all Issuer and Exchange operations.

Definitions:

Fraud – Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§ 470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include, but are not limited to, false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Waste - Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

Abuse – Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include, but not limited to, excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

External Audit – A formal process that includes an independent and objective examination of an organization's programs, operations, and records performed by a third party to evaluate and improve the effectiveness of its policies and procedures. The results, conclusions, and findings of an audit are formally communicated through an audit report delivered to management of the audited entity.

Internal Audit - Is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its

objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Review – A second inspection and verification of documents for accuracy, validity, and authorization for compliance with procedural requirements.

9.1 Prevention / Detection / Response

9.1.1 Describe the roles and responsibilities of those tasked with carrying out dedicated antifraud and fraud risk management activities throughout the organization. If there is a dedicated unit responsible for fraud risk management describe how this unit interacts with the rest of the organization to mitigate fraud, waste and abuse.
200 words.

9.1.2 Applicant must describe anti-fraud strategies and controls including data analytics and fraud risk assessments to circumvent fraud, waste and abuse.
200 words.

9.1.3 Applicant must describe how findings/trends are communicated to the Exchange and other federal/state agencies, law enforcement, etc.
200 words.

9.1.4 Applicant must describe how they safeguard against Social Security number and identity theft within its organization.
200 words.

9.1.5 Once fraud is detected/or discovered what steps are taken to prevent fraudulent services to be paid. Applicant must describe the process to recoup erroneously paid claims from providers.
200 words.

9.1.6 Applicant must describe specific activities Applicant does to identify any violations in the Special Enrollment Period (SEP) policy. Describe the procedures in place to prevent and detect SEP violations. How are the adverse actions communicated to the Exchange?
200 words.

9.1.7 Indicate the types of claims and providers that Applicant typically reviews for possible fraudulent activity. Check all that apply
No space for details provided.
Multi, Checkboxes.
1: General Practice Dentist,
2: Pediatric Dentist,
3: Endodontist,
4: Oral and Maxillofacial Surgeon,
5: Orthodontist,
6: Periodontist,
7: Prosthodontist

9.1.8 Describe the different approaches Applicant takes to monitor the types of providers indicated above in question 9.1.7 for possible fraudulent activity. Applicant must provide an explanation why any provider types not indicated in 9.1.7 are not typically reviewed for possible fraudulent activity.
200 words.

9.1.9 Based on the definition of fraud in the introduction to this section, what was Applicant's recovery success rate and dollars recovered for fraudulent activities for each year below?
No space for details provided.

	Total Loss from Fraud Covered California book of business, if applicable	**Total Loss from Fraud** Total Book of Business	**% of Loss Recovered** Covered California book of business, if applicable	**% of Loss Recovered** Total Book of Business	**Total Dollars Recovered** Covered California book of business, if applicable	**Total Dollars Recovered** Total Book of Business
Calendar Year 2016	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2017	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2018	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

9.1.10 If applicable, explain any trends attributing to the total loss from fraud for Exchange business.
200 words.

9.2 Audits and Reviews
9.2.1 Based on the definition of review in the introduction to this section, indicate how frequently reviews are performed for each of the following areas:
No space for details provided.

	Response	If other

Claims Administration Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Customer Service Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Eligibility and Enrollment Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Utilization Management Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Billing Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*

9.2.2 Based on the definition of internal audit in the introduction to this section, does Applicant maintain an independent, internal audit function? If yes, provide a brief description of Applicant's internal audit function, its reporting structure and what oversight authority is there over the internal audit function? For example: does the internal audit function report to a board, audit committee, or executive office?
Single, Radio group.
1: Yes, describe: [200 words] ,
2: No

9.2.3 If Applicant answered yes to 9.2.2, provide a copy of the organization's internal audit function's annual audit plan applicable to claims administration, eligibility and enrollment, billing, and network providers.
No space for details provided.
Single, Pull-down list.

1: Attached,
2: Not attached

9.2.4 If Applicant answered yes to 9.2.2, based on the definition of internal audit in the introduction to this section, indicate how frequently internal auditing is performed for the following areas:
No space for details provided.

	Response	If other
Audits of Claims Administration and Oversight	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Network Providers	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Eligibility and Enrollment Processes and Compliance with Requirements	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Billing Process	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*

9.2.5 What audit authority does Applicant have over network and non-network providers and contractors (for example: does Applicant conduct audits of network and non-network providers and contractors)?
200 words.

9.2.6 Based on the definition of external audit in the introduction to this section, indicate what external audits were conducted over the last three years by State and Federal Regulatory Agencies? For each audit, specify the year of the audit and the name of the agency that conducted the audit.

200 words.

9.2.7 Describe Applicant's approach to reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed the reasonable and customary threshold.
200 words.

9.2.8 Describe Applicant's approach to the use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers and any additional steps Applicant takes to verify a provider and facility is a legitimate place of business.
200 words.

9.2.9 Describe Applicant's controls in place to monitor referrals of enrollees to any health care facility or business entity in which the provider may have full or partial ownership or own shares. Attach a copy of the applicable conflict of interest statement.
200 words.

9.2.10 Applicant must describe in detail it's policy to validate provider information during initial contracting and when a provider reports a change (including demographic information, address, and network or panel status).
200 words.

9.2.11 Applicant must confirm that, if certified, it will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the California Department of General Services, the California State Auditor or its designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on the Issuer's report, questions pertaining to enrollee premium payments and participation fee payments Issuer made to the Exchange. Applicant also agrees to all audits subject to applicable State and Federal laws and regarding the confidentiality of and release of confidential Protected Health Information (PHI) of enrollees.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

10 System for Electronic Rate and Form Filing (SERFF)

All questions are required for currently contracted Applicants and new entrant Applicants.

10.1 Is Applicant able to populate and submit SERFF templates in an accurate, appropriate, and timely fashion at Exchange request for:

- Rates
- Service Area
- Benefit Plan Designs
- Network
- Plan ID Crosswalk

No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

10.2 Applicant confirms that it will submit and upload corrections to SERFF within three (3) business days of notification by the Exchange, adjusted for any SERFF downtime. Applicant must adhere to amendment language specifications when any item is corrected in SERFF.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

10.3 Applicant may not make any changes to its SERFF templates once submitted to the Exchange without providing prior written notice to the Exchange and only if the Exchange agrees in writing with the proposed changes.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

11 Electronic Data Interface

Questions 11.1 - 11.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

11.1 Applicant must provide an overview of its system, data model, vendors, and any anticipated changes interface partners, a copy of your release schedule and system lifecycle.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

11.2 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between Applicant's systems and the Exchange's systems, including the eligibility and enrollment system used by the Exchange, as early as May 2019. Applicant must confirm it will implement system(s) in order to accept and generate Group XML, 834, and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose.

- See Appendix M 834 Companion Guide Design v2.2, Appendix Q CCSB 820 Companion Guide Design v2.0, and Appendix P CCSB Group XML Schema v2.1a for detailed transaction specifications.
- Note: The Exchange requires Applicants to sign an industry-standard agreement which establishes electronic information exchange standards to participate in the required systems testing.

No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed
Attached Document(s): Appendix Q CCSB EDI 820 Companion Guide V 2 0.pdf, Appendix P CCSB Group XML Schema v2.1a.pdf, Appendix M 834 Companion Guide Design v2.2.pdf

11.3 Applicant must describe its ability to produce financial, eligibility, and enrollment data monthly for reconciliation and experience processing and resolving errors identified by the Reconciliation Process as appropriate and in a timely fashion. Applicant must confirm that it has the capability to accept and complete non-electronic enrollment submissions and changes.
Single, Radio group.
1: Yes, confirmed: [200 words] ,
2: No, not confirmed: [200 words]

11.4 Applicant must communicate any testing or production changes to system configuration (URL, certification, bank information) to the Exchange in a timely fashion.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

11.5 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than August 1, 2019 and confirms it will plan and implement testing jointly with the Exchange to meet system release schedules. Applicant must confirm testing with the Exchange will utilize industry security standards: firewall, certification, and fingerprint. Applicant must confirm it will make dedicated, qualified resources available to participate in the connectivity and testing effort.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

11.6 Applicant must confirm and describe how they proactively monitor and measure system response time and performance processing new enrollment and enrollment changes?
Single, Radio group.
1: Yes, describe [100 words] ,
2: No, describe [100 words]

12 Healthcare Evidence Initiative

To fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, the Exchange relies on evidence about the enrollee experience with health care. The timely and accurate submission of QDP data is an essential component of assessing the quality and value of the coverage and health care received by Exchange enrollees.

This section not required if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.

Questions required only for new entrant Applicants.

12.1 Applicant must describe any contractual agreements with participating providers that preclude Applicant's organization from making contract terms transparent to plan sponsors and members.
Applicant must confirm that, if contracted as a QDP issuer, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Applicant shall, upon renewal of its Provider contract, but in no event later than July 1, 2020, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Applicant agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange (for example, enrollment, medical and prescription claims, and capitation data required by the Exchange's Healthcare Evidence Initiative (HEI) Vendor: allowed amounts; charge and charge submitted amounts; coinsurance, copayment, and deductible amounts; paid and net payment amounts; patient total out-of-pocket amounts; capitation amounts, etc.).

- What specific steps is Applicant taking to change these contract provisions going forward to make this information accessible?
- List provider groups or facilities for which current contract terms preclude provision of information to plan sponsors.
- List provider groups or facilities for which current contract terms preclude provision of information to members.

Single, Radio group.
1: Confirmed, describe [500 words] ,
2: Not confirmed, describe [500 words]

12.2 Applicant must provide the Exchange's HEI Vendor with monthly extracts of all requested detail from applicable fee-for-service (FFS) claims or encounter records for the following claim types. If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic claim types, estimating the number and percentage of affected claims and encounters.
No space for details provided.

Claim Type	Response	If No or Yes with deviation, explain.

Professional	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Institutional	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Pharmacy, if applicable	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Drug (non-Pharmacy), if applicable	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.3 The Exchange is interested in QDP Issuer data that represents the cost of care. Can Applicant provide monthly extracts of complete financial detail for all applicable claims and encounters? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested financial detail, elaborate on problematic data elements, estimating the number and percentage of affected claims and encounters.
No space for details provided.

Financial Detail to be Provided	Response	If No or Yes with deviation, explain.
Submitted Charges	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Discount Amount	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Allowable Charges	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Copayment	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Coinsurance	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Deductibles	*Single, Pull-down list.*	*50 words.*

	1: Yes, 2: No	
Coordination of Benefits	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Plan Paid Amount (Net Payment)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Capitation Financials (per Provider / Facility) ***[1]*** *If a portion of Applicant provider payments are capitated. If capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.*	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.4 Can Applicant provide member and subscriber IDs assigned by the Exchange on all records submitted? In the absence of other Personally Identifiable Information (PII), these elements are critical for the HEI Vendor to generate unique encrypted member identifiers linking eligibility to claims and encounter data, enabling the HEI Vendor to follow the health care experience of each de-identified member, even if he or she moves from one plan to another. If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic data elements, estimating the number and percentage of affected enrollments, claims, and encounters.
No space for details provided.

Detail to be Provided	Response	If No or Yes with deviation, explain.
Covered CA Member ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Covered CA Subscriber ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.5 Can Applicant supply dates, such as starting date of service, in full year / month / day format to the HEI Vendor for data aggregation? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic dates, estimating the number and percentage of affected enrollments, claims, and encounters
No space for details provided.

PHI Dates to be Provided in Full Year / Month / Day Format	Response	If No or Yes with deviation, explain.
Member Date of Birth	*Single, Pull-down list.*	*50 words.*

	1: Yes, 2: No	
Starting Date of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Ending Date of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.6 Can Applicant supply all applicable Provider Tax ID Numbers (TINs) and National Provider Identifiers (NPIs) for individual providers? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic Provider IDs, estimating the number and percentage of affected providers, claims, and encounters.
No space for details provided.

Provider IDs to be Supplied	Response	If No or Yes with deviation, explain.
TIN	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.*
NPI	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.*

12.7 Can Applicant provide detailed coding for procedures, etc. on all claims for all data sources? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested coding detail, elaborate on problematic coding, estimating the number and percentage of affected claims and encounters.
No space for details provided.

Coding to be Provided	Response	If No or Yes with deviation, explain.
Procedure Coding (CDT, HCPCS)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Revenue Codes (Facility Only)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Place of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.8 Can Applicant submit all data directly to the HEI Vendor or is a third party required to submit the data on Applicant's behalf?
Single, Radio group.
1: Yes, describe [50 words] ,
2: No

12.9 If data must be submitted by a third party, can Applicant guarantee that the same information above will also be submitted by the third party?
Single, Radio group.
1: Yes, describe: [50 words] ,
2: No,
3: Not Applicable

13 Privacy and Security Requirements for Personally Identifiable Data

This section not required if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.

Questions required only for new entrant Applicants.

13.1 HIPAA Privacy Rule

Applicant must confirm that it complies with the following privacy-related requirements set forth within Subpart E of the Health Insurance Portability and Accountability Act [45 CFR §164.500 et. seq.]:

13.1.1 Individual access: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with the opportunity to access, inspect and obtain a copy of any Protected Health Information (PHI) contained within their Designated Record Set [45 CFR §§164.501, 524].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.2 Amendment: Applicant must confirm that it provides enrollees with the right to amend inaccurate or incomplete PHI contained within their Designated Record Set [45 CFR §§164.501, 526].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.3 Restriction Requests: Applicant must confirm that it provides enrollees with the opportunity to request restrictions upon Applicant's use or disclosure of their PHI [45 CFR §164.522(a)].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.4 Accounting of Disclosures: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with an accounting of any disclosures made by Applicant of the enrollee's PHI upon the enrollee's request [45 CFR §164.528].

No space for details provided.

Single, Pull-down list.

1: Yes, confirmed,

2: No, not confirmed

13.1.5 Confidential Communication Requests: Applicant must confirm that Applicant permits enrollees to request an alternative means or location for receiving their PHI than what Applicant would typically employ [45 CFR §164.522(b)].
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant discloses or uses only the minimum necessary PHI needed to accomplish the purpose for which the disclosure or use is being made [45 CFR §§164.502(b) & 514(d)].
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that enrollees are aware of their privacy-related rights and Applicant's privacy-related obligations related to the enrollee's PHI [45 CFR §§164.520(a)&(b)].
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2 Safeguards
13.2.1 Applicant must confirm that it has policy, standards, processes, and procedures in place and that its information system is configured with administrative, physical and technical security controls that meet or exceed those standards in the National Institute of Standards and Technology, Special Publication (NIST) 800-53 that appropriately protect the confidentiality, integrity, and availability of the Protected Health Information (PHI) and Personally Identifiable Information (PII) that it creates, receives, maintains, or transmits.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2.2 Applicant must confirm that all Protected Health Information (PHI) and Personally Identifiable Information (PII) is encrypted - both at rest and in transit - employing the validated Federal Information Processing Standards (FIPS) Publication 140-2 Cryptographic Modules.
No space for details provided.
Single, Pull-down list.

1: Yes, confirmed,
2: No, not confirmed

13.2.3 Applicant must confirm that it operates in compliance with applicable federal and state security and privacy laws and regulations, and has an incident response policy, process, and procedures in place and can verify that the process is tested at least annually.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2.4 Applicant must confirm that there is a contingency plan in place that addresses system restoration without deterioration of the security measures originally planned and implemented, and that the plan is tested at least annually.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

13.2.5 Applicant must confirm that when disposal of PHI, PII or the decommissioning of media occurs they adhere to the guidelines for media sanitization as described in the NIST Special Publication 800-88.
No space for details provided.
Single, Pull-down list.
1: Yes, confirmed,
2: No, not confirmed

14 Sales Channels

Question 14.1 is required for currently contracted Applicants. All questions required for new entrant Applicants.

14.1 Applicant must provide its Agent of Record (AOR) Commission Schedule for the small group market in California. Note: successful Applicants will be required to use a standardized Agent commission program with levels and terms that result in the same aggregate compensation amounts to Agents whether products are sold within or outside of the Exchange. Successful Applicants may not vary Agent compensation levels by metal tier and must pay the same commission during Open and Special Enrollment for each plan year.
No space for details provided.

Small Business Market - Commission Rate	**Off-Exchange Business**
Provide AOR Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Provide AOR Change Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)	*50 words.*
Specify if the agent is compensated at a higher level as he or she attains certain levels or amounts of in force business.	*50 words.*
Does the compensation level apply to all plans or does it vary by plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Does compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Describe any business for which Applicant will not compensate Agents.	*50 words.*
Describe any business for which Applicant will not make changes to Agent of Record.	*50 words.*
Additional Comments	*100 words.*

14.2 Applicant must provide a copy of the sales team organizational chart. If applicable, Applicant must identify a primary point of contact for agent services and include the following contact information:

- Name (if applicable)
- Phone Number
- Email Address

50 words.

15 Marketing and Outreach Activities

Questions 15.4 and 15.5 required for currently contracted Applicants. All questions are required for new entrant Applicants.

15.1 The Exchange expects all successful Applicants to promote enrollment in their certified QDPs, including investment of resources and coordination with the Exchange's marketing and outreach efforts. Applicant must provide an organizational chart of its small group sales and/or marketing department(s), including names and titles. Applicant must identify the individual(s) with primary responsibility for sales and marketing of the Exchange Small Business product line, indicate where these individuals fit into the organizational chart and include the following contact information for those who will work on Covered California sales and marketing efforts: name, title, phone number, and email address. Indicate staff members who will oversee Member Communication, Social Media efforts, point of sales collateral materials, and submission of co-branded materials for Exchange review.
No space for details provided.
Single, Pull-down list.
Attachment required
1: Attached,
2: Not attached

15.2 Applicant must confirm that, upon contingent certification of its QDPs, it will cooperate with the Exchange Marketing Department and adhere to the Covered California Brand Style Guide, located at http://hbex.coveredca.com/toolkit/PDFs/Brand_Style_Guide.pdf, (and Marketing Guidelines, if applicable) when co-branding materials are issued to Exchange enrollees. If Applicant is certified, co-branded items must be submitted in a timely manner, but no later than before the material is used; ID cards must be submitted to the Exchange at least 30 days prior to Open Enrollment.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

15.3 Applicant must confirm it will cooperate with Exchange Marketing, Public Relations, and Outreach efforts, which may include: internal and external trainings, press events, social media efforts, collateral materials, member communications, and other efforts. This cooperative obligation includes contractual requirements to submit materials and updates according to deadlines established in the QDP Issuer Model Contract.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

15.4 Applicant submit the following for the Exchange Small Business Market: (1) Proposed Marketing Plan, including the following components:

- Strategy for employer and agent communications,
- Target audience parameters (company size, industry segment),

- (2) Attachment D2 Media Plan Flowchart

No space for details provided.
Single, Pull-down list.
1: Marketing Plan and Attachment D2 Attached,
2: Not attached
Attached Document(s): Attachments D2 D3 - CCSB QDP.xlsx

15.5 Applicant must use Attachment D3 Estimated Annual Marketing Budget by Geography template to indicate estimated total expenditures for Small Group Marketplace related to marketing and advertising functions.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached
Attached Document(s): Attachments D2 D3 - CCSB QDP.xlsx

16 Provider Network

16.1 Network Offerings

All questions are required for currently contracted Applicants and new entrant Applicants.

16.1.1 Applicant must indicate the different network products it intends to offer on the Exchange in the Covered California for Small Business market for coverage year 2020.
No space for details provided.

	Offered	New or Existing Network?	Has Network been Proposed for Individual Exchange Plan Year 2019?	Network Name(s)
HMO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.*
PPO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.*

16.1.2 Provider network data must be included in this submission for all geographic locations to which Applicant is applying for certification as a QDP. Submit provider data according to the data file layout in the Covered California Provider Data Submission Guide, https://hbex.coveredca.com/stakeholders/plan-management/library/Covered-California-Provider-Data-Submission-Guide-V1.9.pdf. The provider network submission for 2020 must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QDP Issuer. The Exchange requires the information, as requested, to allow cross-network comparisons and evaluations.
No space for details provided.
Single, Pull-down list.
1: Attached (confirming provider data is for plan year 2020),
2: Not attached

16.1.3 Applicant must complete and upload through SERFF the Network ID Template located at: https://www.qhpcertification.cms.gov/s/QHP.
No space for details provided.
Single, Pull-down list.
1: Template uploaded,
2: Template not uploaded

16.2 HMO

16.2.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks.

If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.2.1.1 Applicant must complete all tabs in Attachment K1 DHMO Provider Network Tables, for their HMO Network.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached
Attached Document(s): Attachment K1 DHMO Provider Network Tables.xlsx

16.2.1.2 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?
No space for details provided.
Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network

16.2.1.3 If Applicant leases its network, describe the terms of the lease agreement:
No space for details provided.

	Response
Length of the lease agreement	*100 words.*
Start Date	*To the day.*
End Date	*To the day.*
Leasing Organization	*100 words.*

16.2.1.4 If Applicant leases network, does Applicant have the ability to influence provider contract terms for (select all that apply):
Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,

7: If no, describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.2.1.5 Describe in detail how Applicant ensures access to care for all enrollees. This should include:

- If Applicant assesses geographic access to primary and specialist care based on enrollee residence describe tools and brief methodology
- If Applicant tracks ethnic and racial diversity in the population and ensure access to appropriate culturally competent providers, describe tools and brief methodology

200 words.

16.2.1.6 Many California residents live in counties bordering other states where the out of state services are closer than in-state services. Does Applicant offer coverage in a California county or region bordering another state?
No space for details provided.
Single, Radio group.
1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?,
2: No

16.2.1.7 If Applicant answered yes to 16.2.1.6, explain in detail how this coverage is offered.
500 words.

16.2.2 Network Quality

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.2.2.1 Does Applicant currently use patient safety as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.2.2.2 Does Applicant currently use cost efficiency as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.2.2.3 Does Applicant currently use patient reported experience as a criterion for provider selection for Covered California networks? If yes, describe in detail, including the assessment process, the source of the patient reported experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.2.2.4 To what extent does Applicant encourage use of high quality network dental providers?
Multi, Checkboxes.
1: Auto-assign members to high-performing dental providers,
2: Identify high-performing providers through the provider directory or other web site location,
3: Customer service referral to dental provider,
4: Other (explain): [100 words] ,
5: Applicant does not encourage use of high-performing dental providers

16.2.2.5 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?
Multi, Checkboxes.
1: Dental quality measures,
2: Health improvement initiatives,
3: Preventive services rendered,
4: Patient satisfaction,
5: Low occurrence of complaints and grievances,
6: Other (explain): [100 words] ,
7: Applicant does not encourage use of high-performing dental providers

16.2.2.6 If Applicant does not currently identify or encourages use of high-performing dental providers, report how Applicant intends to identify high-performing dental providers.
200 words.

16.2.3 Network Stability

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.2.3.1 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Exchange attention.
100 words.

16.2.3.2 Provide information on any known or anticipated potential network disruption that may affect Applicant's 2020 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.
100 words.

16.3 PPO

16.3.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.3.1.1 Applicant must complete all tabs in Attachment K2 DPPO Provider Network Tables, for their PPO Network.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached
Attached Document(s): Attachment K2 DPPO Provider Network Tables.xlsx

16.3.1.2 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?
No space for details provided.
Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network

16.3.1.3 If Applicant leases network, describe the terms of the lease agreement:
No space for details provided.

	Response
Length of the lease agreement	*100 words.*
Start Date	*To the day.*
End Date	*To the day.*
Leasing Organization	*100 words.*

16.3.1.4 If Applicant leases network, does Applicant have the ability to influence provider contract terms for (select all that apply):
Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,

7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.3.1.5 Describe in detail how Applicant ensures access to care for all enrollees. This should include:

- If Applicant assesses geographic access to primary and specialist care based on enrollee residence, describe tools and brief methodology.
- If Applicant tracks ethnic and racial diversity in the population and ensure access to appropriate culturally competent providers, describe tools and brief methodology

200 words.

16.3.1.6 Many California residents live in counties bordering other states where the out of state services are closer than in-state services. Does Applicant offer coverage in a county or region bordering another state?
No space for details provided.
Single, Radio group.
1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?,
2: No

16.3.1.7 If Applicant answered yes to 16.3.1.6, explain in detail how this coverage is offered.
500 words.

16.3.2 Network Quality

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.3.2.1 Does Applicant currently use patient safety as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.3.2.2 Does Applicant currently use cost efficiency as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.3.2.3 Does Applicant currently use patient reported experience as a criterion for provider selection for Covered California networks? If yes, describe in detail, including the assessment process, the source of the patient reported experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.
Single, Radio group.
1: Yes, explain: [100 words] ,
2: No

16.3.2.4 To what extent does Applicant encourage use of high quality network dental providers?
Multi, Checkboxes.
1: Auto-assign members to high-performing dental providers,
2: Identify high-performing providers through the provider directory or other web site location,
3: Customer service referral to dental provider,
4: Other (explain): [100 words] ,
5: Applicant does not encourage use of high-performing dental providers

16.3.2.5 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?
Multi, Checkboxes.
1: Dental quality measures,
2: Health improvement initiatives,
3: Preventive services rendered,
4: Patient satisfaction,
5: Low occurrence of complaints and grievances,
6: Other (explain): [100 words] ,
7: Applicant does not encourage use of high-performing dental providers

16.3.2.6 If Applicant does not currently identify or encourage use of high-performing dental providers, report how Applicant intends to identify high-performing dental providers.
200 words.

16.3.3 Network Stability

All questions are required for currently contracted Applicants and new entrant Applicants. If network has been proposed for products offered in the Individual Exchange, this section is not required for that network.

16.3.3.1 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Exchange attention.
100 words.

16.3.3.2 Provide information on any known or anticipated potential network disruption that may affect Applicant's 2020 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.
100 words.

17 Essential Community Providers

Question required only for new entrant Applicants.

17.1 Applicant must demonstrate that its QDP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. All the criteria below must be met.

1. Applicants must use Essential Community Provider Network Data Submission to indicate contracts with all providers designated as ECP.
2. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area.

The Exchange will evaluate whether Applicant's essential community provider network has achieved the sufficient geographic distribution and requirements.

Federal regulations currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QDP's benefit plan. Certified QDPs will be required in their contract with the Exchange to operate in compliance with all federal regulations issued pursuant to the Affordable Care Act, including those applicable to essential community providers.

Essential Community Providers include dental providers included in the Covered California Consolidated Essential Community Provider List available at:
http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/

Low-income is defined as a family at or below 200% of Federal Poverty Level. The ECP data supplied by Applicant will allow the Exchange to plot contracted ECPs on maps to compare contracted providers against the supply of ECPs and the distribution of low-income Covered California enrollees.

18 Quality

This section not required if Applicant has completed the Qualified Dental Plan Application Plan Year 2020 Individual Marketplace.

18.1 Quality Improvement Strategy

Questions 18.1.1 and 18.1.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

18.1.1 Consistent with the Exchange's mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, Applicants must confirm it will implement a quality assurance program in accordance with Title 2, CCR, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

18.1.2 Applicant must confirm it will maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations, monitoring, evaluating and taking effective action to address any needed improvements, as identified by the Exchange, in the quality of care delivered to members.
No space for details provided.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

18.1.3 QIP #1: Describe a Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:
- QIP Name/Title:
- Problem Addressed:
- Rationale (why selected):
- Targeted Population:
- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

500 words.

18.1.4 QIP #2: Describe a second Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:

- QIP Name/Title:
- Problem Addressed:
- Rationale (why selected):
- Targeted Population:
- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

500 words.

18.2 Care Management

All questions are required for currently contracted Applicants and new entrant Applicants.

18.2.1 Applicant must confirm it will make available to Exchange enrollees the following programs and services

No space for details provided.

Care Reminders	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
Risk Assessments	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
Disease Management Programs	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed

18.2.2 Which of the following activities are used or will be by Applicant to encourage use of diagnostic and preventive services?

Multi, Checkboxes.

1: Mailed printed materials about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),

2: Emails sent to membership about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),

3: Automated outbound telephone reminders about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),

4: Other (explain): [100 words] ,

5: No current activities used to encourage use of preventive services; discuss any planned activities to encourage use of diagnostic and preventive services: [100 words]

18.2.3 If Applicant indicated that any of the activities in 18.2.2 are used to encourage use of diagnostic and preventive services, upload as an attachment screenshots or other materials demonstrating these activities.

200 words.

18.2.4 Which of the following activities are used or will be by Applicant to communicate oral health and wellness (i.e. self-care for maintaining good oral health)?
Multi, Checkboxes.
1: Mailed printed materials about oral health self-care,
2: Emails sent to membership about oral health self-care,
3: Other (please explain): [100 words] ,
4: No current activities used to encourage oral health self-care; discuss any planned activities to communicate oral health and wellness information to Enrollees: [100 words]

18.2.5 If Applicant indicated that any of the activities in 18.2.4 are used to communicate oral health and wellness, please upload as an attachment screenshots or other materials demonstrating these activities.
200 words.

18.2.6 Indicate the availability of the following demand management activities and health information resources for Exchange members. (Check all that apply)
Multi, Checkboxes.
1: Teledentistry,
2: Decision support,
3: Self-care books,
4: Electronic Preventive care reminders,
5: Web-based health information,
6: Web-based self-care resources,
7: Integration with other health care vendors,
8: Other (describe): [200 words]

18.3 Health Status and Risk Assessment
All questions are required for currently contracted Applicants and new entrant Applicants.

18.3.1 Indicate features of the oral health risk assessment to determine enrollee oral health status. Select all that apply.
No space for details provided.
Multi, Checkboxes.
1: Oral health risk assessment offered online or in print,
2: Oral health risk assessment offered through telephone interview with a live person,
3: Oral health risk assessment offered in multiple languages,
4: Upon completion of oral health risk assessment, risk-factor education is provided to member based on member-specific risk, e.g. if member reports tobacco use, education is provided on gum disease risk,
5: Personalized oral health risk assessment report is generated with risk modification actions,
6: Member is directed to interactive intervention module for behavior change upon risk assessment completion,
7: Email on self-care generated based on enrollee responses,
8: Email or phone call reminders to schedule preventive or diagnostic visits generated based

on enrollee responses,
9: Oral health risk assessment not offered

18.3.2 Does Applicant collect information on enrollee oral health status using any of the following sources of data? Select all that apply.
Multi, Checkboxes.
1: Oral health risk assessment,
2: Claims data,
3: Other (please explain): [100 words] ,
4: Data on oral health status not collected

18.3.3 Discuss any planned activities to build capacity or systems to determine enrollee oral health status, including member outreach or communication strategies to encourage the use of oral health risk self-assessment offered by Applicant.
100 words.

18.3.4 Does Applicant use any of the following sources of data to track changes in oral health status among Plan Enrollees? Select all that apply.
Multi, Checkboxes.
1: Oral health risk assessment,
2: Claims data,
3: Other (please explain): [200 words] ,
4: Data on oral health status not used

18.3.5 Discuss any planned activities to build capacity or systems to track changes in enrollee oral health status.
200 words.

18.3.6 How does Applicant currently identify at-risk enrollees, which may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions?
Single, Radio group.
1: Claims data,
2: Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions,
3: Oral health risk assessment,
4: Other (please explain): [200 words] ,
5: Plan does not currently identify at-risk enrollees

18.3.7 Discuss any planned activities to identify at-risk enrollees.
100 words.

18.3.8 Report the number of enrollees who have been identified as “at-risk.”
No space for details provided.

	Exchange Enrollees, if applicable	Book of Business
Number of enrollees who have been identified as “at-risk”	*Integer.*	*Integer.*
Number of enrollees	*Integer.*	*Integer.*

18.4 Enrollee Population Management
All questions are required for currently contracted Applicants and new entrant Applicants.

18.4.1 Describe practices in place to address population health management across enrolled members. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.4.2 Describe ability to track and monitor member satisfaction. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.4.3 Describe ability to track and monitor cost and utilization management. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.4.4 Describe ability to track and monitor clinical outcome quality. Include measurement strategy and any specific ability to track impact on Exchange enrollees.
100 words.

18.5 Innovations
Question required only for new entrant Applicants.

18.5.1 Describe institutional capacity to plan, implement, evaluate, and replicate future healthcare quality and cost innovations for Exchange Members. Of special interest to Exchange are programs with focus on at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions and those who live in medically underserved areas).
200 words.

18.6 Reducing Health Disparities and Ensuring Health Equity

All questions are required for currently contracted Applicants and new entrant Applicants.

18.6.1 Identify the sources of data used to gather members' race/ethnicity, primary language, and disability status. The response “enrollment form” pertains only to information reported directly by members or passed on by CalHEERS. Report on Exchange membership if applicable.

No space for details provided.

Data Element	Data Collection Method (Select all that apply)	Other, explain	Percent of membership for whom data is captured
Race/ethnicity	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.
Primary language	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (Please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.
Disability	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (Please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.

18.6.2 If Applicant answered “data not collected” to 18.6.1, discuss how Applicant intends to collect data elements to support improving health equity.
200 words.

18.6.3 Indicate how race/ethnicity data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Calculate dental quality performance measures by race/ethnicity, status,
2: Calculate member experience measures by race/ethnicity, status,
3: Identify areas for quality improvement,,
4: Identify areas for health education/promotion,
5: Share provider race/ethnicity/language data with member to enable selection of concordant dentists,
6: Share with dental network to assist them in providing culturally competent care,
7: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
8: Analyze disenrollment patterns,
9: Develop outreach programs that are culturally sensitive (please explain): [100 words] ,
10: Other (please explain): [100 words] ,
11: Race/ethnicity data not used for quality improvement or health equity

18.6.4 Indicate how primary language data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate dental quality performance measures by language status,
3: Calculate member experience measures by language status,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider language data with member to enable selection of concordant dentists,
7: Share with dental network to assist them in providing language assistance and culturally competent care,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Develop outreach programs that are culturally sensitive (please explain): [100 words] ,
11: Other (please explain): [100 words] ,
12: Language data not used for quality improvement or health equity

18.6.5 Indicate how disability status data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Calculate dental quality performance measures by disability status,
2: Calculate member experience measures by disability status,
3: : Identify areas for quality improvement,,
4: Identify areas for health education/promotion,,

5: Share with dental network to assist them in providing culturally competent care,
6: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
7: Analyze disenrollment patterns,
8: Develop outreach programs that are culturally sensitive (please explain): [100 words] ,
9: Other (please explain): [100 words] ,
10: Disability data not used for quality improvement or health equity

18.7 Promotion, Development, and Use of Care Models

All questions are required for currently contracted Applicants and new entrant Applicants.

18.7.1 If applicable to Applicant's delivery system, report the number of enrollees who have been encouraged to select or assigned a primary care dentist.
No space for details provided.

	Exchange Enrollees, if applicable	Book of Business
Number of enrollees who have been encouraged to select or assigned a primary care dentist	*Integer.*	*Integer.*
Number of enrollees	*Integer.*	*Integer.*

18.7.2 If selection of or assignment to a primary care dentist is not required, describe how Applicant encourages member's use of dental home.
100 words.

18.7.3 If selection of or assignment to a primary care dentist is not required, describe how Applicant encourages contracted providers to retain patients for continued care.
100 words.

18.8 Provider Cost and Quality

All questions are required for currently contracted Applicants and new entrant Applicants.

18.8.1 Indicate how Applicant provides members with cost information for network providers. Select all that apply.
Multi, Checkboxes.
1: Web site includes a cost calculator tool for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),
2: Web site provides information on average regional charges for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),

3: Cost information on provider-specific contracted rates available upon request through Web site or customer service line,
4: Members directed to network providers to request cost information,
5: Other (please explain): [100 words] ,
6: Cost information not provided to membership

18.8.2 If the plan does not currently provide members with cost information, report how Applicant intends to make provider-specific cost information available to members.
100 words.

18.9 Community Health and Wellness Promotion

All questions are required for currently contracted Applicants and new entrant Applicants.

18.9.1 Applicant must indicate the type of initiatives, programs, and projects Applicant supports and describe how such activities specifically promote community health and/or address health disparities. Select all that apply and provide a narrative description in the "details" describing the activity.
No space for details provided.

Type of Activity	Response	Details
Internal facing, member-related efforts to promote oral health (e.g. oral health education programs)	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
External facing, high-level community facing activities (e.g. health fairs, attendance at community coalitions, participation in health collaboratives)	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Engaged with non-profit health systems or local health agencies to conduct community risk assessments to identify high priority needs and health disparities related to oral health	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Community oral health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Funded community health programs based on needs assessment or other activity	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*

Plan is currently planning a community oral health promotion activity	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Plan does not conduct any community oral health initiatives	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*

18.10 Utilization

All questions are required for currently contracted Applicants and new entrant Applicants

18.10.1 Applicant must provide dental utilization for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age. Adult membership is defined as 19 years of age and older.
No space for details provided.

Pediatric Utilization	Exchange enrollees, if applicable	California Book of Business
Percentage of membership that received any covered dental service	*Percent.*	*Percent.*
Percentage of membership that received a preventive/diagnostic dental service	*Percent.*	*Percent.*
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)	*Percent.*	*Percent.*
Percentage of members who received a treatment for caries or a caries-preventive procedure	*Percent.*	*Percent.*
Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application	*Percent.*	*Percent.*

Percentage of pediatric membership identified as moderate or high caries risk	*Percent.*	*Percent.*
Percentage of pediatric membership who reached their annual out-of-pocket maximum.	*Percent.*	*Percent.*
Adult Utilization	*Percent.*	*Percent.*
Percentage of membership that received any covered dental service	*Percent.*	*Percent.*
Percentage of membership that received a preventive/diagnostic dental service	*Percent.*	*Percent.*
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)	*Percent.*	*Percent.*
Percentage of members who received a treatment for caries or a caries-preventive procedure	*Percent.*	*Percent.*
Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application	*Percent.*	*Percent.*
Percentage of membership identified as high risk	*Percent.*	*Percent.*
Percentage of members whom reached the plan's maximum annual benefit, if applicable	*Percent.*	*Percent.*

18.10.2 Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator.
No space for details provided.
Single, Pull-down list.
1: Attached,
2: Not attached

YOUR APPLICATION INFORMATION

If you were helped with an application, you may fill out the information on this card to help you remember who helped you apply and details of your account.

Who helped you with the application?

___ Certified Enrollment Counselor ___ County Medi-Cal Office Eligibility Worker ___ Certified Insurance Agent

___ Plan-Based Enroller ___ Service Center Representative

Certified Representative's Contact Information

Full Name: _____ Email: _____

Phone Number: _____ Enroller ID#, if applicable: _____

APPLICATION INFORMATION:

To check the status of your application you may contact your certified representative or Covered California at 1-800-300-1506.

Account Username: _____

Application ID#: _____ Case#: _____

Remember your account password and account PIN. If you forget your account password or PIN please contact Covered California at 1-800-300-1506.

NOTES:

Use the space below to write down any additional information about your application.

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NOTES:

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you should BRING:

FOR EACH FAMILY MEMBER APPLYING

Proof of current income*

CA ID or driver's license of the person who is applying for the family

U.S. passport, legal resident card or certificate of citizenship or naturalization documentation

you should KNOW:

FOR EACH FAMILY MEMBER

Birth dates

Social Security Numbers**

Home ZIP code

GOT QUESTIONS? WE CAN HELP.

Don't forget to tell a friend
"I'm in. You should be too!"

*Proof of current income of all family members applying. (A dependent's income should only be included if their income level requires them to file a tax return.) A family is defined as the person who files taxes as head of household and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

**Families that include unlawfully present immigrants can apply. You can apply for your child even if you are not eligible for coverage.

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SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part II
Medicare

Table of Contents

Revised October 2018

Understanding Medicare Part C & Part D Enrollment Periods

Enrollment in Medicare is limited to certain times. This publication has information about enrolling in Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D), including who can sign up, when to sign up, and how the timing, including signing up late, can affect your costs.

Note: For information about signing up for Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), visit Medicare.gov/publications to view the booklet "Enrolling in Medicare Part A & Part B."

When can I sign up?

There are specific times when you can sign up for a Medicare Advantage Plan (like an HMO or PPO) or Medicare prescription drug coverage, or make changes to coverage you already have:

- During your Initial Enrollment Period when you first become eligible for Medicare or when you turn 65. See page 3.
- During certain enrollment periods that happen each year. See page 5.
- Under certain circumstances that qualify you for a Special Enrollment Period (SEP), like:
  - You move.
  - You're eligible for Medicaid.
  - You qualify for Extra Help with Medicare prescription drug costs.
  - You're getting care in an institution, like a skilled nursing facility or long-term care hospital.
  - You want to switch to a plan with a 5-star overall quality rating. Quality ratings are available on Medicare.gov.

  See the charts beginning on page 7 for a list of different SEPs, including rules about how to qualify.

Note about joining a Medicare Advantage Plan

You must have Medicare Part A and Part B to join a Medicare Advantage Plan. In most cases, if you have End-Stage Renal Disease (ESRD), you can't join a Medicare Advantage Plan.

Initial Enrollment Periods

If this describes you...	You can...	At this time...
You're newly eligible for Medicare because you turn 65.	Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.	During the 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65. If you sign up for a Medicare Advantage Plan during this time, you can drop that plan at any time during the next 12 months and go back to Original Medicare.
You're newly eligible for Medicare because you have a disability and you're under 65.	Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.	Starting 21 months after you get Social Security or Railroad Retirement Board (RRB) disability benefits. Your Medicare coverage begins 24 months after you get Social Security or RRB benefits. Your chance to sign up lasts through the 28th month after you get Social Security or RRB benefits.
You're already eligible for Medicare because of a disability, and you turn 65.	▪ Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan. ▪ Switch from your current Medicare Advantage or Medicare Prescription Drug Plan to another plan. ▪ Drop a Medicare Advantage or Medicare Prescription Drug Plan completely.	During the 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
You have Medicare Part A coverage, and you get Part B for the first time by enrolling during the Part B General Enrollment Period (January 1–March 31).	Sign up for a Medicare Advantage Plan (with or without prescription drug coverage).	Between April 1–June 30.

Part D late enrollment penalty

The late enrollment penalty is an amount that's added to your Part D premium. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. If you have a penalty, you may have to pay it each month for as long as you have Medicare drug coverage. For more information about the late enrollment penalty, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Enrollment periods that happen each year

Each year, you can make changes to your Medicare Advantage or Medicare prescription drug coverage for the following year. There are 2 separate enrollment periods each year. See the chart below for specific dates.

<table>
<tr><th>During this enrollment period...</th><th>You can...</th></tr>
<tr><td>October 15–December 7
(Changes will take effect on January 1.)</td><td>▪ Change from Original Medicare to a Medicare Advantage Plan.
▪ Change from a Medicare Advantage Plan back to Original Medicare.
▪ Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.
▪ Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.
▪ Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.
▪ Join a Medicare Prescription Drug Plan.
▪ Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan.
▪ Drop your Medicare prescription drug coverage completely.</td></tr>
<tr><td rowspan="3">January 1–March 31
Medicare Advantage Open Enrollment Period
(You can only make one change during this period. Changes will take effect the first of the month after the plan gets your request.)</td><td>▪ If you're in a Medicare Advantage Plan (with or without drug coverage), switch to another Medicare Advantage Plan (with or without drug coverage).
▪ Disenroll from your Medicare Advantage Plan and return to Original Medicare. If you choose to do so, you'll be able to join a Medicare Prescription Drug Plan.
▪ If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare.</td></tr>
<tr><td>You can't...</td></tr>
<tr><td>▪ Switch from Original Medicare to a Medicare Advantage Plan.
▪ Join a Medicare Prescription Drug Plan if you're in Original Medicare.
▪ Switch from one Medicare Prescription Drug Plan to another if you're in Original Medicare.</td></tr>
</table>

Special Enrollment Periods

You can make changes to your Medicare health and Medicare prescription drug coverage when certain events happen in your life, like if you move or you lose other insurance coverage. These chances to make changes are called Special Enrollment Periods (SEPs) and are in addition to the regular enrollment periods that happen each year. Rules about when you can make changes and the type of changes you can make are different for each SEP.

The SEPs listed on the next pages are examples. **This list doesn't include every situation.** For more information about SEPs, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Changes in where you live

If this describes you…	You can…	At this time…
You move to a new address that isn't in your plan's service area.*	Switch to a new Medicare Advantage or Medicare Prescription Drug Plan. * **Note:** If you're in a Medicare Advantage Plan and you move outside your plan's service area, you can also choose to return to Original Medicare. If you don't enroll in a new Medicare Advantage Plan during this SEP, you'll be enrolled in Original Medicare when you're disenrolled from your old Medicare Advantage Plan.	If you tell your plan **before** you move, your chance to switch plans begins the month before the month you move and continues for 2 full months after you move. If you tell your plan **after** you move, your chance to switch plans begins the month you tell your plan, plus 2 more full months.
You move to a new address that's still in your plan's service area, but you have new plan options in your new location.		
You move back to the U.S. after living outside the country.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you move back to the U.S.
You just moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital).	▪ Join a Medicare Advantage or Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage.	Your chance to join, switch, or drop coverage lasts as long as you live in the institution and for 2 full months after the month you move out of the institution.
You're released from jail.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you're released from jail.

Changes that cause you to lose your current coverage

If this describes you...	You can...	At this time...
You're no longer eligible for Medicaid.	▪ Join a Medicare Advantage or Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage.	**(New for 2019)** Your chance to change lasts for 3 full months from either the date you're no longer eligible or notified, whichever is later.
You find out that you won't be eligible for Extra Help for the following year.	▪ Join a Medicare Advantage or Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage.	**(New for 2019)** Your chance to change lasts for 3 full months from either the date you're no longer eligible or notified, whichever is later.
You leave coverage from your employer or union.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month your coverage ends.
You involuntarily lose other drug coverage that's as good as Medicare drug coverage (creditable coverage), or your other coverage changes and is no longer creditable.	Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you lose your creditable coverage or are notified of the loss of creditable coverage, whichever is later.
You have drug coverage through a Medicare Cost Plan and you leave the plan.	Join a Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you drop your Medicare Cost Plan.
You drop your coverage in a Program of All-inclusive Care for the Elderly (PACE) Plan.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you drop your PACE plan.

You have a chance to get other coverage

If this describes you...	You can...	At this time...
You have a chance to enroll in other coverage offered by your employer or union.	Drop your current Medicare Advantage or Medicare Prescription Drug Plan to enroll in the private plan offered by your employer or union.	Whenever your employer or union allows you to make changes in your plan.
You have or are enrolling in other drug coverage as good as Medicare prescription drug coverage (like TRICARE or VA coverage).	Drop your current Medicare Advantage Plan with drug coverage or your Medicare Prescription Drug Plan.	Anytime.
You enroll in a Program of All-inclusive Care for the Elderly (PACE) Plan.	Drop your current Medicare Advantage or Medicare Prescription Drug Plan.	Anytime.
You live in the service area of one or more Medicare Advantage or Medicare Prescription Drug Plans with an overall quality rating of 5 stars.	Join a Medicare Advantage, Medicare Cost, or Medicare Prescription Drug Plan with an overall quality rating of 5 stars.	One time between December 8–November 30.

Changes in your plan's contract with Medicare

If this describes you...	You can...	At this time...
Medicare takes an official action (called a "sanction") because of a problem with the plan that affects you.	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Your chance to switch is determined by Medicare on a case-by-case basis.
Your plan's contract ends (terminates) during the contract year.	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Your chance to switch starts 2 months before and ends 1 full month after the contract ends.
Your Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan's contract with Medicare isn't renewed for the next contract year.	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Between October 15 and the last day in February.

Changes due to other special situations

If this describes you…	You can…	At this time…
You're eligible for both Medicare and Medicaid.	Join, switch, or drop a Medicare Advantage Plan or Medicare prescription drug coverage.	**(New for 2019)** Once during each of these periods: ▪ January–March ▪ April–June ▪ July–September (You can also make a change from October 15–December 7, and the change will take effect on January 1.)
You get Extra Help paying for Medicare prescription drug coverage.	Join, switch, or drop Medicare prescription drug coverage.	**(New for 2019)** Once during each of these periods: ▪ January–March ▪ April–June ▪ July–September (You can also make a change from October 15–December 7, and the change will take effect on January 1.)
You're enrolled in a State Pharmaceutical Assistance Program (SPAP).	Join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.	Once during the calendar year.
You're enrolled in a State Pharmaceutical Assistance Program (SPAP) and you lose SPAP eligibility.	Join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.	Your chance to switch starts either the month you lose eligibility or are notified of the loss, whichever is earlier. It ends 2 months after either the month of the loss of eligibility or notification of the loss, whichever is later.
You dropped a Medicare Supplemental Insurance (Medigap) policy the first time you joined a Medicare Advantage Plan.	Drop your Medicare Advantage Plan and enroll in Original Medicare. You'll have special rights to buy a Medigap policy.	Your chance to drop your Medicare Advantage Plan lasts for 12 months after you join the Medicare Advantage Plan for the first time.
You have a severe or disabling condition, and there's a Medicare Chronic Care Special Needs Plan (SNP) available that serves people with your condition.	Join a Medicare Chronic Care SNP that serves people with your condition.	You can join anytime, but once you join, your chance to make changes using this SEP ends.

If this describes you…	You can…	At this time…
You joined a plan, or chose not to join a plan, due to an error by a federal employee.	▪ Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan with drug coverage and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage.	Your chance to change coverage lasts for 2 full months after the month you get a notice of the error from Medicare.
You weren't properly told that your other private drug coverage wasn't as good as Medicare drug coverage (creditable coverage).	Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you get a notice of the error from Medicare.
You weren't properly told that you were losing private drug coverage that was as good as Medicare drug coverage (creditable coverage).	Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you get a notice of the error from Medicare.
You don't have Part A coverage, and you enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31).	Join a Medicare Prescription Drug Plan.	Between April 1–June 30.

Get more information

For more detailed information about signing up, including instructions on how to join, visit Medicare.gov. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Extra Help is available!

If you have limited income and resources, you may be able to get Extra Help paying your prescription drug coverage costs. People who qualify may be able to get their prescriptions filled and pay little or nothing out of pocket. You can apply for Extra Help at any time. There's no cost to apply for Extra Help, so you should apply even if you're not sure if you qualify. To apply online, visit socialsecurity.gov/i1020. Or, call Social Security at 1-800-772-1213 to apply by phone or get a paper application. TTY users can call 1-800-325-0778.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Paid for by the Department of Health & Human Services.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Product No. 11219

Revised May 2019

Things to think about when you compare Medicare drug coverage

There are 2 ways to get Medicare prescription drug coverage. You can join a Medicare Prescription Drug Plan and keep your health coverage under Original Medicare. Or, you could join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage to get your Medicare benefits through a private insurance company. Whichever you choose, prescription drug coverage can vary by cost, coverage, convenience, and quality. Some of these things might be more important to you than others, depending on your situation and prescription drug needs.

No matter which type of Medicare drug plan you join, your plan will send you information about plan changes each fall. You should review your prescription drug needs and compare Medicare drug plans during Medicare Open Enrollment, which runs between October 15–December 7.

Cost

When you get Medicare prescription drug coverage, you pay part of the costs, and Medicare pays part of the costs. Your costs will vary depending on which drug plan you choose and whether or not you get Extra Help (see page 3). You should look at your current prescription drug costs to find a drug plan that works with your financial situation.

Monthly premium

Most drug plans charge a monthly fee that varies by plan. You pay this fee in addition to the Medicare Part B (Medical Insurance) premium. If you have the type of Medicare Advantage Plan or Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium you pay to your plan may include an amount for prescription drug coverage.

Note: What you pay for Medicare prescription drug coverage could be higher based on your income. Visit Medicare.gov to learn more about the monthly premium for drug plans.

Cost (continued)

Consider automatic premium deduction

When you join a Medicare drug plan, think about having your premiums automatically deducted from your Social Security payment. Automatic premium deduction has many benefits:

- It takes the worry out of remembering to pay your premiums
- Your premiums will get paid on time
- You'll be helping the environment by not getting a paper bill from your plan

Yearly deductible

This is the amount you must pay before your drug plan begins to pay its share of your covered drugs. Some drug plans don't have a deductible.

Copayment/coinsurance

This is the amount you pay for each of your prescriptions after you've paid the deductible (if the plan has one). Some drug plans have different levels or "tiers" of coinsurance or copayments, with different costs for different types of drugs. Coinsurance means you pay a percentage (25%, for example) of the cost of the drug. With a copayment, you pay a set amount ($10, for example) for all drugs on a tier. For example, you might have to pay a lower copayment for generic drugs than brand-name drugs, or lower coinsurance for some brand-name drugs than for others.

Coverage gap

Most drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary limit on what the drug plan will cover for drugs. The coverage gap begins after you and your drug plan have spent a certain amount for covered drugs. In 2019, once you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 37% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap.

These amounts all **count** toward you getting out of the coverage gap:

- Your yearly deductible, coinsurance, and copayments
- The discount you get on brand-name drugs in the coverage gap
- What you pay in the coverage gap

Cost (continued)

Coverage gap (continued)

These amounts **don't count** toward you getting out of the coverage gap:

- Your Medicare drug plan premium
- What you pay for non-covered drugs
- What's paid by other insurance

Some plans offer additional coverage during the gap, like for generic drugs, but they may charge a higher monthly premium. Check with the plan first to see if your drugs would be covered during the gap.

In addition to the discount on covered brand-name prescription drugs, there will be increasing coverage for drugs in the coverage gap each year until the gap closes in 2020.

Catastrophic coverage

Once you get out of the coverage gap, you automatically get "catastrophic coverage." Catastrophic coverage means that you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

Late enrollment penalty

If you don't join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage or get Extra Help, you'll likely pay a Part D late enrollment penalty. Creditable prescription drug coverage is coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. If you're subject to the penalty, you may have to pay it each month for as long as you have Medicare drug coverage. For more information about the late enrollment penalty, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Extra Help is available!

If you have limited income and resources, you may be able to get Extra Help paying your prescription drug coverage costs. If you qualify for Extra Help, you may pay little or nothing out of pocket when you fill your prescriptions. You can apply for Extra Help at any time. There's no cost to apply for Extra Help, so you should apply even if you're not sure if you qualify. To apply for Extra Help online, visit socialsecurity.gov/i1020. Or, call Social Security at 1-800-772-1213 to apply by phone or to get a paper application. TTY users can call 1-800-325-0778.

Coverage

Review your prescription drug needs, and look for a plan that meets these needs. Medicare drug plans may vary in what drugs they cover, and some may have special rules that you must follow before a drug is covered.

Formulary

A formulary is a list of the drugs that a drug plan covers. It includes how much you pay for each drug. If the plan uses tiers, the formulary lists which drugs are in each tier. Formularies include both generic and brand-name drugs. In general, each drug plan's formulary must include most types of drugs that people with Medicare use. However, each drug plan has its own formulary, so you should check to make sure your drugs are covered.

Coverage rules

Drug plans may require "prior authorization." This means that before the drug plan will cover certain prescriptions, you must show the plan you meet certain criteria for you to have that particular drug. Your doctor may need to provide additional information about why the drug is medically necessary for you before you can fill the prescription. Plans may also require "step therapy" on certain drugs. This means you must try one or more similar, lower cost drugs before the plan will cover the prescribed drug. Plans may also set "quantity limits"—limits on how much medication you can get.

Convenience

Check with each drug plan you're considering to make sure your current pharmacy is in the plan's network or there are pharmacies convenient to you. Some drug plans charge lower copayments or coinsurance amounts at some pharmacies in their network than at others. Also, some drug plans may offer a mail-order program that will allow you to have drugs sent directly to your home. You should consider the most cost effective and convenient way to have your prescriptions filled.

Important: Even if you're not changing plans, make sure your pharmacy is still in your plan's network next year. Plans may change their network pharmacies each year.

Quality

In addition to a plan's costs, coverage, and convenience, you should also review the quality ratings for plans before you decide which one best meets your needs. Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. A plan can get a rating between 1–5 stars. A 5-star rating is considered excellent. These ratings are listed on the Medicare Plan Finder at Medicare.gov/find-a-plan.

Quality (continued)

5-star Special Enrollment Period

You can switch to a Medicare Advantage Plan or a Medicare Prescription Drug Plan that has 5 stars for its overall plan rating once from December 8, 2018–November 30, 2019. The overall plan ratings are available at Medicare.gov/find-a-plan. Medicare updates these ratings each fall for the following year. These ratings can change each year.

- You can only switch to a 5-star Medicare drug plan if one is available in your area.
- You can only use this Special Enrollment Period once during the above timeframe.

Visit Medicare.gov/find-a-plan to find and compare plans.

Things to consider when choosing Medicare drug coverage

If you:

- **Take specific drugs**, look at drug plans that include your drugs on their formulary (a list of prescription drugs covered by a drug plan). Then, compare costs.
- **Want extra protection from high prescription drug costs**, look at plans offering coverage in the coverage gap, and then check with those plans to make sure they cover your drugs in the gap.
- **Want your drug expenses to be balanced throughout the year**, look at plans with no or a low deductible, or with additional coverage in the coverage gap.
- **Take a lot of generic prescriptions**, look at plans with "tiers" that charge you nothing or low copayments for generic prescriptions.
- **Don't have many drug costs now, but want coverage for peace of mind and to avoid future penalties**, look at plans with a low monthly premium for drug coverage. If you need prescriptions in the future, all plans still must cover most drugs used by people with Medicare.
- **Like the extra benefits and lower costs available by getting your health care and prescription drug coverage from one plan, and you're willing to accept the plan's restrictions on what doctors, hospitals, and other health care providers you can use**, look for a Medicare Advantage Plan (Part C) with prescription drug coverage.

What should I do before making a decision?

Each year, you have the opportunity to join or switch Medicare drug plans during Medicare Open Enrollment, which runs from October 15–December 7. If you switch plans during this time, your coverage with the new plan will start on January 1. As you make a decision about your health and prescription drug coverage, remember to review your current health and prescription drug plans. Health and drug plan benefits and costs can change each year. Look at other plans in your area to see if one may better meet your needs. If you want to keep your current plan, and it's still being offered next year, you don't need to do anything for your enrollment to continue.

Where can I get help?

To help you compare drug plans, think about what you need in terms of cost, coverage, convenience, and quality. Then, visit Medicare.gov/find-a-plan to see which plans are available in your area.

To get personalized information, you need:

- Your Medicare card that has your Medicare number and Medicare effective date (Medicare Part A (Hospital Insurance) or Medicare Part B (Medical Insurance))
- Date of birth
- Last name
- ZIP code

To get general drug plan information or to find out what plans are available in your area, just answer a few simple questions. You can also enter your current prescription drug information to get more detailed cost information.

Note: This tool provides useful information to help you review drug plans based on your current drug needs. The drug costs displayed are estimates and may vary based on the specific quantity, strength and/or dosage of medication, whether you buy your prescriptions at the pharmacy or through mail order, and the pharmacy you use.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP) for personalized counseling at no cost to you. Visit shiptacenter.org, or call 1-800-MEDICARE to find the phone number for your state.

Important: If you have employer or union coverage, call your benefits administrator before you make any changes to your coverage.

Notes

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Paid for by the Department of Health & Human Services.

CMS Product No. 11163

Medicare Factsheet

If you are enrolled in Medicare, you do not need to do anything with Covered California. If you have Medicare you are covered. No matter how you receive your Medicare benefits, whether through Original Medicare or a Medicare Advantage Plan, your Medicare coverage will continue as usual.

Medicare is not part of Covered California and if you are enrolled in Medicare, you cannot purchase a Covered California health plan. Covered California does not offer Medicare supplement insurance, Medigap, or Part D drug plans.

However, if you are low income and meet other requirements, you may still be eligible for additional coverage through Medi-Cal, which you can enroll in through Covered California. Enrollment in Medi-Cal could help pay for Medicare costs and may cover benefits that are not covered by Medicare, like dental coverage and nursing home care.

What is Medicare? Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). There are different parts of Medicare to help cover specific services:

- **Original Medicare (Part A and Part B)** is the traditional Medicare coverage program offered through the federal government. It provides Part A, which covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. It also provides Part B, which covers certain doctors' services, outpatient care, medical supplies, and preventive services.

- **Medicare Advantage Plan (Part C)** is a type of Medicare health plan offered by private companies that contract with Medicare to provide you with all your Part A and Part B benefits. If you are enrolled in a Medicare Advantage Plan, Medicare benefits and services are covered through the private health insurance plan. Most Medicare Advantage Plans include prescription drug coverage.

- **Prescription Drug Plans (Part D),** add prescription drug coverage to Original Medicare (Part A and B) and are typically offered by insurance companies and other private companies approved by Medicare.

- **Medicare Supplemental Plans (Medigap),** are sold by private companies and can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles. Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S.

  A Medigap policy is different from a Medicare Advantage Plan and Part D Prescription Drug plans. The Medicare Advantage plan and Part D Prescription Drug plan provide Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits.

If you are enrolled in Medicare, you do not need to do anything. If you are enrolled in Medicare you are covered. You do not need to do anything with Covered California or anything else related to the new health care law. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan, you will still have the same benefits and security you have now.

Covered California does not offer Medicare or Medicare Supplemental plans. Covered California does not sell Medicare Advantage plans (such as Medicare HMOs and PPOs), Medicare Part D prescription drug plans, or Medigap policies. These plans will be available as they were before.

You can enroll in a Medicare Advantage plan or a Medicare Part D plan on the Medicare website, by signing up directly with the company that offers the plan, or by working with a licensed insurance agent. To learn more about your coverage options and how to enroll in Medicare, including the Medicare Advantage plans, Part D drug plans, and Medigap supplemental policies available in your area, you can go to the Medicare Plan Finder on www.Medicare.gov or call 1-800-MEDICARE.

Getting Medicare and purchasing coverage in Covered California: Most people enrolled in Medicare do not qualify for and should not purchase a Covered California health plan. Purchasing a Covered California health plan would give you the same health benefits you are already receiving on Medicare. However, you may be eligible for additional coverage through Medi-Cal. The Covered California application automatically checks to see if you qualify for Medi-Cal. If you are enrolled in Medicare, you can complete the Covered California application to see if you also qualify for Medical.

If you qualify for Medicare but have to pay a premium for Part A and do not enroll in Medicare Part A, you may be eligible for a Covered California health plan. Depending on your income, you may be eligible for premium assistance and cost-sharing subsidies for the Covered California health plan. However, if you choose to enroll in a Covered California health plan instead of Medicare and then enroll in Medicare later, your premium for Part A, and possibly Part B, could increase by 10% due to paying a late enrollment penalty. (See scenario #3 below.)

Becoming eligible for Medicare while enrolled in a Covered California health plan with premium tax credit: If you are enrolled in a Covered California health plan and you become newly eligible for premium-free Medicare (upon turning 65 for example), you must report your Medicare eligibility to Covered California within 30 days of becoming eligible. You have until the end of your Medicare open enrollment period (which begins three months before the month of your 65th birthday and ends three months after the month of your 65th birthday for a total of seven months) to sign up for Medicare and cancel your Covered California plan.

If you do not report your Medicare eligibility to Covered California and continue receiving premium tax credit, you are deemed ineligible for premium tax credit as of the first day of the fourth calendar month following your 65th birthday (or the date of the event that establishes your Medicare eligibility) and you may have to pay some or all of the premium tax credit you received after that date to the IRS at tax time even if you never sign up for Medicare. (See scenario #4 below.)

Medi-Cal could help with Medicare Costs and could provide additional benefits. If you are currently on Medicare, you may be Medi-Cal eligible, depending on your income and assets. Other requirements also apply. A Medicare beneficiary may be eligible if they are over age 65, blind or have disabilities. If you qualify for both Medi-Cal and Medicare, Medi-Cal will help pay for Medicare premiums and cost-sharing requirements, and may also cover some benefits that are not covered by Medicare, such as dental services, nursing home care, and personal care services. Also, you might qualify for extra financial assistance to help with the cost of Medicare Part D prescription drug coverage.

Getting Information on Medicare or Enrolling: You can review and compare your Medicare options on the Medicare website, by calling 1-800-MEDICARE, or by working with a licensed insurance agent. For questions about changing your address, Medicare Part A or Part B, or a lost Medicare card, call the Social Security Administration at 1-800-772-1213. You can also contact the Health Insurance Counseling & Advocacy Program (HICAP) for free, individual counseling on Medicare coverage questions, your rights, and health care options. Call 1-800-434-0222 to schedule an appointment at a HICAP office near you.

The Medicare open enrollment period for Part D (prescription drug coverage) and Medicare Advantage plans runs from October 15 through December 7 each year.

The Medicare open enrollment period for Medicare Parts A and B (for people who did not sign up when they first became eligible) runs from January 1 through March 31 each year.

You may also be eligible to sign up for any part of Medicare during a special enrollment period if your circumstances have changed. Signing up for Medicare is limited to these enrollment periods and may involve additional costs if you delay enrolling. For more information about enrolling in Medicare, visit the Medicare website, call 1-800-MEDICARE, or work with a licensed insurance agent.

Scenarios:

Scenario 1: ***I have Medicare, but it is expensive and does not cover everything I need. Can I purchase additional coverage in Covered California? Can I receive assistance to help pay for the coverage?***

Covered California does not sell Medicare Advantage plans (such as Medicare HMOs and PPOs), Medicare Part D prescription drug plans, or Medigap policies. If you are enrolled in Medicare, you are not eligible to purchase a subsidized *or* unsubsidized Covered California health plan.

However, you may still be eligible for Medi-Cal, depending on your income and assets. Anyone who completes a Covered California application is automatically screened to see if they qualify for Medi-Cal. A Medicare beneficiary whose income is low or who meets other requirements may qualify if they are over age 65, blind or have other disabilities. If you qualify for both Medi-Cal and Medicare, Medi-Cal will help pay for Medicare premiums and cost-sharing requirements. Medi-Cal may also cover some

benefits that are not covered by Medicare, such as dental services, nursing home care, and personal care services. Also, Medi-Cal may provide extra financial assistance to help with the cost of Medicare Part D prescription drug coverage.

Scenario 2: ***Can I enroll in Medicare and purchase a Covered California health plan and receive tax credits to help me pay for it?***

No. Generally, someone who is eligible for Medicare – even if they do not enroll in it – cannot receive tax credits to help them pay for a Covered California health plan. However, there is an exception for people who have to pay a premium for Medicare Part A (which is free for most people). More information is provided in Scenario 3.

Scenario 3: ***Person is eligible for Medicare, but s/he would have to pay a premium for Part A, can s/he instead enroll in a health plan through Covered California? Can s/he receive assistance to help pay for the coverage?***

If someone qualifies for Medicare but has to pay a premium for Part A, depending on his/her income, s/he may be eligible for premium assistance and cost-sharing subsidies in Covered California, so long as s/he does not enroll in Medicare Part A. However, it is important to know that if you choose to enroll in a Covered California health plan instead of Medicare and then enroll in Medicare later, your premium for Part A, and possibly Part B, could increase by 10% due to paying a late enrollment penalty.

For Part A, the penalty may cause the individual's monthly premium to go up by 10% for 2x the number of years s/he could have had Part A, but did not sign up. For example, if someone was eligible for Part A for two years but did not enroll until the third year, that person would have to pay the higher premium for the first four years of enrollment in Part A.

A penalty applies to Part B, as well. The monthly premium for Part B may go up 10% for each full 12-month period that the individual could have had Part B, but did not sign up for it. For example, if someone was eligible for Part B for two years but did not enroll until the third year, the person would have to pay the higher premium for the first two years of enrollment in Part B.

Individuals who are eligible for Medicare but not enrolled will be subject to the individual shared responsibility tax penalty if they fail to obtain qualifying coverage—such as by paying the premium to enroll in Medicare, or purchasing coverage through Covered California.

Scenario 4: ***An individual who is enrolled in a Covered California health plan and receives premium tax credit becomes eligible for Medicare upon turning 65. Can the individual continue receiving premium tax credits?***

An individual who is enrolled in a Covered California health plan and receives premium tax credit turns 65 on June 3, 2015, and becomes eligible for premium-free Medicare. However, s/he must enroll in Medicare to receive benefits. The individual fails to enroll in the Medicare coverage during his/her initial enrollment period (March 1, 2015 through September 30, 2015). The individual is deemed ineligible for premium tax credit as of

October 1, 2015, the first day of the fourth month following the event that establishes his/her eligibility (turning 65). S/he may have to pay some or all of the premium tax credit s/he received after October 1, 2015 back to the IRS at tax time even if s/he never enrolls in Medicare.

Scenario 5: ***An individual has a permanent disability, but is not eligible for Medicare due to the two-year waiting period for people receiving SSDI payments. Would the individual be eligible for health coverage through Covered California or Medi-Cal?***

An individual who has a permanent disability, but is not yet eligible for Medicare due to the two-year waiting period for people receiving SSDI payments, may purchase health coverage through Covered California. If the individual's income is between 138% and 400% of the federal poverty level (about $16,243 to $46,680 for an individual in 2015), s/he will qualify for premium assistance and/or cost-sharing subsidies to help pay for the cost of a Covered California Health Plan. The individual may also be eligible for Medi-Cal, either through the newly expanded adult program or through other Medi-Cal programs, such as those based on age, disability or blindness.

SSDI recipients who apply for and receive premium assistance and/or cost-sharing subsidies for a Covered California Health Plan, will lose eligibility for the premium assistance and/or cost-sharing subsidies when they become eligible for Medicare. At that point, they will be able to drop their private health plan coverage through Covered California and enroll in Medicare. Similarly, if SSDI recipients enroll in the newly expanded adult Medi-Cal program (covering adults 19-64 up to 138% of the federal poverty level, or $16,242 for an individual in 2015) will lose eligibility for that program when they become eligible for Medicare. At that time, Medi-Cal will automatically reevaluate their circumstances to see if they are eligible for another Medi-Cal program.

Information partners can use on:

Medicare's Limited Income NET Program for people with retroactive Medicaid & SSI eligibility

Medicare's Limited Income NET Program provides temporary drug coverage for people who qualify for Medicare's low-income subsidy (LIS) (also known as Extra Help) and are eligible for both Medicare and Medicaid or both Medicare and Supplemental Security Income (SSI).

Medicare's Limited Income NET Program provides temporary drug coverage for certain dual eligible Medicare/Medicaid or Supplemental Security Income (SSI) only people who qualify for Medicare's low-income subsidy (LIS) (also known as Extra Help). The Limited Income NET Program provides retroactive coverage (if eligible) and immediate, temporary drug coverage (for up to 2 months) until the person with Medicare enrolls in a Medicare Part D drug plan. If a person doesn't select a Part D plan, he or she will be randomly assigned to a plan.

Medicare's Limited Income NET Program handles retroactive Medicare drug coverage for eligible people

People with Medicare who are also eligible for Medicaid or get SSI and have LIS (Extra Help) to help them pay for Medicare drug coverage are eligible for retroactive Medicare drug coverage, in certain cases. When Medicare records show that a person's Medicare/Medicaid full benefit dual eligibility (FBDE) or SSI is retroactive for past months, his or her LIS is retroactive for the same period. People eligible for retroactive LIS will be covered by Medicare's Limited Income NET Program for any uncovered months in the past, the month Medicare gets notified they qualify for Medicaid or SSI, **and** the following month. Going forward, those people will get Medicare drug coverage from the Medicare drug plan they were randomly auto-enrolled into, or from the Medicare drug plan they chose if they joined a plan on their own.

> **Example:** Social Security notified Medicare in February 2019 that Bob Smith was eligible for SSI in November 2018. Medicare's Limited Income NET Program will provide retroactive Medicare drug coverage to Mr. Smith from November 2018 to March 2019. After March 2019, Mr. Smith will get Medicare drug coverage from XYZ Healthcare plan (the plan Medicare auto-enrolled him into).

CMS Product No. 11401-P
Revised August 2019

Not everyone with dual Medicaid or SSI will have retroactive coverage

Certain people with Medicare/Medicaid partial-benefit dual eligibility (PBDE) won't be eligible for retroactive coverage.

How will people know they *may* be eligible for retroactive coverage through Medicare's Limited Income NET Program?

People should check the yellow auto-enrollment notices they get in the mail to learn if they may be eligible for retroactive Medicare drug coverage through Medicare's Limited Income NET Program. Medicare sends this yellow notice to everyone who's newly eligible for Medicaid or SSI. This notice lets people know they automatically get Medicare drug coverage and includes the date their coverage is effective. There are 2 versions of the yellow auto-enrollment notice, as described below.

Notice 11429 shows Medicare's Limited Income NET Program retroactive coverage

People with retroactive coverage will get a yellow auto-enrollment notice in the mail with "CMS Product No. 11429 – YELLOW" printed in the bottom right corner. This notice will provide information about eligibility for retroactive Medicare drug coverage through Medicare's Limited Income NET Program. It lists the name and phone number of the Medicare drug plan that will provide their future drug coverage, and also lists Medicare's Limited Income NET Program's contact information for dates of retroactive coverage. People with retroactive coverage will also get an additional notice from Medicare's Limited Income NET Program with coverage details and instructions on how to get reimbursed for covered prescriptions they filled during any months they were eligible for retroactive coverage.

Notice 11154 shows NO retroactive coverage

People who don't have retroactive coverage will get a yellow auto-enrollment notice in the mail with "CMS Product No. 11154 – YELLOW" printed in the bottom right corner. This notice lists the name and phone number of the Medicare drug plan that will provide their future drug coverage. These people will get prospective coverage until their Medicare drug plan enrollment is effective.

Reimbursement for people with retroactive coverage

People with retroactive coverage may be eligible for reimbursement of covered Part D prescriptions they paid for, from any pharmacy, during any past months in which they were entitled to retroactive coverage under Medicare's Limited Income NET Program. They must present a notice or award letter within 90 days of the date on the notice or letter. Generally, all Medicare Part D prescription drugs are covered, subject to certain standard safety, abuse, and prior authorization limitations.

Medicare's Limited Income NET Program will reimburse eligible people the money they paid out-of-pocket for their covered Part D prescriptions, minus any applicable copayments (up to $3.40 for a generic and up to $8.50 for a brand-name drug in 2019). These amounts will increase to up to $3.60 for a generic and up to $8.95 for a brand-name drug in 2020. People can read the materials they get in the mail from Medicare's Limited Income NET Program for instructions on how to file for reimbursement, or call Humana at 1-800-783-1307. TTY users can call 711.

Once Medicare's Limited Income NET Program gets the written request for reimbursement, Humana has 14 calendar days to let the person know if his or her drug is covered. If Humana determines the claim **is** eligible for reimbursement, Medicare's Limited Income NET Program will mail a check no later than 30 days after that. If they determine that the person's drug isn't covered, the person will get a letter explaining why.

Other people who may be eligible for Medicare's Limited Income NET Program

Medicare may not always have the most current information about a person's Medicaid or SSI eligibility. A person may qualify for retroactive coverage from Medicare's Limited Income NET Program as long as he or she qualified for both Medicare and either Medicaid or SSI on the date of when the claim(s) are submitted within 90 days from the date of retroactive coverage which must be specified in the yellow notice. This means people may get yellow auto-enrollment notice "CMS Product No. 11154 – YELLOW" when they should've gotten "CMS Product No. 11429 – YELLOW." For more information, they can visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. They can also contact their State Health Insurance Assistance Program (SHIP) for free, personalized help. To get their phone number, visit shiptacenter.org or call 1-800-MEDICARE.

Get more information about Medicare's Limited Income NET Program

For questions about Medicare's Limited Income NET Program or a person's retroactive coverage, call Medicare's Limited Income NET Program at 1-800-783-1307. TTY users can call 711. Someone will be available to take your call from 8 a.m. – 8 p.m. in each U.S. time zone (may be different in Alaska and Hawaii).

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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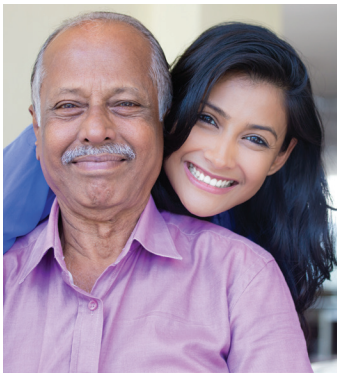
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

THE OFFICIAL U.S. GOVERNMENT MEDICARE HANDBOOK

MEDICARE & YOU






2019

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

You're getting a new Medicare card

We've been mailing new Medicare cards since April 2018.

Your new card has a Medicare Number that's unique to you, **instead of your Social Security Number**. We did this to protect your information and help prevent Medicare fraud.

When you get your new card:

- **Destroy your old Medicare card.** Make sure you destroy your old card so no one can get your personal information.
- **Start using your new Medicare card right away!** Your doctors, other health care providers, and facilities will ask for your new number, so carry your new card with you when you need care.
- **Keep your other plan cards.** If you're in a Medicare Advantage Plan (like an HMO or PPO) or a Medicare drug plan, keep using that Plan ID card whenever you need care or prescriptions. However, you should carry your new Medicare card too—you may be asked to show it.
- **Protect your Medicare Number like you do your Social Security Number.** Only give your new Medicare Number to doctors, pharmacists, other health care providers, your insurer, or people you trust to work with Medicare on your behalf.

Still waiting for your new card?

Your new Medicare card should have arrived in the mail by now. If you didn't get it, here's what to do next:

- Look around the house for any old or unopened mail. Your new Medicare card will come in a plain white envelope from the Department of Health and Human Services.
- If you still can't find it, **call us at 1-800-MEDICARE** (1-800-633-4227). TTY users can call 1-877-486-2048. We may not have your correct address on file. Our call center representatives can help you check your address and fix it if needed.
- In the meantime, **use your current Medicare card to get health care services**.

Get started

If you're new to Medicare:

- **Learn about your Medicare choices.** There are 2 different ways to get your Medicare coverage—see the next few pages to learn more.
- **Find out how and when you can sign up.** If you don't have Medicare Part A or Part B, see Section 1, which starts on page 15. If you don't have Medicare prescription drug coverage (Part D), see Section 6, which starts on page 73. There may be penalties if you don't sign up when you're first eligible.
- **If you have other health insurance**, see pages 20–21 to find out how it works with Medicare.

If you already have Medicare:

- **You don't need to sign up for Medicare each year.** However, you can **review your Medicare health and prescription drug coverage** and make changes each year.

- **Mark your calendar with these important dates!** This may be the only chance you have each year to make changes to your coverage.

October 1, 2018	**Start comparing your coverage with other options.** You may be able to save money. Visit Medicare.gov/find-a-plan.
October 15 to December 7, 2018	**Change your Medicare health or prescription drug coverage for 2019, if you decide to.** This includes returning to Original Medicare or joining a Medicare Advantage Plan.
January 1, 2019	**New coverage begins if you made a change.** If you kept your existing coverage and your plan's costs or benefits changed, those changes will also start on this date.
January 1 to March 31, 2019	**If you're in a Medicare Advantage Plan**, you can make one change to a different plan or switch back to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan) once during this time. Any changes you make will be effective the first of the month after the plan gets your request. See page 57.

Pages 4–8 provide an overview of your Medicare options.

What are the parts of Medicare?

Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

See pages 25–28.

Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment and supplies)
- Many preventive services (like screenings, shots, and yearly "Wellness" visits)

See pages 29–49.

Part D (Prescription drug coverage)

Helps cover:

- Cost of prescription drugs

Part D plans are run by private insurance companies that follow rules set by Medicare.

See pages 73–82.

Your Medicare options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- If you want drug coverage, you can join a separate Part D plan.
- To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can also shop for and buy supplemental coverage.

☑ **Part A**

☑ **Part B**

You can add:

☐ **Part D**

You can also add:

☐ **Supplemental coverage**

(Some examples include coverage from a Medicare Supplement Insurance (Medigap) policy, or coverage from a former employer or union.)

Medicare Advantage
(also known as Part C)

- Medicare Advantage is an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- Some plans may have lower out-of-pocket costs than Original Medicare.
- Some plans offer extra benefits that Original Medicare doesn't cover— like vision, hearing, or dental.

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

Some plans also include:

☐ **Lower out-of-pocket costs**

☐ **Extra benefits**

AT A GLANCE

Original Medicare vs. Medicare Advantage

Doctor and hospital choice

Original Medicare	Medicare Advantage
You can go to **any doctor that accepts Medicare**.	In most cases, you'll need to use **doctors who are in the plan's network** (for non-emergency or non-urgent care). Ask your doctor if they participate in any Medicare Advantage Plans.
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

Cost

Original Medicare	Medicare Advantage
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible.	**Out-of-pocket costs vary**—some plans have low or no out-of-pocket costs.
You **pay a premium (monthly payment) for Part B**. If you choose to buy prescription drug coverage, you'll pay that premium separately.	You may **pay a premium for the plan** (most include prescription drug coverage) **and a premium for Part B**. Some plans have a $0 premium or will help pay all or part of your Part B premium.
There's **no yearly limit** on what you pay out-of-pocket.	Plans have a **yearly limit** on what you pay out-of-pocket for Medicare Part A and B covered services. Once you reach your plan's limit, you'll pay nothing for Part A- and Part B-covered services for the rest of the year.
You **can buy** supplemental coverage to help pay your out-of-pocket costs (like your deductible and 20% coinsurance).	You **can't buy or use** separate supplemental coverage—but some plans have lower out-of-pocket costs than Original Medicare.

Coverage

Original Medicare	Medicare Advantage
Original Medicare covers medical services and supplies in hospitals, doctors' offices, and other health care settings.	Plans must cover all of the services that Original Medicare covers. Some plans **offer extra benefits that Original Medicare doesn't cover**—like vision, hearing, or dental.
You can join a **separate Medicare Prescription Drug Plan** to get drug coverage.	**Prescription drug coverage is included** in most plans.
In most cases, you don't have to get a service or supply approved ahead of time for it to be covered.	In some cases, you have to get a service or supply approved ahead of time for it to be covered by the plan.

Travel

Original Medicare	Medicare Advantage
Original Medicare generally **doesn't cover care outside the U.S.** You may be able to buy supplemental coverage that covers care outside the U.S.	Plans usually **don't cover care outside the U.S.** Also, plans usually don't cover non-emergency care you get outside of your plan's network.

These topics are explained in more detail throughout this book.

- **Original Medicare:** See Section 3 (starting on page 51).
- **Medicare Advantage:** See Section 4 (starting on page 55).

Get the most out of Medicare

Get help choosing the coverage option that's right for you:

- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP)—see pages 109–112 for the phone number.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit the Medicare Plan Finder at **Medicare.gov/find-a-plan**.

Get free help with your Medicare questions

For general Medicare questions, visit **Medicare.gov**, or call 1-800-MEDICARE. See pages 101–104 to learn about other resources.

Get preventive services

Ask your doctor or other health care provider which preventive services (like screenings, shots, and tests) you need to get. Medicare covers many common preventive services at no cost to you. See pages 29-49 and look for the  to learn more.

Get help paying for health care

Find out if you can get help paying your health and prescription drug costs. Go to Section 7, which starts on page 83, to see if you qualify.

Go paperless

Help save tax dollars by choosing to access future "Medicare & You" handbooks electronically. See page 103 to find out how. To access and manage your personalized Medicare information online, visit **MyMedicare.gov**. See page 103 for details.

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Topics

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Note: The page numbers shown in **bold** provide the most detailed information.

SECTION 1

Signing up for Medicare

Some people get Part A and Part B automatically

If you're already getting benefits from Social Security or the Railroad Retirement Board (RRB), you'll automatically get Part A and Part B starting the first day of the month you turn 65. (If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.)

If you're under 65 and have a disability, you'll automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months.

> If you live in Puerto Rico, you don't automatically get Part B. You must sign up for it. See page 16 for more information.

If you have ALS (amyotrophic lateral sclerosis, also called Lou Gehrig's disease), you'll get Part A and Part B automatically the month your Social Security disability benefits begin.

If you're automatically enrolled, you'll get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or 25th month of disability benefits. If you do nothing, you'll keep Part B and will have to pay Part B premiums. You can choose not to keep Part B, but if you decide you want Part B later, you may have to wait to enroll and pay a penalty for as long as you have Part B. See page 22.

Note: If you don't get your card in the mail, call Social Security at 1-800-772-1213 and let them know. TTY users can call 1-800-325-0778. If you get RRB benefits, call 1-877-772-5772. TTY users can call 1-312-751-4701.

Some people have to sign up for Part A and/or Part B

If you're close to 65, but not getting Social Security or Railroad Retirement Board (RRB) benefits, you'll need to sign up for Medicare. Contact Social Security 3 months before you turn 65. You can also apply for Part A and Part B at socialsecurity.gov/retirement. If you worked for a railroad, contact the RRB. **In most cases, if you don't sign up for Part B when you're first eligible, you may have a delay in getting Medicare coverage in the future, and you may have to pay a late enrollment penalty for as long as you have Part B.**

If you have End-Stage Renal Disease (ESRD) and you want Medicare, you'll need to sign up. Contact Social Security to find out when and how to sign up for Part A and Part B. For more information, visit Medicare.gov/publications to view the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Important!

If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the first day of the month you turn 65 or after you get disability benefits for 24 months. **However, if you want Part B, you'll need to sign up for it by completing an "Application for Enrollment in Part B Form" (CMS-40B). If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B.** Visit CMS.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms017339.html to get Form CMS-40B in English or Spanish. Contact your local Social Security office or RRB for more information.

Where can I get more information?

Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility and to sign up for Part A and/or Part B. TTY users can call 1-800-325-0778. If you worked for a railroad or get RRB benefits, call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

You can also get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

No matter how you enroll in Medicare, you'll need to decide how to get your Medicare coverage. You can choose between Original Medicare or a Medicare Advantage Plan. See pages 4–8 for more information.

If I'm not automatically enrolled, when can I sign up?

If you're not automatically enrolled in premium-free Part A, you can sign up for Part A once your Initial Enrollment Period starts. Your Part A coverage will start 6 months back from the date you apply for Medicare (or Social Security/RRB benefits), but no earlier than the first month you were eligible for Medicare. However, you can only sign up for Part B (or Part A if you have to buy it) during the times listed below. **Remember, in most cases, if you don't sign up for Part A (if you have to buy it) and Part B when you're first eligible, you may have to pay a late enrollment penalty.**

Initial Enrollment Period

You can first sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

If you sign up for Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage starts the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage will start the first day of the prior month.

If you enroll in Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, the start date for your Medicare coverage will be delayed.

Special Enrollment Period

After your Initial Enrollment Period is over, you may have a chance to sign up for Medicare during a Special Enrollment Period. If you didn't sign up for Part B (or Part A if you have to buy it) when you were first eligible because you're covered under a group health plan based on current employment (your own, a spouse's, or a family member's (if you have a disability)), you can sign up for Part A and/or Part B:

- Anytime you're still covered by the group health plan
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first

Usually, you don't pay a late enrollment penalty if you sign up during a Special Enrollment Period. This Special Enrollment Period doesn't apply to people who are eligible for Medicare based on End-Stage Renal Disease (ESRD). It also doesn't apply if you're still in your Initial Enrollment Period.

Note: If you have a disability, and the group health plan coverage is based on the current employment of a family member, the employer offering the group health plan must have 100 or more employees for you to get a Special Enrollment Period.

Important!

COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, retiree health plans, and individual health coverage (like through the Health Insurance Marketplace) aren't considered coverage based on current employment. You aren't eligible for a Special Enrollment Period to sign up for Medicare when that coverage ends. To avoid paying a higher premium, make sure you sign up for Medicare when you're first eligible. See page 81 for more information about COBRA coverage.

To learn more about enrollment periods, visit **Medicare.gov**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

General Enrollment Period

If you didn't sign up for Part A (if you have to buy it) and/or Part B (for which you must pay premiums) during your Initial Enrollment Period, and you don't qualify for a Special Enrollment Period, you can sign up between January 1–March 31 each year. **Your coverage won't start until July 1 of that year, and you may have to pay a higher Part A and/or Part B premium for late enrollment.** See pages 16–18.

Should I get Part B?

This information can help you decide if you should get Part B:

Employer or union coverage: If you or your spouse (or family member if you have a disability) **is still working** and you have health coverage through that employer or union, contact your employer or union benefits administrator to find out how your coverage works with Medicare. This includes federal or state employment and active-duty military service. It might be to your advantage to delay Part B enrollment.

Note: Remember, coverage based on current employment doesn't include:

- COBRA
- Retiree coverage
- VA coverage
- Individual health coverage (like through the Health Insurance Marketplace)

TRICARE: If you have TRICARE (health care program for active-duty and retired service members and their families), **you generally must enroll in Part A and Part B when you're first eligible to keep your TRICARE coverage.** However, if you're an active-duty service member or an active-duty family member, you don't have to enroll in Part B to keep your TRICARE coverage. For more information, contact TRICARE. See page 82.

If you have CHAMPVA coverage, you must enroll in Part A and Part B to keep it. Call 1-800-733-8387 for more information about CHAMPVA.

Health Insurance Marketplace: If you have coverage through an individual Marketplace plan (not through an employer), you may want to end your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. It's important to terminate your Marketplace coverage in a timely manner to avoid an overlap in coverage. Once you're considered eligible for Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you may have to pay back the help you got when you file your taxes. Visit **HealthCare.gov** to connect to the Marketplace in your state and learn more. You can also find out how to terminate your Marketplace plan or Marketplace financial help when your Medicare enrollment begins. You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Health savings accounts (HSAs): You can't contribute to your HSA once your Medicare coverage begins. However, you may use money that's already in your HSA after you enroll in Medicare to help pay for deductibles, premiums, copayments, or coinsurance. If you contribute to your HSA after your Medicare coverage starts, you may have to pay a tax penalty. If you'd like to continue contributing to your HSA, you shouldn't apply for Medicare, Social Security, or Railroad Retirement Board (RRB) benefits.

Remember, premium-free Part A coverage begins 6 months back from the date you apply for Medicare (or Social Security/RRB benefits), but no earlier than the first month you were eligible for Medicare. To avoid a tax penalty, you should stop contributing to your HSA at least 6 months before you apply for Medicare.

A Medicare Advantage Medical Savings Account (MSA) Plan might be an option if you'd like to continue to get health benefits through an HSA-like benefit structure. See page 55 for more information.

How does my other insurance work with Medicare?

When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

If you have **retiree** insurance (insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **20 or more employees**...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **fewer than 20 employees**...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your family member's **current** employment, and the employer has **100 or more employees**...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **fewer than 100 employees**...	Medicare pays first.
If you have Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.

Note: In some cases, your employer may join with other employers or unions to form or sponsor a multiple-employer plan. If this happens, the size of the largest employer/union determines whether Medicare pays first or second.

Here are some important facts to remember:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your employer insurance is the secondary payer, you might need to enroll in Part B before your insurance will pay.
- Medicaid pays after Medicare.

For more information, visit **Medicare.gov/publications** to view the booklet "Medicare & Other Health Benefits: Your Guide to Who Pays First."

If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare's Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627. TTY users can call 1-855-797-2627.

Important!

If you have Medicare Part A (including coverage in a Medicare Advantage Plan), you meet the requirement for having health coverage. You'll have to report this on your federal income tax return, and you won't have to pay a penalty for not having health coverage.

If you have Part A, you may get a Health Coverage form (IRS Form 1095-B) from Medicare by early 2019. This form verifies that you had health coverage in 2018. Keep the form for your records. Not everyone will get this form. If you don't get Form 1095-B, don't worry, you don't need to have it to file your taxes.

How much does Part A coverage cost?

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working for a certain amount of time. This is sometimes called premium-free Part A. If you aren't eligible for premium-free Part A, you may be able to buy Part A.

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. If you choose NOT to buy Part A, you can still buy Part B.

The **2019** Part A premium amounts weren't available at the time of printing. To get the most up-to-date cost information, visit **Medicare.gov** later this fall.

What's the Part A late enrollment penalty?

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

Example: If you were eligible for Part A for 2 years but didn't sign up, you'll have to pay a 10% higher premium for 4 years.

How much does Part B coverage cost?

The standard Part B premium amount for **2018** is $134. However, some people who get Social Security benefits will pay less than this amount ($130 on average). You'll pay the standard premium amount if:

- You enroll in Part B for the first time in 2018.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $134 in 2018.)

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

The **2019** Part B premium amount wasn't available at the time of printing. To get the most up-to-date cost information, visit **Medicare.gov** later this fall.

What's the Part B late enrollment penalty?

If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Your monthly premium for Part B may go up 10% for each full 12-month period that you could've had Part B, but didn't sign up for it. If you're allowed to sign up for Part B during a Special Enrollment Period, you usually don't pay a late enrollment penalty. See page 17.

> **Example:** Mr. Smith's Initial Enrollment Period ended December 2016. He waited to sign up for Part B until March 2019 during the General Enrollment Period. His coverage starts July 1, 2019. His Part B premium penalty is 20%, and he'll have to pay this penalty for as long as he has Part B. (Even though Mr. Smith wasn't covered a total of 27 months, this included only 2 full 12-month periods.)

How can I pay my Part B premium?

If you get Social Security or Railroad Retirement Board (RRB) benefits, your Medicare Part B (Medical Insurance) premium will be deducted from your benefit payment.

If you're a federal retiree with an annuity from OPM and not entitled to RRB or SSA benefits, you may request to have your Part B premiums deducted from your annuity. Call 1-800-MEDICARE (1-800-633-4227) to make your request. TTY users can call 1-877-486-2048.

If you don't get these benefit payments, you'll get a bill. If you choose to buy Medicare Part A (Hospital Insurance), you'll always get a bill for your premium. There are 4 ways to pay these bills:

1. **Pay by check or money order.** Write your Medicare Number on your payment, and mail it with your payment coupon to:

   Medicare Premium Collection Center
   P.O. Box 790355
   St. Louis, MO 63179-0355

2. **Pay by credit/debit card.** To do this, complete the bottom portion of the payment coupon on your Medicare Premium Bill, and mail it to the address above. Payments submitted without the bottom portion of the payment coupon may not be processed.

3. **Sign up for Medicare Easy Pay.** This is a free service that automatically deducts your premium payments from your savings or checking account each month. Visit Medicare.gov or call 1-800-MEDICARE and to find out how to sign up.

4. **Make an online bill payment.** This is a more secure and faster way to make your payment without sending your personal information in the mail. Ask your financial institution if it allows customers to pay bills online. Not all financial institutions offer this service and some may charge a fee. You'll need to give your financial institution this information:

   - **Account number:** This is your Medicare Number. It's important that you use the exact number on your red, white, and blue Medicare card, but without the dashes.
   - **Biller name:** CMS Medicare Insurance
   - **Remittance address:**
     Medicare Premium Collection Center
     P.O. Box 790355
     St. Louis, MO 63179-0355

Note to RRB Annuitants: If you get a bill from the RRB, mail your premium payments to:

RRB Medicare Premium Payments
P.O. Box 979024
St. Louis, MO 63197-9000

If you have questions about your premiums or need to change your address on your bill, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If your bills are from the RRB, call 1-877-772-5772. TTY users can call 1-312-751-4701.

If you'd like more information about paying your Medicare premiums, visit **Medicare.gov** to view the brochure "Understanding the Medicare Premium Bill Form (CMS-500)."

If you need help paying your Part B premium, see pages 86–88.

SECTION 2

Find out if Medicare covers your test, service, or item

What services does Medicare cover?

Medicare Part A and Part B cover certain medical services and supplies in hospitals, doctors' offices, and other health care settings. Prescription drug coverage is provided through Medicare Part D.

If you have both Part A and Part B, you can get all of the Medicare-covered services listed in this section, whether you have Original Medicare or a Medicare health plan.

Important! To get Medicare-covered Part A and/or Part B services, you must be a U.S. citizen or be lawfully present in the U.S.

What does Part A cover?

Part A (Hospital Insurance) helps cover:

- Inpatient care in a hospital
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Hospice care
- Home health care
- Inpatient care in a religious nonmedical health care institution

You can find out if you have Part A by looking at your red, white, and blue Medicare card. If you have it, it will be listed as "HOSPITAL" and will have an effective date. If you have Original Medicare, you'll use this card to get your Medicare-covered services. If you join a Medicare health plan, in most cases, you must use the card from the plan to get your Medicare-covered services.

Note: Definitions of blue words are on pages 113–116.

What do I pay for Part A-covered services?

Copayments, coinsurance, or deductibles may apply for each service listed on the following pages. Visit **Medicare.gov**, or call 1-800-MEDICARE (1-800-633-4227) to get specific cost information. TTY users can call 1-877-486-2048.

If you're in a Medicare Advantage Plan or have other insurance (like a Medicare Supplement Insurance (Medigap) policy, or employer or union coverage), your copayments, coinsurance, or deductibles may be different. Contact the plans you're interested in to find out about the costs, or visit the Medicare Plan Finder at **Medicare.gov/find-a-plan**.

Part A-covered services

Blood

If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Home health services

You can use your home health benefits under Part A and/or Part B. See page 41 for more information about home health benefits.

Hospice care

To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of 6 months or less. You must accept palliative care (for comfort) instead of care to cure your illness. You also must sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions. Coverage includes:

- All items and services needed for pain relief and symptom management
- Medical, nursing, and social services
- Drugs
- Certain durable medical equipment
- Aide and homemaker services
- Other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling

A Medicare-certified hospice usually gives hospice care in your home or other facility where you live, like a nursing home.

Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice. Medicare also covers inpatient respite care, which is care you get in a Medicare-approved facility so that your usual caregiver (family member or friend) can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness or related conditions. After 6 months, you can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies (at a face-to-face meeting) that you're terminally ill.

- You pay nothing for hospice care.
- You pay a copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D.
- You pay 5% of the Medicare-approved amount for inpatient respite care.

Original Medicare will cover your hospice care, even if you're in a Medicare Advantage Plan.

Hospital care (inpatient care)

Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or other hospital. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it generally covers 80% of the Medicare-approved amount for doctor's services you get while you're in a hospital.

- You pay a deductible and no coinsurance for days 1–60 of each benefit period.
- You pay coinsurance per day for days 61–90 of each benefit period.
- You pay coinsurance per "lifetime reserve day" after day 90 of each benefit period (up to 60 days over your lifetime).
- You pay all costs for each day after you use all the lifetime reserve days.
- Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime.

Am I an inpatient or outpatient?

Staying overnight in a hospital doesn't always mean you're an inpatient. Your doctor must order your hospital admission and the hospital must formally admit you for you to be inpatient. Without the formal inpatient admission, you're still an outpatient, even if you stay overnight in a regular hospital bed, and/or you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. **You or a family member should always ask the hospital and/or your doctor if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and can affect whether you'll qualify for Part A coverage in a skilled nursing facility.**

A "Medicare Outpatient Observation Notice" (MOON) is a document that lets you know you're an outpatient in a hospital or critical access hospital. You must receive this notice if you're getting observation services as an outpatient for more than 24 hours. The MOON will tell you why you're an outpatient receiving observation services, rather than an inpatient. It will also let you know how this may affect what you pay while in the hospital, and for care you get after leaving the hospital.

Religious non-medical health care institution (inpatient care)

In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, Medicare will only cover the inpatient, non-religious, non-medical items and services. Examples are room and board, or any items and services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker.

Skilled nursing facility care

Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other medically necessary services and supplies furnished in a skilled nursing facility after a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital formally admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged. You may get coverage of skilled nursing care or skilled therapy care if it's necessary to help improve or maintain your current condition.

To qualify for skilled nursing facility care coverage, your doctor must certify that you need daily skilled care (like intravenous injections or physical therapy) which, as a practical matter, can only be provided in a skilled nursing facility if you're an inpatient.

You pay:

- Nothing for the first 20 days of each benefit period
- Coinsurance per day for days 21–100 of each benefit period
- All costs for each day after day 100 in a benefit period

Visit **Medicare.gov** later this fall to find out what you'll pay for inpatient hospital stays and skilled nursing facility care in 2019.

Note: Medicare doesn't cover long-term care or custodial care.

Medicare Advantage Plans can't charge more than Original Medicare for skilled nursing facility care services.

What does Part B cover?

Medicare Part B (Medical Insurance) helps cover medically necessary doctors' services, outpatient care, home health services, durable medical equipment, mental health services, and other medical services. Part B also covers many preventive services. You can find out if you have Part B by looking at your red, white, and blue Medicare card. If you have it, it will be listed as "MEDICAL" and will have an effective date. See pages 30–49 for a list of common Part B-covered services and general descriptions. Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose or treat a condition. To find out if Medicare covers a service not on this list, visit **Medicare.gov/coverage**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. For more details about Medicare covered services, visit **Medicare.gov/publications** to view the booklet "Your Medicare Benefits." Call 1-800-MEDICARE to find out if a copy can be mailed to you.

What do I pay for Part B-covered services?

The alphabetical list on the following pages gives general information about what you pay if you have Original Medicare and see doctors or other health care providers who accept assignment. See page 53. You'll pay more if you see doctors or providers who don't accept assignment. **If you're in a Medicare health plan or have other insurance, your costs may be different. Contact your plan or benefits administrator directly to find out about the costs.**

Under Original Medicare, if the Part B deductible ($183 in 2018) applies, you must pay all costs (up to the Medicare-approved amount) until you meet the yearly Part B deductible. After your deductible is met, Medicare begins to pay its share and you typically pay 20% of the Medicare-approved amount of the service, if the doctor or other health care provider accepts assignment. There's no yearly limit for what you pay out-of-pocket. Visit **Medicare.gov**, or call 1-800-MEDICARE to get specific cost information.

You pay nothing for most covered preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment. However, for some preventive services, you may have to pay a deductible, coinsurance, or both. These costs may also apply if you get a preventive service in the same visit as a non-preventive service.

See page 60 to find out what affects your Medicare Advantage Plan costs.

Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. See page 57.

Part B-covered services

You'll see this apple next to the preventive services on pages 30–49.

Abdominal aortic aneurysm screening

Medicare covers a one-time abdominal aortic aneurysm screening ultrasound for people at risk. You must get a referral from your doctor or other qualified health care practitioner. You pay nothing for the screening if the doctor or other qualified health care practitioner accepts assignment.

Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65–75 and you've smoked at least 100 cigarettes in your lifetime, you're considered at risk.

Advance care planning

Medicare covers voluntary advance care planning as part of the yearly "Wellness" visit. This is planning for care you would want to get if you become unable to speak for yourself. You can talk about an advance directive with your health care professional, and he or she can help you fill out the forms, if you want to. An advance directive is an important legal document that records your wishes about medical treatment at a future time, if you're not able to make decisions about your care. You pay nothing if it's provided as part of the yearly "Wellness" visit and the doctor or other qualified health care provider accepts assignment.

Note: Medicare may also cover this service as part of your medical treatment. When advance care planning isn't part of your yearly "Wellness" visit, the Part B deductible and coinsurance apply.

Alcohol misuse screening and counseling

Medicare covers one alcohol misuse screening per year for adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency. If your health care provider determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling). You must get counseling in a primary care setting (like a doctor's office). You pay nothing if the doctor or other qualified health care provider accepts assignment.

Ambulance services

Medicare covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide.

In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary. An example may be a medically necessary ambulance transport to a dialysis facility for someone with End-Stage Renal Disease (ESRD).

Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need.

You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Ambulatory surgical centers

Medicare covers the facility service fees related to approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is expected to be released within 24 hours). Except for certain preventive services (for which you pay nothing if the doctor or other health care provider accepts assignment), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you, and the Part B deductible applies. You pay all of the facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

Behavioral health integration services

If you have a behavioral health condition (like depression, anxiety, or another behavioral health condition), Medicare may pay for a health care provider's help to manage that condition if your provider offers the Psychiatric Collaborative Care Model. The Psychiatric Collaborative Care Model is a set of integrated behavioral health services that includes care management support if you have a behavioral health condition. This care management support may include care planning for behavioral health conditions, ongoing assessment of your condition, medication support, counseling, or other treatments that your provider recommends. Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis. You pay a monthly fee, and the Part B deductible and coinsurance apply.

Blood

If the provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. However, you'll pay a copayment for the blood processing and handling services for each unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year, or have the blood donated by you or someone else.

Bone mass measurement (bone density)

This test helps to see if you're at risk for broken bones. It's covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay nothing for this test if the doctor or other qualified health care provider accepts assignment.

Breast cancer screening (mammograms)

Medicare covers screening mammograms to check for breast cancer once every 12 months for all women with Medicare who are 40 and older. Medicare covers one baseline mammogram for women between 35–39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

Note: Part B also covers diagnostic mammograms more frequently than once a year when medically necessary. You pay 20% of the Medicare-approved amount for diagnostic mammograms, and the Part B deductible applies.

Cardiac rehabilitation

Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet at least one of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable, chronic heart failure

Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor's office or hospital outpatient setting. You pay 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible applies.

Cardiovascular disease (behavioral therapy)

Medicare will cover one visit per year with a primary care doctor in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, the doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you eat well. You pay nothing if the doctor or other qualified health care provider accepts assignment.

Cardiovascular disease screenings

These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening tests once every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels. You pay nothing for the tests if the doctor or other qualified health care provider accepts assignment.

Cervical and vaginal cancer screenings

Part B covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months. Medicare covers these screening tests once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.

Part B also covers Human Papillomavirus (HPV) tests (when received with a Pap test) once every 5 years if you're age 30–65 without HPV symptoms.

You pay nothing for the lab Pap test or for the lab HPV with Pap test if your doctor or other qualified health care provider accepts assignment. You also pay nothing for the Pap test specimen collection and pelvic and breast exams if the doctor or other qualified health care provider accepts assignment.

Chemotherapy

Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer. You pay a copayment for chemotherapy in a hospital outpatient setting.

For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

For chemotherapy in a hospital inpatient setting covered under Part A, see Hospital care (inpatient care) on pages 27–28.

> Visit the Eldercare Locator at **eldercare.acl.gov** to get help with advance directives.

Chiropractic services (limited coverage)

Medicare covers manipulation of the spine if medically necessary to correct a subluxation (when one or more of the bones of your spine move out of position) when provided by a chiropractor or other qualified provider. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note: Medicare doesn't cover other services or tests ordered by a chiropractor, including X-rays, massage therapy, and acupuncture. If you think your chiropractor is billing Medicare for services that aren't covered, you can report suspected Medicare fraud by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Chronic care management services

If you have 2 or more serious, chronic conditions (like arthritis, asthma, diabetes, hypertension, heart disease, osteoporosis, and other conditions) that are expected to last at least a year, Medicare may pay for a health care provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other health care providers, medications, community services you have and need, and other information about your health. It also explains the care you need and how your care will be coordinated. Your health care provider will ask you to sign an agreement to provide this service. If you agree, he or she will prepare the care plan, help you with medication management, provide 24/7 access for urgent care needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs. You pay a monthly fee, and the Part B deductible and coinsurance apply.

Clinical research studies

Clinical research studies test how well different types of medical care work and if they're safe. Medicare covers some costs, like office visits and tests, in qualifying clinical research studies. You may pay 20% of the Medicare-approved amount, and the Part B deductible may apply.

Note: If you're in a Medicare Advantage Plan (like an HMO or PPO), some costs may be covered by Original Medicare and some may be covered by your Medicare Advantage Plan.

Colorectal cancer screenings

Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of these tests may be covered:

- **Multi-target stool DNA test**: This lab test is generally covered once every 3 years if you meet all of these conditions:
  - Are between ages 50–85.
  - Show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test.
  - At average risk for developing colorectal cancer, meaning:
    - Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
    - Have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

- **Screening fecal occult blood test**: This test is covered once every 12 months if you're 50 or older. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.
- **Screening flexible sigmoidoscopy**: This test is generally covered once every 48 months if you're 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.
- **Screening colonoscopy**: This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.
  Note: If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting. The Part B deductible doesn't apply.
- **Screening barium enema**: This test is generally covered once every 48 months if you're 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount for the doctor services. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible doesn't apply.

Continuous Positive Airway Pressure (CPAP) therapy

Medicare covers a 3-month trial of CPAP therapy if you've been diagnosed with obstructive sleep apnea. Medicare may cover it longer if you meet with your doctor in person, and your doctor documents in your medical record that the CPAP therapy is helping you.

You pay 20% of the Medicare-approved amount for rental of the machine and purchase of related supplies (like masks and tubing), and the Part B deductible applies. Medicare pays the supplier to rent the machine for 13 months if you've been using it without interruption. After you've rented the machine for 13 months, you own it.

Note: If you had a CPAP machine before you got Medicare, Medicare may cover rental or a replacement CPAP machine and/or CPAP accessories if you meet certain requirements.

Defibrillator (implantable automatic)

Medicare covers these devices for some people diagnosed with heart failure. If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for the doctor's services. If you get the device as a hospital outpatient, you also pay the hospital a copayment. In most cases, the copayment amount can't be more than the Part A hospital stay deductible. The Part B deductible applies. Part A covers surgeries to implant defibrillators in a hospital inpatient setting. See Hospital care (inpatient care) on pages 27–28.

Depression screening

Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and referrals. You pay nothing for this screening if the doctor or other qualified health care provider accepts assignment.

Diabetes screenings

Medicare covers these screenings if your doctor determines you're at risk for diabetes or diagnosed with prediabetes. You may be eligible for up to 2 diabetes screenings each year. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.

New!

Medicare Diabetes Prevention Program

Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough yet to be diagnosed as having type 2 diabetes. Fortunately, type 2 diabetes can sometimes be delayed or prevented with health behavior changes. If you have prediabetes, losing even a small amount of weight if you're overweight and getting regular exercise can lower your risk for developing type 2 diabetes.

If you have Medicare Part B, have prediabetes, and meet other criteria, Medicare covers a proven health behavior change program to help you prevent diabetes. The program begins with at least 16 core sessions offered in a group setting over a 6-month period. After the core sessions, you may be eligible for additional monthly sessions will help you maintain healthy habits.

The diabetes prevention program sessions will include:

- Training to make realistic, lasting lifestyle changes
- Tips on how to get more exercise
- Strategies for controlling your weight
- A lifestyle coach, specially trained to help keep you motivated
- Support from people with similar goals and challenges

If you think you're at risk, ask your doctor to be tested for prediabetes to find out if you have the condition. If you qualify for the program, you can join a program at no out-of-pocket cost without a referral from your doctor. If you're in a Medicare Advantage Plan, contact your plan for more information.

Diabetes self-management training

Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other qualified health care provider who's treating your diabetes. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Diabetes supplies

Medicare covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Medicare only covers insulin if it's medically necessary and you use an external insulin pump to administer the insulin. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note: Medicare prescription drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), and some oral diabetes drugs. Check with your plan for more information.

Doctor and other health care provider services

Medicare covers medically necessary doctor services (including outpatient services and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical social workers, physical therapists, and clinical psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Durable medical equipment (DME)

Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Make sure your doctors and DME suppliers are enrolled in Medicare. Doctors and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If your doctors or suppliers aren't enrolled, Medicare won't pay the claims they submit. It's also important to ask your suppliers if they participate in Medicare before you get DME. If suppliers are participating suppliers, they must accept assignment (that is, they're limited to charging you only coinsurance and the Part B deductible for the Medicare-approved amount). If suppliers aren't participating and don't accept assignment, there's no limit on the amount they can charge you. To find suppliers who accept assignment, visit **Medicare.gov/supplierdirectory** or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also call 1-800-MEDICARE if you're having problems with your DME supplier, or you need to file a complaint.

For more information, visit **Medicare.gov/publications** to view the booklet "Medicare Coverage of Durable Medical Equipment and Other Devices."

EKG or ECG (electrocardiogram) screening

Medicare covers a one-time screening EKG/ECG if referred by your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit. See page 48. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. An EKG/ECG is also covered as a diagnostic test. See page 46. If you have the test at a hospital or a hospital-owned clinic, you also pay the hospital a copayment.

Emergency department services

These services are covered when you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a specified copayment for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. The Part B deductible applies. However, your costs may be different if you're admitted to the hospital as an inpatient.

Eyeglasses (after cataract surgery)

Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note: Medicare will only pay for contact lenses or eyeglasses provided by a supplier enrolled in Medicare, no matter who submits the claim (you or your provider).

Federally Qualified Health Center (FQHC) services

FQHCs provide many outpatient primary care and preventive health services. There's no deductible, and generally, you're responsible for paying 20% of the charges. You pay nothing for most preventive services. All FQHCs offer discounts if your income is limited. To find an FQHC near you, visit **findahealthcenter.hrsa.gov**.

Flu shots

Medicare covers one flu shot per flu season. You pay nothing for the flu shot if the doctor or other qualified health care provider accepts assignment for giving the shot.

Foot exams and treatment

Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Glaucoma tests

These tests are covered once every 12 months for people at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic and 65 or older. An eye doctor who's legally allowed by the state must do the tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Hearing and balance exams

Medicare covers these exams if your doctor or other health care provider orders them to see if you need medical treatment. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Note: Original Medicare doesn't cover hearing aids or exams for fitting hearing aids.

Hepatitis B shots

Medicare covers these shots for people at medium or high risk for Hepatitis B. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, if you live with someone who has Hepatitis B, or if you're a health care worker and have frequent contact with blood or body fluids. Check with your doctor to see if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if the doctor or other qualified health care provider accepts assignment.

Hepatitis B Virus (HBV) infection screening

Medicare covers HBV infection screenings if you meet one of these conditions:

- You're at high risk for HBV infection.
- You're pregnant.

Medicare will only cover HBV infection screenings if they're ordered by a primary care provider.

HBV infection screenings are covered:

- Annually only for those with continued high risk who don't get a Hepatitis B vaccination.
- For pregnant women:
  - At the first prenatal visit for each pregnancy.
  - At the time of delivery for those with new or continued risk factors.
  - At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results.

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment.

Hepatitis C screening test

Medicare covers one Hepatitis C screening test if you meet one of these conditions:

- You're at high risk because you have a current or past history of illicit injection drug use.
- You had a blood transfusion before 1992.
- You were born between 1945–1965.

Medicare also covers yearly repeat screenings for certain people at high risk.

Medicare will only cover Hepatitis C screening tests if they're ordered by your health care provider. You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment.

HIV (Human Immunodeficiency Virus) screening

Medicare covers HIV screenings once every 12 months if you're:

- Between the ages of 15–65.
- Younger than 15 and older than 65, and at increased risk.

Note: Medicare also covers this test up to 3 times during a pregnancy.

You pay nothing for the HIV screening if the doctor or other qualified health care provider accepts assignment.

Home health services

You can use your home health benefits under Part A and/or Part B to pay for home health services. Medicare covers medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, or continued occupational therapy services. A doctor, or certain health care professionals who work with a doctor, must see you face-to-face before a doctor can certify that you need home health services. A doctor must order your care, and a Medicare-certified home health agency must provide it.

Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.
- Leaving your home isn't recommended because of your condition.
- You're normally unable to leave your home because it's a major effort.

You pay nothing for covered home health services. You pay 20% of the Medicare-approved amount, and the Part B deductible applies, for Medicare-covered medical equipment.

Kidney dialysis services and supplies

Generally, Medicare covers 3 dialysis treatments per week if you have End-Stage Renal Disease (ESRD). This includes most ESRD-related drugs and biologicals, and all laboratory tests, home dialysis training, support services, equipment, and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Kidney disease education services

Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV chronic kidney disease, and your doctor or other health care provider refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Laboratory services

Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these services.

Lung cancer screening

Medicare covers a lung cancer screening with Low Dose Computed Tomography (LDCT) once per year if you meet all of these conditions:

- You're 55–77.
- You're asymptomatic (don't have signs or symptoms of lung cancer).
- You're either a current smoker or have quit smoking within the last 15 years.
- You have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years).
- You get a written order from a doctor or other qualified health care provider.

You generally pay nothing for this service if the health care provider accepts assignment.

Note: Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

Medical nutrition therapy services

Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months, and your doctor or other health care provider refers you for the service. You pay nothing for these services if the doctor or other qualified health care provider accepts assignment.

Mental health care (outpatient)

Medicare covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor's or other health care provider's office, hospital outpatient department, or community mental health center), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker. Laboratory tests are also covered. Certain limits and conditions may apply.

Generally, you pay 20% of the Medicare-approved amount and the Part B deductible applies for mental health care services.

Note: Inpatient mental health care is covered under Part A.

Obesity screening and counseling

If you have a body mass index (BMI) of 30 or more, Medicare covers face-to-face individual behavioral therapy sessions to help you lose weight. This counseling may be covered if you get it in a primary care setting (like a doctor's office), where it can be coordinated with your other care and a personalized prevention plan. You pay nothing for this service if the doctor or other qualified health care provider accepts assignment.

Occupational therapy

Medicare covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Outpatient hospital services

Medicare covers many diagnostic and treatment services in hospital outpatient departments. Generally, you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You may pay more for services you get in a hospital outpatient setting than you'll pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you'll also usually pay the hospital a copayment for each service you get in a hospital outpatient setting, except for certain preventive services that don't have a copayment. In most cases, the copayment can't be more than the Part A hospital stay deductible for each service. The Part B deductible applies, except for certain preventive services. If you get hospital outpatient services in a critical access hospital, your copayment may be higher and may exceed the Part A hospital stay deductible.

Outpatient medical and surgical services and supplies

Medicare covers approved procedures like X-rays, casts, stitches, or outpatient surgeries. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. In most cases, for each service provided, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, and you pay all costs for items or services that Medicare doesn't cover.

Physical therapy

Medicare covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other health care provider certifies your need for it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Pneumococcal shots

Medicare covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. Medicare covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots. You pay nothing for these shots if the doctor or other qualified health care provider accepts assignment for giving the shots.

Prescription drugs (limited)

Medicare covers a limited number of drugs like injections you get in a doctor's office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), immunosuppressant drugs (see page 47), and, under very limited circumstances, certain drugs you get in a hospital outpatient setting. You pay 20% of the Medicare-approved amount for these covered drugs, and the Part B deductible applies.

If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay a copayment for the services. However, other types of drugs in a hospital outpatient setting (sometimes called "self-administered drugs" or drugs you'd normally take on your own) aren't covered by Part B. What you pay depends on whether you have Part D or other prescription drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network. Contact your prescription drug plan to find out what you pay for drugs you get in a hospital outpatient setting that aren't covered under Part B.

Other than the examples above, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage. See pages 73–82 for more information about Part D.

Prostate cancer screenings

Medicare covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every 12 months for men over 50 (beginning the day after your 50th birthday). You pay nothing for the PSA test. For the digital rectal exam, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Prosthetic/orthotic items

Medicare covers arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after a mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a doctor or other health care provider enrolled in Medicare.

For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Pulmonary rehabilitation

Medicare covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor treating this chronic respiratory disease. You pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay the hospital a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.

Rural Health Clinic (RHC) services

RHCs furnish many outpatient primary care and preventive health services. RHCs are located in rural and underserved areas. Generally, you're responsible for paying 20% of the charges, and the Part B deductible applies. You pay nothing for most preventive services.

Second surgical opinions

Medicare covers second surgical opinions for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Sexually transmitted infection (STI) screening and counseling

Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered if you're pregnant or at increased risk for an STI when the tests are ordered by a primary care provider. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare also covers up to 2 individual, 20–30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other primary care practitioner and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

You pay nothing for these services if the primary care doctor or other qualified health care provider accepts assignment.

Shots

Part B covers:

- Flu shots. See page 38.
- Hepatitis B shots. See page 39.
- Pneumococcal shots. See page 43.

Note about the shingles shot: The shingles shot isn't covered by Part A or Part B. Generally, Medicare Prescription Drug Plans (Part D) cover the shingles shot, as well as all commercially available vaccines needed to prevent illness. Contact your Medicare drug plan for more information about coverage.

Smoking and tobacco-use cessation (counseling to stop smoking or using tobacco products)

Medicare covers up to 8 face-to-face visits in a 12-month period. All people with Medicare who use tobacco are covered. You pay nothing for the counseling sessions if the doctor or other qualified health care provider accepts assignment.

Speech-language pathology services

Medicare covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Surgical dressing services

Medicare covers medically necessary treatment of a surgical or surgically treated wound. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You pay a fixed copayment for these services when you get them in a hospital outpatient setting. The Part B deductible applies. You pay nothing for the supplies.

Telehealth

Medicare covers services like office visits, psychotherapy, consultations, and certain other medical or health services provided using an interactive, two-way telecommunications system (like real-time audio and video) by an eligible provider who isn't at your location. These services are available in rural areas, under certain conditions, but only if you're located at: a doctor's office, hospital, critical access hospital, Rural Health Clinic, Federally Qualified Health Center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. For most of these services, you'll pay the same amount that you would if you got the services in person.

Tests (other than lab tests)

Medicare covers X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you get the test at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare-approved amount, but, in most cases, this amount can't be more than the Part A hospital stay deductible. See Laboratory services on page 41 for other Part B-covered tests.

Transitional care management services

Medicare may cover this service if you're returning to your community after a stay at certain facilities, like a hospital or skilled nursing facility. The health care provider who's managing your transition back into the community will work to coordinate and manage your care for the first 30 days after you return home. He or she will work with you, your family, and caregiver(s), as appropriate, and other health care providers. You'll also be able to get an in-person office visit within 2 weeks of your return home. The health care provider may also review information on the care you received in the facility, provide information to help you transition back to living at home, work with other care providers, help you with referrals or arrangements for follow-up care or community resources, assist you with scheduling, and help you manage your medications. The Part B deductible and coinsurance apply.

Transplants and immunosuppressive drugs

Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions but only in Medicare-certified facilities. Medicare also covers bone marrow and cornea transplants under certain conditions.

Note: The transplant surgery may be covered as a hospital inpatient service under Part A. See pages 27–28 for more information.

Medicare covers immunosuppressive drugs if the transplant was covered by Medicare or an employer or union group health plan was required to pay before Medicare paid for the transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount for the drugs, and the Part B deductible applies.

If you're thinking about joining a Medicare Advantage Plan (like an HMO or PPO) and are on a transplant waiting list or believe you need a transplant, check with the plan before you join to make sure your doctors, other health care providers, and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization.

Note: Medicare drug plans (Part D) may cover immunosuppressive drugs if they aren't covered by Original Medicare.

Medicare pays the full cost of care for your kidney donor. You and your donor won't have to pay a deductible, coinsurance, or any other costs for their hospital stay.

Travel (health care needed when traveling outside the U.S.)

Medicare generally doesn't cover health care while you're traveling outside the U.S. (The "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.) There are some exceptions, including cases where Medicare may pay for services you get while on board a ship within the territorial waters adjoining the land areas of the U.S. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in these rare cases:

- You're in the U.S. when an emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another U.S. state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Medicare may cover medically necessary ambulance transportation to a foreign hospital only with admission for medically necessary covered inpatient hospital services. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Urgently needed care

Medicare covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

"Welcome to Medicare" preventive visit

During the first 12 months that you have Part B, you can get a "Welcome to Medicare" preventive visit. This visit includes a review of your medical and social history related to your health, and education and counseling about preventive services, including certain screenings, flu and pneumococcal shots, and referrals for other care, if needed. When you make your appointment, let your doctor's office know that you'd like to schedule your "Welcome to Medicare" preventive visit. You pay nothing for the "Welcome to Medicare" preventive visit if the doctor or other qualified health care provider accepts assignment.

Important! If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under this preventive benefit, you may have to pay coinsurance, and the Part B deductible may apply.

Yearly "Wellness" visit

If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit to develop or update a personalized plan to prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.

Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. When you make your appointment, let your doctor's office know that you'd like to schedule your yearly "Wellness" visit.

Note: Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" preventive visit to qualify for a yearly "Wellness" visit.

You pay nothing for the yearly "Wellness" visit if the doctor or other qualified health care provider accepts assignment.

Important! If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under this preventive benefit, you may have to pay coinsurance, and the Part B deductible may apply.

What's NOT covered by Part A and Part B?

Medicare doesn't cover everything. If you need certain services that aren't covered under Medicare Part A or Part B, you'll have to pay for them yourself unless:

- You have other coverage (including Medicaid) to cover the costs.
- You're in a Medicare Advantage Plan that covers these services.

Some of the items and services that Medicare doesn't cover include:

- ✖ Most dental care.
- ✖ Eye examinations related to prescribing glasses.
- ✖ Dentures.
- ✖ Cosmetic surgery.
- ✖ Massage therapy.
- ✖ Acupuncture.
- ✖ Hearing aids and exams for fitting them.
- ✖ Long-term care. See the next page for more information about paying for long-term care.
- ✖ Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care).

Some Medicare Advantage Plans may choose to cover these services. See page 65.

Paying for long-term care

Long-term care (sometimes called "long-term services and supports") includes non-medical care for people who have a chronic illness or disability. This includes non-skilled personal care assistance, like help with everyday activities, including dressing, bathing, and using the bathroom. **Medicare and most health insurance plans, including Medicare Supplement Insurance (Medigap) policies, don't pay for this type of care, sometimes called "custodial care." You may be eligible for this type of care through Medicaid, or you can choose to buy private long-term care insurance.** Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home. It's important to start planning for long-term care now to maintain your independence and to make sure you get the care you may need, in the setting you want, in the future.

Long-term care resources

Use these resources to get more information about long-term care:

- Visit **longtermcare.gov** to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Visit **Medicare.gov/contacts**, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.
- Call the National Association of Insurance Commissioners at 1-866-470-6242 to get a copy of "A Shopper's Guide to Long-Term Care Insurance."
- Call your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.
- Visit the Eldercare Locator, a public service of the U.S. Administration on Aging, at **eldercare.acl.gov** to find help in your community.

SECTION 3

Original Medicare

How does Original Medicare work?

Original Medicare is one of your health coverage choices as part of Medicare. You'll have Original Medicare unless you choose a Medicare Advantage Plan or other type of Medicare health plan.

Original Medicare is coverage managed by the federal government. You generally have to pay a portion of the cost for each service covered by Original Medicare. See the next page for the general rules about how it works.

Original Medicare

Can I get my health care from any doctor, other health care provider, or hospital?	In most cases, yes. You can go to any doctor, other health care provider, hospital, or other facility that's enrolled in Medicare and accepting Medicare patients. Visit **Medicare.gov** to search for and compare health care providers, hospitals, and facilities in your area.
Are prescription drugs covered?	No, with a few exceptions (see pages 26–27, 41, and 43), most prescriptions aren't covered. You can add drug coverage by joining a Medicare Prescription Drug Plan (Part D). See pages 73–82.
Do I need to choose a primary care doctor?	No.
Do I have to get a referral to see a specialist?	In most cases, no, but the specialist must be enrolled in Medicare.
Should I get a supplemental policy?	You may already have employer or union coverage that may pay costs that Original Medicare doesn't. If not, you may want to buy a Medicare Supplement Insurance (Medigap) policy if you're eligible. See pages 69–72.

What else do I need to know about Original Medicare?	• You generally pay a set amount for your health care (deductible) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (coinsurance/copayment) for covered services and supplies. There's no yearly limit for what you pay out-of-pocket. • You usually pay a monthly premium for Part B. See pages 86–88 for information about help paying your Part B premium. • You generally don't need to file Medicare claims. The law requires providers (like doctors, hospitals, skilled nursing facilities, and home health agencies) and suppliers to file your claims for the covered services and supplies you get.

What do I pay?

Your out-of-pocket costs in Original Medicare depend on:

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor, other health care provider, or supplier accepts "assignment." See the next page for more information.
- The type of health care you need and how often you need it.
- Whether you choose to get services or supplies Medicare doesn't cover. If you do, you pay all costs unless you have other insurance that covers them.
- Whether you have other health insurance that works with Medicare.
- Whether you have Medicaid or get help from your state paying your Medicare costs.
- Whether you have a Medicare Supplement Insurance (Medigap) policy.
- Whether you and your doctor or other health care provider sign a private contract. See page 54.

How do I know what Medicare paid?

If you have Original Medicare, you'll get a "Medicare Summary Notice" (MSN) in the mail every 3 months that lists all the services billed to Medicare. The MSN shows what Medicare paid and what you may owe the provider. The MSN isn't a bill. Review your MSNs to be sure you got all the services, supplies, or equipment listed.

If you need to change your address on your MSN, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If you get Railroad Retirement Board (RRB) benefits, call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

New!

Your MSN will tell you if you're enrolled in the Qualified Medicare Beneficiary Program (QMB). If you have QMB, Medicare providers aren't allowed to bill you for Medicare Part A and/or Part B deductibles, coinsurance, or copayments. For more information about QMB and steps to take if you get billed for these costs, see page 86.

Important!

Get your Medicare Summary Notices electronically

Go paperless and get your "Medicare Summary Notices" electronically (also called "eMSNs"). You can sign up by visiting **MyMedicare.gov**. If you sign up for eMSNs, we'll send you an email each month when they're available in your **MyMedicare.gov** account. The eMSNs contain the same information as paper MSNs. You won't get printed copies of your MSNs in the mail if you choose eMSNs.

What's assignment?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

If your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less.
- They agree to charge you only the Medicare deductible and coinsurance amount and usually wait for Medicare to pay its share before asking you to pay your share.
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

Non-participating providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. These providers are called "non-participating." Here's what happens if your doctor, provider, or supplier doesn't accept assignment:

- **You might have to pay the entire charge at the time of service.** Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. If they don't submit the Medicare claim once you ask them to call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- **They can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge."**

To find out if someone accepts assignment or participates in Medicare, visit **Medicare.gov/physician** or **Medicare.gov/supplier**. Or, you can call 1-800-MEDICARE.

Certain doctors and other health care providers who don't want to enroll in the Medicare program may "opt out" of Medicare. You can still see these providers, but they must enter into a private contract with you (unless you're in need of emergency or urgently needed care). Medicare won't pay for any services you get under a private contract, so you'll pay the provider's entire charge out of your own pocket. You and your provider will set up your own payment terms through the private contract.

You can contact your State Health Insurance Assistance Program (SHIP) to get free help with these topics. See pages 109–112 for the phone number.

SECTION 4

Medicare Advantage Plans & other options

What are Medicare Advantage Plans?

A Medicare Advantage Plan (like an HMO or PPO) is another way to get your Medicare coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you'll still have Medicare but you'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare. In most cases, you'll need to use health care providers who participate in the plan's network. Some plans offer out-of-network coverage. Remember, in most cases, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your Medicare card in a safe place because you'll need it if you ever switch back to Original Medicare.

What are the different types of Medicare Advantage Plans?

- **Health Maintenance Organization (HMO) plans**: See page 61.
- **Preferred Provider Organization (PPO) plans**: See page 62.
- **Private Fee-for-Service (PFFS) plans**: See page 63.
- **Special Needs Plans (SNPs)**: See page 64.
- **HMO Point-of-Service (HMOPOS) plans**: These are HMO plans that may allow you to get some services out-of-network for a higher copayment or coinsurance.
- **Medical Savings Account (MSA) Plans**: These plans combine a high-deductible health plan with a bank account that the plan selects. The plan deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year. MSA Plans don't offer Medicare drug coverage. If you want drug coverage, you have to join a Medicare Prescription Drug Plan. For more information on MSA Plans, visit Medicare.gov. To find out if an MSA Plan is available in your area, visit **Medicare.gov/find-a-plan**.

Note: Definitions of blue words are on pages 113–116.

Medicare Advantage Plans cover all Medicare Part A and Part B services

In all types of Medicare Advantage Plans, you're always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers. However, if you're in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies.

Some Medicare Advantage Plans offer coverage for things that aren't covered by Original Medicare, like vision, hearing, dental, and other health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B premium, you might have to pay a monthly premium for the Medicare Advantage Plan.

Organization determinations

You (or a provider acting on your behalf) can request to see if an item or service will be covered by the plan in advance. Sometimes you must do this for the service to be covered. This is called an "organization determination." If your plan denies coverage, the plan must tell you in writing.

You don't have to pay more than the plan's usual cost-sharing for a service or supply if a network provider didn't get an organization determination and either of these is true:

- The provider gave you or referred you for services or supplies that you reasonably thought would be covered.
- The provider referred you to an out-of-network provider for plan-covered services.

Contact your plan for more information.

Medicare Advantage Plans must follow Medicare's rules

Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan's network for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year. Remember, you have the option each year to keep your current plan, choose a different plan, or switch to Original Medicare. See page 65.

In most cases, you don't need a referral to see a specialist if you have Original Medicare. See page 51.

Important!

Read the information you get from your plan

If you're in a Medicare Advantage Plan, review the "Annual Notice of Change" (ANOC) and "Evidence of Coverage" (EOC) from your plan each year:

- **The ANOC:** Includes any changes in coverage, costs, service area, and more that will be effective starting in January. Your plan will send you a printed copy by September 30.
- **The EOC:** Gives you details about what the plan covers, how much you pay, and more. Your plan will send you a notice (or printed copy) by October 15, which will include information on how to access the EOC electronically or request a printed copy.

If you don't get these important documents, contact your plan.

What else should I know about Medicare Advantage Plans?

- You have Medicare rights and protections, including the right to appeal. See pages 89–94.
- You must follow plan rules. It's important to check with the plan for information about your rights and responsibilities.
- If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network for non-emergency or non-urgent care services, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- Providers can join or leave a plan's provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider. You generally can't change plans during the year if this happens.
- Plans may offer supplemental benefits, like fitness or wellness benefits.
- Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. Each plan can have a different limit, and the limit can change each year. You should consider this when choosing a plan.

Joining and leaving

- You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD), for which there are special rules. See page 59.
- **You can only join or leave a Medicare Advantage Plan at certain times during the year.** See pages 65–66.
- Each year, Medicare Advantage Plans can choose to leave Medicare or make changes to the services they cover and what you pay. If the plan decides to stop participating in Medicare, you'll have to join another Medicare Advantage Plan or return to Original Medicare. See page 90.
- Medicare Advantage Plans must follow certain rules when giving you information about how to join their plan. See page 98 for more information about these rules and how to protect your personal information.

Prescription drug coverage
You usually get prescription drug coverage (Part D) through the Medicare Advantage Plan. In certain types of plans that can't offer drug coverage (like MSA plans) or choose not to offer drug coverage (like some PFFS plans), you can join a separate Medicare Prescription Drug Plan. **If you're in a Medicare Advantage HMO or PPO, and you join a separate Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.**

Who can join?
You must meet these conditions to join a Medicare Advantage Plan:

- You have Part A and Part B.
- You live in the plan's service area.
- You're a U.S. citizen, U.S. national, or lawfully present in the U.S.
- You don't have End-Stage Renal Disease (ESRD), except as explained on page 59.

What if I have other coverage?
Talk to your employer, union, or other benefits administrator about their rules before you join a Medicare Advantage Plan. In some cases, joining a Medicare Advantage Plan might cause you to lose your employer or union coverage. If you lose coverage for yourself, you may also lose coverage for your spouse and dependents. In other cases, if you join a Medicare Advantage Plan, you may still be able to use your employer or union coverage along with the Medicare Advantage Plan you join. **Remember, if you lose your employer or union coverage, you may not be able to get it back.**

A Medicare Advantage Plan with drug coverage is an option if you're interested in enrolling in Part D but can't afford a separate premium for prescription drug coverage. See page 83.

What if I have a Medicare Supplement Insurance (Medigap) policy?
You can't enroll in (and don't need) a Medicare Supplement Insurance (Medigap) policy while you're in a Medicare Advantage Plan. You can't use it to pay for any expenses (copayments, deductibles, and premiums) you have under a Medicare Advantage Plan. If you already have a Medigap policy and join a Medicare Advantage Plan, you'll probably want to drop your Medigap policy. **If you drop your Medigap policy, you may not be able to get it back.** See page 72.

What if I have End-Stage Renal Disease (ESRD)?
If you have End-Stage Renal Disease (ESRD), you can only join a Medicare Advantage Plan in certain situations:

- If you're already in a Medicare Advantage Plan when you develop ESRD, you can stay in your plan or you may be able to join another Medicare Advantage Plan offered by the same company.
- If you're in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan.
- If you have an employer or union health plan or other health coverage through a company that offers one or more Medicare Advantage Plan(s), you may be able to join one of that company's Medicare Advantage Plans.
- If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.
- You may be able to join a Medicare Special Needs Plan (SNP) that covers people with ESRD if one is available in your area.

For more information, visit **Medicare.gov/publications** to view the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Note: If you have ESRD and Original Medicare, you may join a Medicare Prescription Drug Plan.

What do I pay?

Your out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium. You pay this in addition to the Part B premium.
- Whether the plan pays any of your monthly Medicare premiums. Some Medicare Advantage Plans will help pay all or part of your Part B premium. This benefit is sometimes called a "Medicare Part B premium reduction."
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- How much you pay for each visit or service (copayments or coinsurance).
- The type of health care services you need and how often you get them.
- Whether you get services from a network provider or a provider that doesn't contract with the plan.
- Whether you go to a doctor or supplier who accepts assignment (if you're in a Preferred Provider Organization, Private Fee-for-Service Plan, or Medical Savings Account Plan and you go out-of-network). See page 53 for more information about assignment.
- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if you need to pay an extra premium for them.
- The plan's yearly limit on your out-of-pocket costs for all medical services. Once you reach this limit, you'll pay nothing for covered services.
- Whether you have Medicaid or get help from your state.

To learn more about your costs in specific Medicare Advantage Plans, visit **Medicare.gov/find-a-plan**.

Types of Medicare Advantage Plans

HMO

Health Maintenance Organization (HMO) plan

Can I get my health care from any doctor, other health care provider, or hospital?
No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.

Are prescription drugs covered?
In most cases, yes. If you want Medicare drug coverage, you must join an HMO plan that offers prescription drug coverage.

Do I need to choose a primary care doctor?
In most cases, yes.

Do I have to get a referral to see a specialist?
In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

What else do I need to know about this type of plan?

- If your doctor or other health care provider leaves the plan's network, your plan will notify you. You may choose another doctor in the plan's network.
- If you get health care outside the plan's network, you may have to pay the full cost.
- It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.
- If you need more information than what's listed on this page, check with the plan.

PPO

Preferred Provider Organization (PPO) plan

Can I get my health care from any doctor, other health care provider, or hospital?
In most cases, yes. PPO plans have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.

Are prescription drugs covered?
In most cases, yes. If you want Medicare drug coverage, you must join a PPO plan that offers prescription drug coverage.

Do I need to choose a primary care doctor?
No.

Do I have to get a referral to see a specialist?
In most cases, no.

What else do I need to know about this type of plan?

- PPO plans aren't the same as Original Medicare or Medigap.
- Medicare PPO plans usually offer more benefits than Original Medicare, but you may have to pay extra for these benefits.
- If you need more information than what's listed on this page, check with the plan.

PFFS

Private Fee-for-Service (PFFS) plan

Can I get my health care from any doctor, other health care provider, or hospital?
You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. If you join a PFFS plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but you may pay more.

Are prescription drugs covered?
Sometimes. If your PFFS plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan to get coverage.

Do I need to choose a primary care doctor?
No.

Do I have to get a referral to see a specialist?
No.

What else do I need to know about this type of plan?

- PFFS plans aren't the same as Original Medicare or Medigap.
- The plan decides how much you pay for services.
- Some PFFS plans contract with a network of providers who agree to always treat you, even if you've never seen them before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat you, even if you've seen them before.
- For each service you get, make sure to show your plan member card before you get treated.
- In a medical emergency, doctors, hospitals, and other providers must treat you.
- If you need more information than what's listed on this page, check with the plan.

SNP

Special Needs Plan (SNP)

Can I get my health care from any doctor, other health care provider, or hospital?
You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).

Are prescription drugs covered?
Yes. All SNP plans must provide Medicare prescription drug coverage.

Do I need to choose a primary care doctor?
Generally, yes.

Do I have to get a referral to see a specialist?
In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

What else do I need to know about this type of plan?

- A plan must limit membership to these groups: 1) people who live in certain institutions (like nursing homes) or who require nursing care at home, or 2) people who are eligible for both Medicare and Medicaid, or 3) people who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease, HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership.
- Your plan will coordinate the services and providers you need to help you stay healthy and follow doctors' or other health care providers' orders.
- Visit Medicare.gov/find-a-plan to see if there are SNPs available in your area.
- If you need more information than what's listed on this page, check with the plan.

When can I join, switch, or drop a Medicare Advantage Plan?

- When you first become eligible for Medicare, you can sign up during your Initial Enrollment Period. See page 17.
- If you have Part A coverage and you get Part B for the first time during the General Enrollment Period, you can also join a Medicare Advantage Plan at that time. Your coverage may not start until July 1. See page 18.
- Between October 15–December 7, anyone with Medicare can join, switch, or drop a Medicare Advantage Plan. Your coverage will begin on January 1, as long as the plan gets your request by December 7.

If you drop a Medigap policy to join a Medicare Advantage Plan, you might not be able to get it back. Rules vary by state and your situation. See page 58 for more information.

> Always review the materials your plan sends you (like the "Annual Notice of Change" and "Evidence of Coverage"), and make sure your plan will still meet your needs for the following year.

New!

Can I make changes to my coverage after December 7?
Starting in 2019, between January 1–March 31 each year, you can make these changes during the **Medicare Advantage Open Enrollment Period**:

- If you're in a Medicare Advantage Plan (with or without drug coverage), you can switch to another Medicare Advantage Plan (with or without drug coverage).
- You can disenroll from your Medicare Advantage Plan and return to Original Medicare. If you choose to do so, you'll be able to join a Medicare Prescription Drug Plan.
- If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare.

During this period, you **can't**:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Join a Medicare Prescription Drug Plan if you're in Original Medicare.
- Switch from one Medicare Prescription Drug Plan to another if you're in Original Medicare.

You can only make one change during this period, and any changes you make will be effective the first of the month after the plan gets your request.

Important!

Thinking about joining a Medicare Advantage Plan between October 15–December 7, but aren't sure? The Medicare Advantage Open Enrollment Period (January 1 – March 31) gives you an opportunity to switch back to Original Medicare depending on which coverage works better for you.

Special Enrollment Periods

In most cases, you must stay enrolled for the calendar year starting the date your coverage begins. However, in certain situations, you may be able to join, switch, or drop a Medicare Advantage Plan during a Special Enrollment Period. Some examples are:

- You move out of your plan's service area.
- You have (or lose) Medicaid.
- You qualify for (or lose) Extra Help. See pages 84–85.
- You live in an institution (like a nursing home).

5-star Special Enrollment Period

You can switch to a Medicare Advantage Plan or Medicare Cost Plan (see page 74) that has **5 stars for its overall star rating** from December 8, 2018–November 30, 2019. You can only use this Special Enrollment Period once during this timeframe. The overall star ratings are available at **Medicare.gov/find-a-plan**. See pages 105–106 for more information.

Important! You may lose your prescription drug coverage if you move from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't. You'll have to wait until your next enrollment opportunity to get drug coverage, and you may have to pay a Part D late enrollment penalty. See pages 84–85.

How do I switch?

Follow these steps if you're already in a Medicare Advantage Plan and want to switch:

- **To switch to a new Medicare Advantage Plan,** simply join the plan you choose during one of the enrollment periods explained on page 65. You'll be disenrolled automatically from your old plan when your new plan's coverage begins.
- **To switch to Original Medicare,** contact your current plan, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. If you don't have drug coverage, you should consider joining a Medicare Prescription Drug Plan to avoid paying a penalty if you decide to join later. You may also want to consider joining a Medicare Supplement Insurance (Medigap) policy if you're eligible. See page 69 for more information about buying a Medigap policy.

For more information on joining, dropping, and switching plans, visit **Medicare.gov** or call 1-800-MEDICARE.

Are there other types of Medicare health plans and projects?

Some types of Medicare health plans that provide health coverage aren't Medicare Advantage Plans but are still part of Medicare. Some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.

Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan available in certain areas of the country. Here's what you should know about Medicare Cost Plans:

- You can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. You'll pay the Part A and Part B coinsurance and deductibles.
- You can join anytime the Cost Plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the Cost Plan (if offered) or you can join a Medicare Prescription Drug Plan. Even if the Cost Plan offers prescription drug coverage, you can choose to get drug coverage from a different plan.

  Note: You can add or drop Medicare prescription drug coverage only at certain times. See pages 74–75.

For more information about Medicare Cost Plans, visit the Medicare Plan Finder at **Medicare.gov/find-a-plan**. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 109–112 for the phone number.

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community. To qualify for PACE, you must meet these conditions:

- You're 55 or older.
- You live in the service area of a PACE organization.
- You're certified by your state as needing a nursing home-level of care.
- At the time you join, you're able to live safely in the community with the help of PACE services.

PACE provides coverage for many services, including prescription drugs, doctor or other health care practitioner visits, transportation, home care, hospital visits, and even nursing home stays whenever necessary.

If you have Medicaid, you won't have to pay a monthly premium for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you'll be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE, there's never a deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.

Visit **Medicare.gov/find-a-plan**, to see if there's a PACE organization that serves your community.

Medicare Innovation Projects

Medicare develops innovative models, demonstrations, and pilot projects to test and measure the effect of potential changes in Medicare. These projects help to find new ways to improve health care quality and reduce costs. Usually, they operate only a limited time for a specific group of people and/or are offered only in specific areas. Examples of current models, demonstrations, and pilot projects include innovations in primary care, care related to specific procedures (like hip and knee replacements), cancer care, and care for people with End-Stage Renal Disease. To learn more about the current Medicare models, demonstrations, and pilot projects, visit **innovation.cms.gov**. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION 5

Medicare Supplement Insurance (Medigap) policies

Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medicare Supplement Insurance policies, sold by private companies, can help pay some of the remaining health care costs for covered services and supplies, like copayments, coinsurance, and deductibles. **Medicare Supplement Insurance policies are also called Medigap policies.**

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. Generally, Medigap policies don't cover long-term care (like care in a nursing home), vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Medigap policies are standardized

Every Medigap policy must follow federal and state laws designed to protect you, and they must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" policy identified in most states by letters A through D, F through G, and K through N. All policies offer the same basic benefits, but some offer additional benefits so you can choose which one meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

Important!

Starting January 1, 2020, Medigap plans sold to new people with Medicare won't be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare starting on January 1, 2020. If you already have either of these 2 plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you'll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

Note: Definitions of blue words are on pages 113–116.

How do I compare Medigap policies?

The chart below shows basic information about the different benefits that Medigap policies cover for 2018. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

	Medicare Supplement Insurance (Medigap) plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2018**			
							$5,240	$2,620		

* Plan F also offers a high-deductible plan in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,240 in 2018 before your policy pays anything.

** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($183 in 2018), the Medigap plan pays 100% of covered services for the rest of the calendar year.

** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

What else should I know about Medicare Supplement Insurance (Medigap)?

Important facts

- You must have Part A and Part B.
- You pay the private insurance company a monthly premium for your Medigap policy in addition to your monthly Part B premium that you pay to Medicare. Also, if you join a Medigap policy and a Medicare drug plan offered by the same company, you may need to make 2 separate premium payments for your coverage. Contact the company to find out how to pay your premiums.
- A Medigap policy only covers one person. Spouses must buy separate policies.
- You can't have prescription drug coverage in both your Medigap policy and a Medicare drug plan. See page 81. The same insurance company may offer Medigap policies and Medicare Prescription Drug Plans.
- It's important to compare Medigap policies since the costs can vary between insurance companies for exactly the same coverage, and may go up as you get older. Some states limit Medigap premium costs.
- In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. If you buy a Medicare SELECT policy, you have rights to change your mind within 12 months and switch to a standard Medigap policy.

When to buy

- The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This 6-month period begins on the first day of the month in which you're 65 or older **and** enrolled in Part B. (Some states have additional Open Enrollment Periods.) After this enrollment period, you may not be able to buy a Medigap policy. If you're able to buy one, it may cost more.
- If you delay enrolling in Part B because you have group health coverage based on your (or your spouse's) current employment, your Medigap Open Enrollment Period won't start until you sign up for Part B.
- Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65. If you're under 65, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65. If you're able to buy one, it may cost more.

How does Medigap work with Medicare Advantage Plans?

- If you have a Medicare Advantage Plan (like an HMO or PPO), it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare. If you're not planning to leave your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.
- If you have a Medigap policy and join a Medicare Advantage Plan, you may want to drop your Medigap policy. Your Medigap policy **can't** be used to pay your Medicare Advantage Plan copayments, deductibles, and premiums. If you want to cancel your Medigap policy, contact your insurance company. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you won't be able to get it back.
- If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you'll have special rights under federal law to buy a Medigap policy if you return to Original Medicare within 12 months of joining.
    - If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
    - If you joined a Medicare Advantage Plan when you were first eligible for Medicare, you can choose from any Medigap policy within the first year of joining.
    - You may be able to join a Medicare Prescription Drug Plan.
    - Some states provide additional special rights.

Where can I get more information?

- Visit **Medicare.gov** to find policies in your area.
- Visit **Medicare.gov/publications** to view the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."
- Call your State Insurance Department. Visit **Medicare.gov/contacts**, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

SECTION 6

Medicare prescription drug coverage (Part D)

How does Medicare prescription drug coverage (Part D) work?

Medicare prescription drug coverage is an optional benefit. Medicare offers drug coverage to everyone with Medicare. Even if you don't take prescriptions now, you should consider joining a Medicare drug plan. If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage or get Extra Help, you'll likely pay a late enrollment penalty if you join a plan later. Generally, you'll pay this penalty for as long as you have Medicare prescription drug coverage. See pages 77–78. To get Medicare prescription drug coverage, you must join a plan approved by Medicare that offers Medicare drug coverage. Each plan can vary in cost and specific drugs covered. Visit the Medicare Plan Finder at **Medicare.gov/find-a-plan** for more information about plans in your area.

There are 2 ways to get Medicare prescription drug coverage:

1. **Medicare Prescription Drug Plans.** These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) plans, and Medicare Medical Savings Account (MSA) plans. You must have Part A and/or Part B to join a Medicare Prescription Drug Plan.

2. **Medicare Advantage Plans (like HMOs or PPOs) or other Medicare health plans that offer Medicare prescription drug coverage.** You get all of your Part A, Part B, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs." Remember, you must have Part A and Part B to join a Medicare Advantage Plan, and not all of these plans offer drug coverage.

In either case, you must live in the service area of the Medicare drug plan you want to join. **Both types of plans are called "Medicare drug plans" in this handbook.**

Note: Definitions of blue words are on pages 113–116.

If you have employer or union coverage

Important!

Call your benefits administrator before you make any changes, or sign up for any other coverage. Signing up for other coverage could cause you to lose your employer or union health and drug coverage for you and your dependents. If you lose your employer or union coverage, you may not be able to get it back. If you want to know how Medicare prescription drug coverage works with other drug coverage you may have, see page 58.

When can I join, switch, or drop a Medicare drug plan?

- When you first become eligible for Medicare, you can join during your Initial Enrollment Period. See page 17.
- If you get Part B for the first time during the General Enrollment Period, you can also join a Medicare drug plan from April 1–June 30. Your coverage will start on July 1. See page 18.
- You can join, switch, or drop between October 15–December 7 each year. Your changes will take effect on January 1 of the following year, as long as the plan gets your request before December 7.

New!

- If you're enrolled in a Medicare Advantage Plan, you can join, switch, or drop a plan during the Medicare Advantage Open Enrollment Period, between January 1–March 31 each year. See page 65 for more information.
- If you qualify for a Special Enrollment Period. See the next page.

Special Enrollment Periods

Special Enrollment Periods are times when you can join, switch, or drop your Medicare drug coverage if you meet certain requirements. Generally you must stay enrolled in your Medicare drug plan for the entire year, but you can change your coverage mid-year if you qualify for a Special Enrollment Period. Some examples are if you:

- Move out of your plan's service area.
- Lose other creditable prescription drug coverage.
- Live in an institution (like a nursing home).
- Have (or lose) Medicaid.
- Qualify for (or lose) Extra Help. See pages 97–98.

5-star Special Enrollment Period

You can switch to a Medicare Prescription Drug Plan that has **5 stars for its overall star rating** from December 8, 2018 – November 30, 2019. You can only use this Special Enrollment Period once during this timeframe. The overall star ratings are available at **Medicare.gov/find-a-plan**.

Important!

If you have a Medicare Advantage Plan

If your Medicare Advantage Plan includes prescription drug coverage, and you use an enrollment period to join a Medicare Prescription Drug Plan, you'll be disenrolled from your Medicare Advantage Plan, including the health benefit. You'll be returned to Original Medicare for coverage of your health services.

How do I switch?

You can switch to a new Medicare drug plan simply by joining another drug plan during one of the times listed on pages 74–75. **You don't need to cancel your old Medicare drug plan.** Your old Medicare drug plan coverage will end when your new drug plan coverage begins. You should get a letter from your new Medicare drug plan telling you when your coverage with the new plan begins. You can switch plans by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

How do I drop a Medicare drug plan?

If you want to drop your Medicare drug plan and don't want to join a new plan, you can only do so during certain times. See pages 74–75. You can disenroll by calling 1-800-MEDICARE. You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty if you don't have creditable prescription drug coverage. See pages 77–79.

Read the information you get from your plan

Review the "Evidence of Coverage" (EOC) and "Annual Notice of Change" (ANOC) your plan sends you each year. The EOC gives you details about what the plan covers, how much you pay, and more. The ANOC includes any changes in coverage, costs, provider networks, service area, and more that will be effective in January. If you don't get these important documents in the early fall, contact your plan.

How much do I pay?

Below and continued on the next page are descriptions of what you pay in your Medicare drug plan. **Your actual drug plan costs will vary depending on:**

- Your prescriptions and whether they're on your plan's formulary (list of covered drugs) and depending on what "tier" the drug is in. See page 79.
- Which phase of your drug benefit that you're in (some examples include whether or not you met your deductible, if you're in the coverage gap, etc.)
- The plan you choose. Remember, plan costs can change each year.
- Which pharmacy you use (whether it offers preferred or standard cost sharing, is out-of-network, or is mail order). Your out-of-pocket prescription drug costs may be less at a preferred pharmacy because it has agreed with your plan to charge less.
- Whether you get Extra Help paying your Part D costs. See pages 83–84.

Monthly premium

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. If you're in a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage.

Note: Contact your drug plan (not Social Security or the Railroad Retirement Board (RRB)) if you want your premium deducted from your monthly Social Security or RRB payment. If you want to stop premium deductions and get billed directly, contact your drug plan.

Important!

If you have a higher income, you might pay more for your Part D coverage. If your income is above a certain limit ($85,000 if you file individually or $170,000 if you're married and file jointly), you'll pay an extra amount in addition to your plan premium (sometimes called "Part D-IRMAA"). This doesn't affect everyone, so most people won't have to pay a higher amount. You'll also have to pay this extra amount if you're in a Medicare Advantage Plan that includes drug coverage.

Usually, the extra amount will be deducted from your Social Security check. If you get benefits from the Railroad Retirement Board (RRB), the extra amount will be deducted from your RRB check. **If you're billed the amount by Medicare or the RRB, you must pay the extra amount to Medicare or the RRB and not your plan.** If you don't pay the extra amount, you could lose your Part D coverage. You may not be able to enroll in another plan right away, and you may have to pay a late enrollment penalty for as long as you have Part D.

If you have to pay an extra amount and you disagree (for example, you have a life event that lowers your income), visit **socialsecurity.gov** or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Yearly deductible

This is the amount you must pay before your drug plan begins to pay its share of your covered drugs. Some drug plans don't have a deductible.

Copayments or coinsurance

These are the amounts you pay for your covered prescriptions after the deductible (if the plan has one). You pay your share and your drug plan pays its share for covered drugs. If you pay a coinsurance, these amounts may vary throughout the year due to changes in the drug's total cost.

Coverage gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after you and your drug plan together have spent a certain amount for covered drugs. In 2019, once you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 37% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap because their drug costs won't be high enough.

These costs (sometimes called true out-of-pocket, or "TrOOP," costs) all **count** toward you getting out of the coverage gap:

- Your yearly deductible, coinsurance, and copayments
- The discount you get on covered brand-name drugs in the coverage gap
- What you pay in the coverage gap

The drug plan premium and what you pay for drugs that aren't covered **don't count** toward getting you out of the coverage gap.

Some plans offer additional cost-sharing reductions in the gap beyond the standard benefits and discounts on brand-name and generic drugs, but they may charge a higher monthly premium. Check with the plan first to see if your drugs would have additional cost-sharing reductions while you're in the gap.

Catastrophic coverage

Once you've met the out-of-pocket cost requirements of the coverage gap (or threshold), you automatically get "catastrophic coverage." With catastrophic coverage, you only pay a reduced coinsurance amount or copayment for covered drugs for the rest of the year.

Note: If you get Extra Help, you won't have some of these costs. See pages 83–84.

Important!

Visit **Medicare.gov/find-a-plan** to get specific Medicare drug plan costs, and call the plans you're interested in to get more details. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

What's the Part D late enrollment penalty?

The late enrollment penalty is an amount that's permanently added to your Part D premium. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage. You'll generally have to pay the penalty for as long as you have Part D coverage.

Note: If you get Extra Help, you don't pay a late enrollment penalty.

3 ways to avoid paying a penalty:

1. **Join a Medicare drug plan when you're first eligible.** Even if you don't take prescriptions now, you should consider joining a Medicare drug plan or a Medicare Advantage Plan that offers drug coverage to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly premiums. See pages 4–8 to learn more about your choices.

2. **Enroll in a Medicare drug plan if you lose other creditable coverage.** Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or individual health insurance coverage. Your plan must tell you each year if your drug coverage is creditable coverage. If you go 63 days or more in a row without a Medicare drug plan or other creditable prescription drug coverage, you may have to pay a penalty if you join later.

3. **Keep records showing when you had creditable drug coverage, and tell your plan if they ask about it.** If you don't tell the plan about your creditable prescription drug coverage, you may have to pay a penalty for as long as you have Part D coverage.

How much more will I pay?
The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" ($35.02 in 2018) by the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase each year. After you join a Medicare drug plan, the plan will tell you if you owe a penalty and what your premium will be.

Example:
Mrs. Martin didn't join when she was first eligible—by June 2015. She doesn't have prescription drug coverage from any other source. She joined a Medicare drug plan during November 2017, and her coverage began on January 1, 2018.

Since Mrs. Martin was without creditable prescription drug coverage from July 2015–December 2017, her penalty in 2018 is 30% (1% for each of the 30 months) of $35.02 (the national base beneficiary premium for 2018), which is $10.50. She'll be charged $10.50 each month in addition to her plan's monthly premium in 2018. She'll continue to pay a penalty for as long as she has Part D coverage, and the amount may go up each year.

Here's the math:

.30 (30% penalty) × **$35.02** (2018 base beneficiary premium) = **$10.50**

$10.50 = **Mrs. Martin's monthly late enrollment penalty for 2018**

What if I don't agree with the penalty?

If you disagree with your penalty, you can ask for a review or reconsideration. Generally, you must request this review within 60 days from the date on the first letter you get stating you have to pay a late enrollment penalty. You'll need to fill out a reconsideration request form (that your Medicare drug plan will send you) by the date listed in the letter. You can provide proof that supports your case, like information about previous creditable prescription drug coverage. If you need help, call your plan.

Which drugs are covered?

Information about a plan's list of covered drugs (called a "formulary") isn't included in this handbook because each plan has its own formulary. Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier. In some cases, if your drug is in a higher tier and your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) thinks you need that drug instead of a similar drug in a lower tier, you or your prescriber can ask your plan for an exception to get a lower coinsurance or copayment for the drug in the higher tier. See page 92 for more information on exceptions.

Formularies are subject to change and can be changed by the plan. Your plan will notify you of any formulary changes that affect drugs you're taking.

Contact the plan for its current formulary, or visit the plan's website. You can also visit the Medicare Plan Finder at **Medicare.gov/find-a-plan**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Your plan will notify you of any formulary changes.

Important!

Each month that you fill a prescription, your drug plan mails you an "Explanation of Benefits" (EOB) notice. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes. If you suspect fraud, call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). See page 98 for more information about the MEDIC.

Plans may have these coverage rules:

- **Prior authorization**: You and/or your prescriber must contact the drug plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is medically necessary for the plan to cover it.
- **Quantity limits**: Limits on how much medication you can get at a time.
- **Step therapy**: You must try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.

Before your prescriptions are filled, your Medicare drug plan will also perform additional safety checks, like checking for unsafe amounts of opioid pain medications.

If you or your prescriber believe that one of these coverage rules should be waived, you can ask for an exception. See page 92.

Do you get automatic prescription refills in the mail?

Some people with Medicare get their prescription drugs by using an "automatic refill" service that automatically delivers prescription drugs when they're about to run out. To make sure you still need a prescription before they send you a refill, prescription drug plans should get your approval to deliver a new or refilled prescription before each delivery, except when you ask for the refill or new prescription. If you get a prescription automatically by mail that you don't want, and you weren't contacted to see if you wanted it before it shipped, you may be eligible for a refund.

Medication Therapy Management (MTM) Program

Plans with Medicare prescription drug coverage must offer additional Medication Therapy Management (MTM) services to plan members who meet certain requirements. Members who qualify can get these MTM services to help them understand how to manage their medications and use them safely. The MTM services offered may vary in some plans. MTM services are free and usually include a discussion with a pharmacist or health care provider to review your medications. The pharmacist or health care provider may talk with you about:

- How well your medications are working
- Whether your medications have side effects
- If there might be interactions between the drugs you're taking
- Whether your costs can be lowered
- Other problems you're having

Visit **Medicare.gov/find-a-plan** to get general information about program eligibility for your Medicare drug plan or for other plans that interest you. Contact each drug plan for specific details.

Drug Management Programs

Medicare drug plans may also have Drug Management Programs to monitor the safe use of prescription drugs that are frequently abused. Medicare drug plans can limit drug coverage if you may be at risk of abusing certain drugs. If you use opioid medications from several doctors and/or pharmacies, your plan may communicate with the doctors who prescribed these medications to make sure this use is appropriate and medically necessary. Your plan will give you a letter in advance if coverage of your opioid or benzodiazepine medications will be limited, or if you'll be required to get your opioid or benzodiazepine prescriptions from certain doctors or pharmacies. If you disagree with the plan's decision, you and your prescriber have the right to appeal the determination that you're an at-risk beneficiary by contacting your plan. Also, you may be exempt from a Drug Management Program if, for example, you have cancer and/or you're in hospice or long-term care facility.

How do other insurance and programs work with Part D?

The next 2 pages provide information about how other insurance you have works with, or is affected by, Medicare prescription drug coverage (Part D).

Employer or union health coverage

This is health coverage from your, your spouse's, or other family member's current or former employer or union. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your prescription drug coverage is creditable. **Keep the information you get.** Call your benefits administrator for more information before making any changes to your coverage.

Note: If you join a Medicare drug plan, you, your spouse, or your dependents may lose your employer or union health coverage.

COBRA

This is a federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. As explained on page 18, there may be reasons why you should take Part B instead of, or in addition to, COBRA coverage. However, if you take COBRA and it includes creditable prescription drug coverage, you'll have a Special Enrollment Period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends. Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you. See pages 109–112 for the phone number.

Medicare Supplement Insurance (Medigap) policy with prescription drug coverage

You may choose to join a Medicare drug plan because most Medigap drug coverage isn't creditable, and you may pay more if you join a drug plan later. See pages 77–78. Medigap policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Medigap policy, you can keep it. If you join a Medicare drug plan, tell your Medigap insurance company so they can remove the prescription drug coverage under your Medigap policy and adjust your premiums. Call your Medigap insurance company for more information.

Note: Keep any creditable prescription drug coverage information you get from your plan. You may need it if you decide to join a Medicare drug plan later. Don't send creditable coverage letters or certificates to Medicare.

How does other government insurance work with Part D?

The types of insurance on the next page are all considered creditable prescription drug coverage, and in most cases, it will be to your advantage to keep this coverage if you have it.

Federal Employee Health Benefits (FEHB) Program: This is health coverage for current and retired federal employees and covered family members. FEHB plans usually include prescription drug coverage, so you don't need to join a Medicare drug plan. However, if you decide to join a Medicare drug plan, you can keep your FEHB plan, and in most cases, the Medicare plan will pay first. For more information for retirees, visit **opm.gov/healthcare-insurance/healthcare**, or call the Office of Personnel Management at 1-888-767-6738. TTY users can call 1-800-878-5707. If you're an active federal employee, contact your Benefits Officer. Visit **apps.opm.gov/abo** for a list of Benefits Officers. You can also call your plan if you have questions.

Veterans' benefits: This is health coverage for veterans and people who have served in the U.S. military. You may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a Medicare drug plan, but if you do, you can't use both types of coverage for the same prescription at the same time. For more information, visit **va.gov**, or call the VA at 1-800-827-1000. TTY users can call 1-800-829-4833.

TRICARE (military health benefits): This is a health care plan for active-duty service members, military retirees, and their families. **Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits**. If you have TRICARE, you don't need to join a Medicare Prescription Drug Plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a Medicare Advantage Plan (like an HMO or PPO) with prescription drug coverage, your Medicare Advantage Plan and TRICARE may coordinate their benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy. Otherwise, you can file your own claim to get paid back for your out-of-pocket expenses. For more information, visit **tricare.mil**, or call the TRICARE Pharmacy Program at 1-877-363-1303. TTY users can call 1-877-540-6261.

Indian Health Service (IHS): The IHS is the primary health care provider to the American Indian/Alaska Native Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services through a network of hospitals, clinics, and other entities. Many Indian health facilities participate in the Medicare prescription drug program. If you get prescription drugs through an Indian health facility, you'll continue to get drugs at no cost to you, and your coverage won't be interrupted. Joining a Medicare drug plan may help your Indian health facility because the drug plan pays the Indian health facility for the cost of your prescriptions. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

Note: If you're getting care through an IHS or tribal health facility or program without being charged, you can continue to do so for some or all of your care. Getting Medicare doesn't affect your ability to get services through the IHS and tribal health facilities.

SECTION 7

Get help paying your health & prescription drug costs

What if I need help paying my Medicare prescription drug costs?

If you have limited income and resources, you may qualify for help to pay for some health care and prescription drug costs.

Note: Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. See page 88 for information about programs that are available in those areas.

Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs. You may qualify for Extra Help if your yearly income and resources are below these limits in 2018:

	Yearly income	Other resources
Single person	less than $18,210 per year	resources less than $14,100 per year
Married person living with a spouse and no other dependents	less than $24,690	less than $28,150 per year

These amounts may change in 2019. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents living with you). Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources **don't** include your home, car, household items, burial plot, up to $1,500 for burial expenses (per person), or life insurance policies.

If you qualify for Extra Help and join a Medicare drug plan, you'll:

- Get help paying your Medicare drug plan's costs.
- Have no coverage gap.
- Have no late enrollment penalty.

Note: Definitions of blue words are on pages 113–116.

Most people with Medicare can only make changes to their drug coverage certain times of the year. If you newly get, lose, or have a change in your Medicaid or Extra Help status, you'll get a Special Enrollment Period to change plans.

If you have Medicaid or get Extra Help, you'll also be able to make changes to your coverage one time during each of these periods:

- January–March
- April–June
- July–September

If you made a change during one of these periods, it will take effect on the first day of the following month. You'll have to wait for the next period to make another change. You can't use this Special Enrollment Period from October–December. However, all people with Medicare can make changes to their coverage from October 15–December 7, and the changes will take effect on January 1.

You automatically qualify for Extra Help if you have Medicare and meet any of these conditions:

- You have full Medicaid coverage.
- You get help from your state Medicaid program paying your Part B premiums (in a Medicare Savings Program). See pages 86–87.
- You get Supplemental Security Income (SSI) benefits.

To let you know you automatically qualify for Extra Help, Medicare will mail you a purple letter that you should keep for your records. You don't need to apply for Extra Help if you get this letter.

- If you aren't already in a Medicare drug plan, you must join one to use this Extra Help.
- If you don't join a Medicare drug plan, Medicare may enroll you in one so that you'll be able to use the Extra Help. If Medicare enrolls you in a plan, you'll get a yellow or green letter letting you know when your coverage begins, and you'll have a Special Enrollment Period to change plans.
- Different plans cover different drugs. Check to see if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. Visit **Medicare.gov/find-a-plan**, or call 1-800-MEDICARE (1-800-633-4227) to compare with other plans in your area. TTY users can call 1-877-486-2048.
- If you have Medicaid and live in certain institutions (like a nursing home) or get home- and community-based services, you pay nothing for your covered prescription drugs.

If you don't want to join a Medicare drug plan (for example, because you want only your employer or union coverage), call the plan listed in your letter, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Tell them you don't want to be in a Medicare drug plan (you want to "opt out"). If you continue to qualify for Extra Help or if your employer or union coverage is creditable prescription drug coverage, you won't have to pay a penalty if you join later.

Important! If you have employer or union coverage and you join a Medicare drug plan, you may lose your employer or union coverage (for you and your dependents) even if you qualify for Extra Help. Call your employer's benefits administrator before you join a Medicare drug plan.

If you didn't automatically qualify for Extra Help, you can apply anytime:

- Visit **socialsecurity.gov/i1020** to apply online.
- Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Drug costs in 2019 for people who qualify will be no more than $3.40 for each generic drug and $8.50 for each brand-name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

To get answers to your questions about Extra Help and help choosing a drug plan, call your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number. You can also call 1-800-MEDICARE.

What if I need help paying my Medicare health care costs?

Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs if you meet certain conditions.

There are 4 kinds of Medicare Savings Programs:

1. **Qualified Medicare Beneficiary (QMB) Program:** If you're eligible, the QMB Program helps pay for Part A and/or Part B premiums. In addition, Medicare providers aren't allowed to bill you for Medicare deductibles, coinsurance, and copayments when you get services and items Medicare covers, except outpatient prescription drugs.

   To make sure your provider knows you have QMB, show both your Medicare and Medicaid or QMB card each time you get care. If you get a bill for medical care Medicare covers, call your provider about the charges. If you have Original Medicare, show your provider your Medicare Summary Notice (see page 52). It will show you have QMB and that you shouldn't be billed. Tell them that you have QMB and can't be charged for Medicare deductibles, coinsurance, and copayments. If this doesn't resolve the billing problem, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Medicare will ask the provider to stop improper billing, and refund any incorrect payments you made. If you're in a Medicare Advantage Plan, call your plan.

2. **Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay Part B premiums only.

3. **Qualifying Individual (QI) Program:** Helps pay Part B premiums only. You must apply each year for QI benefits and the applications are granted on a first-come, first-served basis.

4. **Qualified Disabled and Working Individuals (QDWI) Program:** Helps pay Part A premiums only. You may qualify for this program if you have a disability and are working.

If you qualify for a QMB, SLMB, or QI Program, you automatically qualify to get Extra Help paying for Medicare prescription drug coverage. See pages 83–85.

Important! The names of these programs and how they work may vary by state. Medicare Savings Programs aren't available in Puerto Rico and the U.S. Virgin Islands.

How do I qualify?

In most cases, to qualify for a Medicare Savings Program, you must have income and resources below a certain limit.

Many states figure your income and resources differently, so you should check with your state to see if you qualify.

For more information

- Call or visit your Medicaid office, and ask for information about Medicare Savings Programs. To get the phone number for your state, visit **Medicare.gov/contacts**. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Contact your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs if you have limited income and/or resources and meet other requirements. Some people qualify for both Medicare and Medicaid.

What does Medicaid cover?

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You can get your Medicare coverage through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO).
- If you have Medicare and/or full Medicaid coverage, Medicare covers your Part D prescription drugs. Medicaid may still cover some drugs and other care that Medicare doesn't cover.
- People with Medicaid may get coverage for services that Medicare may not or may partially cover, like nursing home care, personal care, and home- and community-based services.

How do I qualify?

- Medicaid programs vary from state to state. They may also have different names, like "Medical Assistance" or "Medi-Cal."
- Each state has different income and resource requirements.
- In some states, you may need to be enrolled in Medicare, if eligible, to get Medicaid.
- Call your Medicaid office (State Medical Assistance Office) for more information and to see if you qualify. Visit **Medicare.gov/contacts**, or call 1-800-MEDICARE.

Demonstration plans for people who have both Medicare and Medicaid

Medicare is working with some states and health plans to offer demonstration plans for certain people who have both Medicare and Medicaid, called Medicare-Medicaid Plans. If you're interested in joining a Medicare-Medicaid Plan, visit **Medicare.gov/find-a-plan** to see if one is available in your area and if you qualify. Call your Medicaid office for more information.

State Pharmacy Assistance Programs (SPAPs)

Many states have SPAPs that help certain people pay for prescription drugs based on financial need, age, or medical condition. To find out if there's an SPAP in your state and how it works, call your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

Pharmaceutical Assistance Programs (also called Patient Assistance Programs)

Many major drug manufacturers offer assistance programs for people with Medicare drug coverage who meet certain requirements. Visit **Medicare.gov/pharmaceutical-assistance-program** to learn more about Pharmaceutical Assistance Programs.

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who need a nursing home-level of care to remain in the community. See page 68 for more information.

Supplemental Security Income (SSI) benefits

SSI is a cash benefit paid by Social Security to people with limited income and resources who are blind, 65 or older, or have a disability. SSI benefits aren't the same as Social Security retirement benefits.

You can visit **benefits.gov/ssa**, and use the "Benefit Eligibility Screening Tool" to find out if you're eligible for SSI or other benefits. Call Social Security at 1-800-772-1213 or contact your local Social Security office for more information. TTY users can call 1-800-325-0778.

Note: People who live in Puerto Rico, the U.S. Virgin Islands, Guam, or American Samoa can't get SSI.

Programs for people who live in the U.S. territories

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your Medicaid office (State Medical Assistance Office) to learn more. Visit **Medicare.gov/contacts**, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.

SECTION 8

Know your rights & protect yourself from fraud

What are my Medicare rights?

No matter how you get your Medicare, you have certain rights and protections. All people with Medicare have the right to:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have personal and health information kept private
- Get information in a way they understand from Medicare, health care providers, and Medicare contractors
- Have questions about Medicare answered
- Have access to doctors, other health care providers, specialists, and hospitals
- Learn about their treatment choices in clear language that they can understand, and participate in treatment decisions
- Get Medicare-covered services in an emergency
- Get a decision about health care payment, coverage of services, or prescription drug coverage
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- File complaints (sometimes called "grievances"), including complaints about the quality of their care

Note: Definitions of blue words are on pages 113–116.

What are my rights if my plan stops participating in Medicare?

Medicare health and prescription drug plans can decide not to participate in Medicare for the coming year. In these cases, your coverage under the plan will end after December 31. Your plan will send you a letter explaining your options. If this happens:

- You can choose another plan between October 15–December 7. Your coverage will begin January 1.
- **You'll also have a special right to join another Medicare plan until February 28, 2019.**
- You may have the right to buy certain Medigap policies within 63 days after your plan coverage ends.

What's an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan denies:

- A request for a health care service, supply, item, or prescription drug that you think should be covered by Medicare.
- A request for payment of a health care service, supply, item, or prescription drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug.

You can also appeal:

- If Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.
- An at-risk determination made under a drug management program that limits access to coverage for frequently abused drugs (see page 80).

If you decide to file an appeal, you can ask your doctor, supplier, or other health care provider for any information that may help your case. This will make your appeal stronger. Keep a copy of everything related to your appeal, including what you send to Medicare or your plan.

How do I file an appeal?

How you file an appeal depends on the type of Medicare coverage you have:

If you have Original Medicare

- Get the "Medicare Summary Notice" (MSN) that shows the item or service you're appealing. See page 52 for more information about MSNs.
- Circle the item(s) on the MSN you disagree with. Write an explanation of why you disagree with the decision. You can write on the MSN or on a separate piece of paper and attach it to the MSN.
- Include your name, phone number, and Medicare Number on the MSN, and sign it. Keep a copy for your records.
- Send the MSN, or a copy, to the company that handles bills for Medicare (Medicare Administrative Contractor or MAC) listed on the MSN. You can include any other additional information you have about your appeal. Or, you can use CMS Form 20027. To view or print this form, visit **CMS.gov/cmsforms/downloads/cms20027.pdf**, or call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users can call 1-877-486-2048.
- You must file the appeal within 120 days of the date you get the MSN in the mail.
- You'll generally get a decision from the Medicare Administrative Contractor (MAC) within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

If you have a Medicare health plan

The time frame for filing an appeal may be different than Original Medicare. Learn more by looking at the materials your plan sends you, calling your plan, or visiting **Medicare.gov/appeals**.

In some cases, you can file a fast appeal. See materials from your plan and page 92.

If you have a Medicare Prescription Drug Plan

You have the right to do all of these (even before you buy a certain drug):

- Get a written explanation (called a "coverage determination") from your Medicare drug plan. A coverage determination is the first decision your Medicare drug plan (not the pharmacy) makes about your benefits. This can be a decision about if your drug is covered, if you met the plan's requirements to cover the drug, or how much you pay for the drug. You'll also get a coverage determination decision if you ask your plan to make an exception to its rules to cover your drug.
- Ask for an exception if you or your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) believes you need a drug that isn't on your plan's formulary.
- Ask for an exception if you or your prescriber believes that a coverage rule (like prior authorization) should be waived.
- Ask for an exception if you think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can't take any of the lower tier (less expensive) drugs for the same condition.

How do I ask for a coverage determination or exception?

You or your prescriber must contact your plan to ask for a coverage determination or an exception. If your network pharmacy can't fill a prescription, the pharmacist will give you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't give you this notice, ask for a copy.

If you're asking for prescription drug benefits you haven't gotten yet, you or your prescriber may make a standard request by phone or in writing. If you're asking to get paid back for prescription drugs you already bought, your plan can require you or your prescriber to make the standard request in writing.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't gotten the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

Important! If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why your plan should approve the exception.

What are my rights if I think my services are ending too soon?

If you're getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon (or that you're being discharged too soon), you can ask for a fast appeal. Your provider will give you a notice before your services end that will tell you how to ask for a fast appeal. The notice might call it an "immediate appeal" or an "expedited appeal." You should read this notice carefully. If you don't get this notice, ask your provider for it. With a fast appeal, an independent reviewer will decide if your services should continue.

How can I get help filing an appeal?

You can appoint a representative to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor or someone else who will act on your behalf. For more information, visit Medicare.gov/appeals. You can also get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

What's an "Advance Beneficiary Notice of Noncoverage" (ABN)?

If you have Original Medicare, your doctor, other health care provider, or supplier may give you a notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) if they think the care they'll provide isn't covered by Medicare. This notice says Medicare probably (or certainly) won't pay for some services in certain situations.

What happens if I get an ABN?

- You'll be asked to choose whether to get the items or services listed on the ABN.
- If you choose to get the items or services listed on the ABN, you're agreeing to pay if Medicare doesn't.
- You'll be asked to sign the ABN to say that you've read and understood it.
- Doctors, other health care providers, and suppliers don't have to (but still may) give you an ABN for services that Medicare never covers. See page 92.
- An ABN isn't an official denial of coverage by Medicare. If Medicare denies payment, you can still file an appeal. However, you'll have to pay for the items or services if Medicare decides that the items or services aren't covered (and no other insurer is responsible for payment).

Can I get an ABN for other reasons?

You may get a "Skilled Nursing Facility ABN" when the facility believes Medicare will no longer cover your stay or other items and services.

What if I didn't get an ABN?

If your provider was required to give you an ABN but didn't, in most cases, your provider must give you a refund for what you paid for the item or service.

Where can I get more information about appeals and ABNs?

- Visit **Medicare.gov/appeals**.
- Visit **Medicare.gov/publications** to view the booklet "Medicare Appeals."
- If you're in a Medicare plan, call your plan to find out if a service or item will be covered.

Your right to access your personal health information

By law, you or your legal representative generally has the right to view and/or get copies of your personal health information from health care providers who treat you, or by health plans that pay for your care, including Medicare. In most cases, you also have the right to have a provider or plan send copies of your information to a third party that you choose, like other providers who treat you, a family member, a researcher, or a mobile application (or "app") you use to manage your personal health information.

This includes:

- Claims and billing records
- Information related to your enrollment in health plans, including Medicare
- Medical and case management records (except psychotherapy notes)
- Any other records that contain information that doctors or health plans use to make decisions about you

You may have to fill out a health information "request" form, and pay a reasonable, cost-based fee for copies. Your providers or plans should tell you about the fee when you make the request. If they don't, you should ask. The fee can only be for the labor to make the copies, copying supplies, and postage (if needed). In most cases, you shouldn't be charged for viewing, searching, downloading, or sending your information through an electronic portal.

Generally, you can get your information on paper or electronically. If your providers or plans store your information electronically, they generally must give you electronic copies, if that's your preference.

You have the right to get your information in a timely manner, but it may take up to 30 days to fill the request.

For more information, visit **hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html**.

How does Medicare use my personal information?

Medicare protects the privacy of your health information. The next 2 pages describe how your information may be used and given out, and explain how you can get this information.

Notice of Privacy Practices for Original Medicare

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.

The law requires Medicare to protect the privacy of your personal medical information. It also requires us to give you this notice so you know how we may use and share ("disclose") the personal medical information we have about you.

We must provide your information to:

- You, to someone you name ("designate"), or someone who has the legal right to act for you (your personal representative)
- The Secretary of the Department of Health and Human Services, if necessary
- Anyone else that the law requires to have it

We have the right to use and provide your information to pay for your health care and to operate Medicare. For example:

- Medicare Administrative Contractors use your information to pay or deny your claims, collect your premiums, share your benefit payment with your other insurer(s), or prepare your "Medicare Summary Notice."
- We may use your information to provide you with customer services, resolve complaints you have, contact you about research studies, and make sure you get quality care.

We may use or share your information under these limited circumstances:

- To state and other federal agencies that have the legal right to get Medicare data (like to make sure Medicare is making proper payments and to help federal/state Medicaid programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like investigating fraud and abuse)
- For judicial and administrative proceedings (like responding to a court order)
- For law enforcement purposes (like providing limited information to find a missing person)
- For research studies that meet all privacy law requirements (like research to prevent a disease or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you about new or changed Medicare benefits
- To create a collection of information that no one can trace to you
- To practitioners and their contractors for care coordination and quality improvement purposes, like Accountable Care Organizations (ACOs).

- We must have your written permission (an "authorization") to use or share your information for any purpose that isn't described in this notice. We don't sell or use and share your information to tell you about health products or services ("marketing"). You may take back ("revoke") your written permission at any time, unless we've already shared information because you gave us permission.

You have the right to:

- See and get a copy of the information we have about you.
- Have us change your information if you think it's wrong or incomplete, and we agree. If we disagree, you may have a statement of your disagreement added to your information.
- Get a list of people who get your information from us. The listing won't cover information that we gave to you, your personal representative, or law enforcement, or information that we used to pay for your care or for our operations.
- Ask us to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask us to limit how we use your information and how we give it out to pay claims and run Medicare. We may not be able to agree to your request.
- Get a letter that tells you about the likely risk to the privacy of your information ("breach notification").
- Get a separate paper copy of this notice.
- Speak to a Customer Service Representative about our privacy notice. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you believe your privacy rights have been violated, you may file a privacy complaint with:

- The Centers for Medicare & Medicaid Services (CMS). Visit Medicare.gov, or call 1-800-MEDICARE.
- The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). Visit hhs.gov/hipaa/filing-a-complaint.
- Filing a complaint won't affect your coverage under Medicare.
- The law requires us to follow the terms in this notice. We have the right to change the way we use or share your information. If we make a change, we'll mail you a notice within 60 days of the change.

The Notice of Privacy Practices for Original Medicare became effective September 23, 2013.

How can I protect myself from identity theft?

Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name and your Social Security, Medicare, credit card, or bank account numbers. Guard your cards and protect your Medicare and Social Security Numbers. **Keep this information safe.**

Only give personal information, like your Medicare Number, to doctors, insurers or plans acting on your behalf, or trusted people in the community who work with Medicare like your State Health Insurance Assistance Program (SHIP). Don't share your Medicare Number or other personal information with anyone who contacts you by phone, email, or in person. Medicare, or someone representing Medicare, will only call you in limited situations:

- A Medicare health or drug plan can call you if you're already a member of the plan. The agent who helped you join can also call you.
- A customer service representative from 1-800-MEDICARE can call you if you've called and left a message, or a representative said that someone would call you back. If you suspect identity theft, or feel like you gave your personal information to someone you shouldn't have, call your local police department and the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338. TTY users can call 1-866-653-4261. Visit **ftc.gov/idtheft** to learn more about identity theft.

How can I protect myself and Medicare from fraud?

Medicare fraud and abuse can cost taxpayers billions of dollars each year. One common form of Medicare fraud is when a provider bills Medicare for services you never got. When you get health care services, record the dates on a calendar and save the receipts and statements you get from providers to check for mistakes. If you think you see an error or are billed for services you didn't get, take these steps to find out what was billed:

- Check your "Medicare Summary Notice" (MSN) if you have Original Medicare to see if the service was billed to Medicare. If you're in a Medicare health plan, check the statements you get from your plan.
- If you know the health care provider or supplier, call and ask for an itemized statement. They should give this to you within 30 days.
- Visit **MyMedicare.gov** to view your Medicare claims if you have Original Medicare. Your claims are generally available online within 24 hours after processing. You can also download your claims information by using Medicare's Blue Button. See page 103. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you've contacted the provider and you suspect that Medicare is being charged for a service or supply that you didn't get, or you don't know the provider on the claim, call 1-800-MEDICARE.

For more information on protecting yourself from Medicare fraud and tips for spotting and reporting fraud, visit **Medicare.gov**, or contact your local Senior Medicare Patrol (SMP) Program. For more information about the SMP program, visit smpresource.org or call 1-877-808-2468.

You can also visit **oig.hhs.gov** or call the fraud hotline of the Department of Health and Human Services Office of the Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users can call 1-800-377-4950.

Plans must follow rules

Medicare plans must follow certain rules when marketing their plans and getting your enrollment information. They can't ask you for credit card or banking information over the phone or via email, unless you're already a member of that plan. Medicare plans can't enroll you into a plan over the phone unless you call them and ask to enroll, or you've given them permission to contact you.

Important!

Call 1-800-MEDICARE to report any plans that:

- Ask for your personal information over the phone or email
- Call to enroll you in a plan
- Use false information to mislead you

You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). The MEDIC helps prevent inappropriate activity and fights fraud, waste, and abuse in Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Programs.

Fighting fraud can pay

You may get a reward if you help us fight fraud and meet certain conditions. For more information, visit **Medicare.gov**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Investigating fraud takes time

Every tip counts. Medicare takes all reports of suspected fraud seriously. When you report fraud, you may not hear of an outcome right away. It takes time to investigate your report and build a case, but rest assured that your information is helping us protect Medicare.

What's the Medicare Beneficiary Ombudsman?

An "ombudsman" is a person who reviews questions, concerns, and challenges with how a program is administered, and helps to resolve them when possible.

There are several resources to get answers to your Medicare questions and to get assistance with your Medicare, like **Medicare.gov**, 1-800-MEDICARE, and State Health Insurance Assistance Programs (SHIPs). The Medicare Beneficiary Ombudsman works closely with those resources and Medicare to help make sure information and assistance are available for you, and works to improve your experience with Medicare.

Visit **Medicare.gov** for information on how the Medicare Beneficiary Ombudsman can help you.

Notice of Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides auxiliary aids and services to help us better communicate with people with disabilities. Auxiliary aids include materials in Braille, audio/data CD or other accessible formats.

Note: You can get this handbook electronically in standard print, large print, or as an eBook.

For general Medicare inquiries and Medicare publications, call us at 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

For all other CMS publications and documents in accessible formats, you can contact our Customer Accessibility Resource Staff:

- Call 1-844-ALT-FORM (1-844-258-3676). TTY: 1-844-716-3676.
- Send a fax to 1-844-530-3676.
- Send an email to AltFormatRequest@cms.hhs.gov.
- Send a letter to:
  Centers for Medicare & Medicaid Services
  Offices of Hearings and Inquiries (OHI)
  7500 Security Boulevard, Mail Stop S1-13-25
  Baltimore, MD 21244-1850
  Attn: Customer Accessibility Resource Staff

You can also contact the Customer Accessibility Resource staff:

- To inquire about a request for accessible formats.
- To submit concerns and issues about accessible communications, including the quality and timeliness of your request.

Note: Your request for a CMS publication or document should include:

- Your name, phone number, and the mailing address where we should send the publications or documents.
- The publication title and CMS Product No., if known.
- The format you need, like Braille, large print, or data/audio CD.

Note: If you're enrolled in a Medicare Advantage or Prescription Drug Plan, you can contact your plan to request their documents in an accessible format.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

How to file a complaint

If you believe you've been subjected to discrimination in a CMS program or activity, there are 3 ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. **Online at:** hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. **By phone:** Call 1-800-368-1019. TTY users can call 1-800-537-7697.
3. **In writing:** Send information about your complaint to:
   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

SECTION 9

Get more information

Where can I get personalized help?

1-800-MEDICARE (1-800-633-4227)

TTY users call 1-877-486-2048

Get information 24 hours a day, including weekends

- Speak clearly and follow the voice prompts to pick the category that best meets your needs.
- Have your Medicare card in front of you, and be ready to give your Medicare Number.
- When prompted for your Medicare Number, speak the numbers and letters clearly one at a time.
- If you need help in a language other than English or Spanish, or need to request a Medicare publication in an accessible format (like large print or Braille), let the customer service representative know.

Important!

Do you need someone to be able to call 1-800-MEDICARE on your behalf?

You can fill out a "Medicare Authorization to Disclose Personal Health Information" form so Medicare can give your personal health information to someone other than you. You can find the form by visiting Medicare.gov/medicareonlineforms or get a copy of the form by calling 1-800-MEDICARE. You may want to do this now in case you become unable to do it later.

Did your household get more than one copy of "Medicare & You?"

If you want to get only one copy in the future, call 1-800-MEDICARE.
If you want to stop getting paper copies in the mail, visit Medicare.gov/gopaperless.

Note: Definitions of blue words are on pages 113–116.

What are State Health Insurance Assistance Programs (SHIPs)?

SHIPs are state programs that get money from the federal government to give local health insurance counseling to people with Medicare at no cost to you. SHIPs aren't connected to any insurance company or health plan. SHIP volunteers work hard to help you with these Medicare questions or concerns:

- Your Medicare rights.
- Billing problems.
- Complaints about your medical care or treatment.
- Plan choices.
- How Medicare works with other insurance.
- Finding help paying for health care costs.

See pages 109–112 for the phone number of your local SHIP. If you would like to become a volunteer SHIP counselor, contact the SHIP in your state to learn more.

Where can I find general Medicare information online?

Visit Medicare.gov

- Get information about the Medicare health and prescription drug plans in your area, including what they cost and what services they provide.
- Find doctors or other health care providers and suppliers who participate in Medicare.
- See what Medicare covers, including preventive services.
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospices, inpatient rehabilitation facilities, and long-term care hospitals.
- Look up helpful websites and phone numbers.

Where can I find personalized Medicare information online?

Register at MyMedicare.gov

- Manage your personal information (like medical conditions, allergies, and implanted devices).
- Sign up to get your "Medicare Summary Notices" (eMSNs) and this handbook electronically. You won't get printed copies if you choose to get them electronically.
- Manage your personal drug list and pharmacy information.
- Search for, add to, and manage a list of your favorite providers and access quality information about them.
- Select your primary clinician from your list of favorite providers. Your primary clinician is the practitioner who you want responsible for coordinating your overall care, regardless of where you choose to get services. By choosing a primary clinician, your doctor may have access to more tools or services for your care available to patients of doctors participating in an Accountable Care Organization or certain other Medicare alternative payment models. (This is also known as "voluntary alignment.")
- Track Original Medicare claims and your Part B deductible status.
- Print an official copy of your new Medicare card once it's mailed to you.

MyMedicare.gov's Blue Button®

MyMedicare.gov's Blue Button makes it easy for you to download your personal health information to a file. Having access to your information can help you make more informed decisions about your health care. Blue Button is safe, secure, reliable, and easy to use. By getting your information through Blue Button, you can:

- Download and save a file of your personal health information on your computer or other device, including your Part A, Part B, and Part D claims.
- Print or email the information to share with others after you've saved the file.
- Import your saved file into other computer-based personal health management tools.

Visit **MyMedicare.gov** to use Blue Button today.

How do I compare the quality of health care providers?

Medicare collects information about the quality and safety of medical care and services given by most health care providers (and facilities).

Visit Medicare.gov/quality-care-finder and use the Compare tools to get a snapshot of the quality of care health care providers (and facilities) give their patients. Some of these tools feature a star rating system to help you compare quality measures that are important to you. Find out more about the quality of care by:

- Asking what your health care provider does to ensure and improve the quality of care. Each health care provider should have someone you can talk to about quality.
- Asking your doctor or other health care provider what he or she thinks about the quality of care other providers give. You can also ask your doctor or other health care provider about the quality of care information you find on the Medicare.gov Compare tools.

How do I compare the quality of Medicare health and drug plans?

The Medicare Plan Finder at Medicare.gov/find-a-plan features a star rating system for Medicare health and drug plans. The Overall Star Rating gives an overall rating of the plan's quality and performance for the types of services each plan offers.

For plans covering health services, this is an overall rating for the quality of many medical/health care services that fall into 5 categories:

1. **Staying healthy—screening tests and vaccines:** Includes whether members got various screening tests, vaccines, and other check-ups to help them stay healthy.
2. **Managing chronic (long-term) conditions:** Includes how often members with certain conditions got recommended tests and treatments to help manage their condition.
3. **Member experience with the health plan:** Includes member ratings of the plan.
4. **Member complaints and changes in the health plan's performance:** Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
5. **Health plan customer service:** Includes how well the plan handles member appeals.

For plans covering drug services, this is an overall rating for the quality of prescription-related services that fall into 4 categories:

1. **Drug plan customer service:** Includes how well the plan handles member appeals.
2. **Member complaints and changes in the drug plan's performance:** Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
3. **Member experience with plan's drug services:** Includes member ratings of the plan.
4. **Drug safety and accuracy of drug pricing:** Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that's safer and clinically recommended for their condition.

For plans covering both health and drug services, the overall rating for quality and performance covers all of the topics above.

You can compare the quality of care and services given by health care providers and Medicare plans nationwide by visiting **Medicare.gov** or by calling your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

What's Medicare doing to better coordinate my care?

Medicare continues to look for ways to better coordinate your care and to make sure that you get the best health care possible.

Here are examples of how your **health care providers** can better coordinate your care:

Electronic Health Records (EHRs)
EHRs are records that your doctor, other health care provider, medical office staff, or hospital keeps on a computer about your health care or treatments.

- EHRs can help lower the chances of medical errors, eliminate duplicate tests, and may improve your overall quality of care.
- Your doctor's EHR may be able to link to a hospital, lab, pharmacy, or other doctors, so the people who care for you can have a more complete picture of your health.

Electronic prescribing
This is an electronic way for your prescribers (your doctor or other health care provider who's legally allowed to write prescriptions) to send your prescriptions directly to your pharmacy. Electronic prescribing can save you money and time, and help keep you safe.

Accountable Care Organizations (ACOs)
An ACO is a group of doctors, hospitals, and other health care providers who agree to work together with Medicare to give you more coordinated service and care.

If you have Original Medicare and your doctor has decided to participate in an ACO, you'll be notified. A poster with information about your doctor's participation in an ACO may be displayed at the office, or your doctor may give you this information in writing.

To help you get better, more coordinated care, Medicare will share certain health information with ACOs working with your doctors and other health care providers about the care you get from your doctors and other providers. Just like Medicare, ACOs must put important safeguards in place to make sure your health care information is safe.

Your doctor may ask you to select them as your primary clinician on **MyMedicare.gov**. Medicare may use your selection to hold your doctor's ACO accountable for the quality of your care and overall medical costs. See page 103 for more information.

You can ask Medicare not to share certain information with the ACO about the care you got from your doctors and other health care providers. To do this, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048 and tell us you don't want us to share this information. You can also change your data sharing preferences at any time by calling 1-800-MEDICARE. Even if you ask Medicare not to share your information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of providers participating in ACOs. Also, Medicare may share some of your information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

Your Medicare benefits, services, costs, and protections won't change if your doctor participates in an ACO or if you ask that Medicare not share your information. You still have the right to visit and get care from any doctor or hospital that accepts Medicare at any time, the same way you do now.

The poster in your doctor's office (or written notification) should let you know whether the doctor or ACO has asked Medicare for access to your information about the care you get through Medicare. With the information Medicare shares, the doctors and other health care providers in the ACO can have a complete picture of your health and be better able to coordinate your care.

For more information about ACOs, visit **Medicare.gov**, or call 1-800-MEDICARE.

Are there other ways to get Medicare information?

Publications
Visit Medicare.gov/publications to view, print, or download copies of publications on different Medicare topics. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Accessible formats are available at no cost. See page 99 for more information.

Social media
Stay up to date and connect with other people with Medicare by following us on Facebook (facebook.com/Medicare) and Twitter (twitter.com/MedicareGov).

Videos
Visit YouTube.com/cmshhsgov to see videos covering different health care topics on Medicare's YouTube channel.

Blogs
Visit blog.medicare.gov for up-to-date information on important topics.

Other helpful contacts

Social Security
Find out if you're eligible for Part A and/or Part B and how to enroll, make changes to your Part A and/or Part B coverage, get a replacement Social Security card, report a change to your address or name, apply for Extra Help with Medicare prescription drug costs, ask questions about Part A and Part B premiums, and report a death.

1-800-772-1213, TTY: 1-800-325-0778
socialsecurity.gov

Benefits Coordination & Recovery Center (BCRC)
Contact the BCRC to report changes in your insurance information or to let Medicare know if you have other insurance.

1-855-798-2627, TTY: 1-855-797-2627

Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO)
Contact a BFCC-QIO to ask questions or report complaints about the quality of care you got for a Medicare-covered service (and you aren't satisfied with the way your provider has responded to your concern). Or, you can contact the BFCC-QIO if you think Medicare coverage for your service is ending too soon (for example, if your hospital says that you must be discharged and you disagree). Visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. to get the phone number of your BFCC-QIO.

Department of Defense

Get information about TRICARE for Life (TFL) and the TRICARE Pharmacy Program.

TFL:
1-866-773-0404
TTY: 1-866-773-0405
tricare.mil/tfl
tricare4u.com

Tricare Pharmacy Program:
1-877-363-1303
TTY: 1-877-540-6261
tricare.mil/pharmacy
express-scripts.com/tricare

Department of Veterans Affairs

Contact the VA if you're a veteran or have served in the U.S. military and you have questions about VA benefits.

1-800-827-1000, TTY: 1-800-829-4833
va.gov
vets.gov
eBenefits.va.gov

Office of Personnel Management

Get information about the Federal Employee Health Benefits (FEHB) Program for current and retired federal employees.

Retirees: 1-888-767-6738, TTY: 1-800-878-5707
opm.gov/healthcare-insurance

Active federal employees: Contact your Benefits Officer.
Visit apps.opm.gov/abo for a list of Benefits Officers.

Railroad Retirement Board (RRB)

If you get benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, or report a death.

1-877-772-5772, TTY: 1-312-751-4701
rrb.gov

State Health Insurance Assistance Programs (SHIPs)

For free, personalized help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

Alabama

State Health Insurance Assistance Program (SHIP)
1-800-243-5463

Alaska

Medicare Information Office
1-800-478-6065
TTY: 1-800-770-8973

Arizona

Arizona State Health Insurance Assistance Program (SHIP)
1-800-432-4040

Arkansas

Senior Health Insurance Information Program (SHIIP)
1-800-224-6330

California

California Health Insurance Counseling & Advocacy Program (HICAP)
1-800-434-0222

Colorado

State Health Insurance Assistance Program (SHIP)
1-888-696-7213

Connecticut

Connecticut program for Health insurance assistance, Outreach, Information & referral, Counseling and Eligibility Screening (CHOICES)
1-800-994-9422

Delaware

Delaware Medicare Assistance Bureau
1-800-336-9500

Florida

SHINE (Serving Health Insurance Needs of Elders)
1-800-963-5337
TTY: 1-800-955-8770

Georgia

GeorgiaCares Program
1-866-552-4464

Guam

Guam Medicare Assistance Program (GUAM MAP)
1-671-735-7415

Hawaii

Hawaii SHIP
1-888-875-9229
TTY: 1-866-810-4379

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)
1-800-247-4422

Illinois

Senior Health Insurance Program (SHIP)
1-800-252-8966
TTY: 1-888-206-1327

Indiana

State Health Insurance Assistance Program (SHIP)
1-800-452-4800
TTY: 1-866-846-0139

Iowa

Senior Health Insurance Information Program (SHIIP)
1-800-351-4664
TTY: 1-800-735-2942

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)
1-800-860-5260

Kentucky

State Health Insurance Assistance Program (SHIP)
1-877-293-7447

Louisiana

Senior Health Insurance Information Program (SHIIP)
1-800-259-5300

Maine

Maine State Health Insurance Assistance Program (SHIP)
1-800-262-2232

Maryland

State Health Insurance Assistance Program (SHIP)
1-800-243-3425

Massachusetts

Serving Health Insurance Needs of Everyone (SHINE)
1-800-243-4636
TTY: 1-877-610-0241

Michigan

MMAP, Inc.
1-800-803-7174

Minnesota

Minnesota State Health Insurance Assistance Program/ Senior LinkAge Line
1-800-333-2433

Mississippi

MS State Health Insurance Assistance Program (SHIP)
844-822-4622

Missouri

CLAIM
1-800-390-3330

Montana

Montana State Health Insurance Assistance Program (SHIP)
1-800-551-3191

Nebraska

Nebraska Senior Health Insurance Information Program (SHIIP)
1-800-234-7119

Nevada

State Health Insurance Assistance Program (SHIP)
1-800-307-4444

New Hampshire

NH SHIP – ServiceLink Resource Center
1-866-634-9412

New Jersey

State Health Insurance Assistance Program (SHIP)
1-800-792-8820

New Mexico

New Mexico ADRC/SHIP
1-800-432-2080

New York

Health Insurance Information Counseling and Assistance Program (HIICAP)
1-800-701-0501

North Carolina

Seniors' Health Insurance Information Program (SHIIP)
1-855-408-1212

North Dakota

State Health Insurance Counseling (SHIC)
1-888-575-6611
TTY: 1-800-366-6888

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)
1-800-686-1578

Oklahoma

Oklahoma Medicare Assistance Program (MAP)
1-800-763-2828

Oregon

Senior Health Insurance Benefits Assistance (SHIBA)
1-800-722-4134

Pennsylvania

APPRISE
1-800-783-7067

Puerto Rico

State Health Insurance Assistance Program (SHIP)
1-877-725-4300
TTY: 1-787-919-7291

Rhode Island

Senior Health Insurance Program (SHIP)
1-888-884-8721

South Carolina

(I-CARE) Insurance Counseling Assistance and Referrals for Elders
1-800-868-9095

South Dakota

Senior Health Information & Insurance Education (SHIINE)
1-800-536-8197

Tennessee

TN SHIP
1-877-801-0044
TTY: 1-800-848-0299

Texas

Health Information Counseling and Advocacy Program (HICAP)
1-800-252-9240

Utah

Senior Health Insurance Information Program (SHIP)
1-800-541-7735

Vermont

State Health Insurance Assistance Program (SHIP)
1-800-642-5119

Virgin Islands

Virgin Islands State Health Insurance Assistance Program (VI SHIP)
(STX) 1-340-772-7368

Virginia

Virginia Insurance Counseling and Assistance Program (VICAP)
1-800-552-3402

Washington

Statewide Health Insurance Benefits Advisors (SHIBA)
1-800-562-6900
TTY: 1-360-586-0241

Washington D.C.

Health Insurance Counseling Project (HICP)
1-202-994-6272

West Virginia

West Virginia State Health Insurance Assistance Program (WV SHIP)
1-877-987-4463

Wisconsin

Wisconsin SHIP
1-800-242-1060
TTY: 1-888-758-6049

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)
1-800-856-4398

SECTION 10

Definitions

Assignment
An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period
The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Coinsurance
An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment
An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Creditable prescription drug coverage
Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Critical access hospital
A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Custodial care
Non-skilled personal care, like help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible
The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Demonstrations
Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and/or in specific areas.

Extra Help
A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Formulary
A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Inpatient rehabilitation facility
A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Institution
For the purposes of this publication, an institution is a facility that provides short-term or long-term care, like a nursing home, skilled nursing facility (SNF), or rehabilitation hospital. Private residences, like an assisted living facility or group home, aren't considered institutions for this purpose.

Lifetime reserve days
In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-term care hospital
Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medically necessary
Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)
A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organization
- Private Fee-for-Service Plan
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Medicare services aren't paid for by Original Medicare

Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount
In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan
Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare plan
Any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Premium
The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services
Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care doctor
The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you 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 Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Referral
A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Service area
A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled nursing facility (SNF) care
Skilled nursing care and rehabilitation services provided on a daily basis, in a skilled nursing facility (SNF). Examples of SNF care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Notes

Help in other languages

If you, or someone you're helping, has questions about Medicare, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-MEDICARE (1-800-633-4227).

العربية (Arabic) إن كان لديك أو لدى شخص تُساعده أسئلة بخصوص Medicare فإن من حقك الحصول على المساعدة و المعلومات بلغتك من دون أي تكلفة. للتحدث مع مترجم إتصل بالرقم 1-800-MEDICARE (1-800-633-4227).

հայերեն (Armenian) Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Medicare-ի մասին, ապա Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով:

中文 (Chinese-Traditional) 如果您，或是您正在協助的個人，有關於聯邦醫療保險的問題，您有權免費以您的母語，獲得幫助和訊息。與翻譯員交談，請致電 1-800-MEDICARE (1-800-633-4227).

فارسی (Farsi) اگر شما، یا شخصی که به او کمک میرسانید سوالی در مورد اعلامیه مختصر مدیکردارید، حق این را دارید که کمک و اطلاعات به زبان خود به طور رایگان دریافت نمایید. برای مکالمه با مترجم با این شماره زیر تماس بگیریدMEDICARE-1-800 (1-800-633-4227).

Français (French) Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions au sujet de l'assurance-maladie Medicare, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le 1-800-MEDICARE (1-800-633-4227)

Deutsch (German) Falls Sie oder jemand, dem Sie helfen, Fragen zu Medicare haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-MEDICARE (1-800-633-4227) an.

Kreyòl (Haitian Creole) Si oumenm oswa yon moun w ap ede, gen kesyon konsènan Medicare, se dwa w pou jwenn èd ak enfòmasyon nan lang ou pale a, san pou pa peye pou sa. Pou w pale avèk yon entèprèt, rele nan 1-800-MEDICARE (1-800-633-4227).

Italiano (Italian) Se voi, o una persona che state aiutando, vogliate chiarimenti a riguardo del Medicare, avete il diritto di ottenere assistenza e informazioni nella vostra lingua a titolo gratuito. Per parlare con un interprete, chiamate il numero 1-800-MEDICARE (1-800-633-4227).

日本語 (Japanese) Medicare (メディケア) に関するご質問がある場合は、ご希望の言語で情報を取得し、サポートを受ける権利があります (無料)。通訳をご希望の方は、1-800-MEDICARE (1-800-633-4227) までお電話ください。

한국어(Korean) 만약 귀하나 귀하가 돕는 어느 분이 메디케어에 관해서 질문을 가지고 있다면 비용 부담이 없이 필요한 도움과 정보를 귀하의 언어로 얻을 수 있는 권리가 귀하에게 있습니다. 통역사와 말씀을 나누시려면 1-800-MEDICARE(1-800-633-4227)로 전화하십시오.

Polski (Polish) Jeżeli Państwo lub ktoś komu Państwo pomagają macie pytania dotyczące Medicare, mają Państwo prawo do uzyskania bezpłatnej pomocy i informacji w swoim języku. Aby rozmawiać z tłumaczem, prosimy dzwonić pod numer telefonu 1-800-MEDICARE (1-800-633-4227).

Português (Portuguese) Se você (ou alguém que você esteja ajudando) tiver dúvidas sobre a Medicare, você tem o direito de obter ajuda e informações em seu idioma, gratuitamente. Para falar com um intérprete, ligue para 1-800-MEDICARE (1-800-633-4227).

Русский (Russian) Если у вас или лица, которому вы помогаете, возникли вопросы по поводу программы Медикэр (Medicare), вы имеете право на бесплатную помощь и информацию на вашем языке. Чтобы воспользоваться услугами переводчика, позвоните по телефону 1-800-MEDICARE (1-800-633-4227).

Tagalog (Tagalog) Kung ikaw, o ang isang tinutulungan mo, ay may mga katanungan tungkol sa Medicare, ikaw ay may karapatan na makakuha ng tulong at impormasyon sa iyong lenguwahe ng walang gastos. Upang makipag-usap sa isang tagasalin ng wika, tumawag sa 1-800-MEDICARE (1-800-633-4227).

Tiếng Việt (Vietnamese) Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Medicare, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện qua thông dịch viên, gọi số 1-800-MEDICARE (1-800-633-4227).

The information in "Medicare & You" describes the Medicare Program at the time it was printed. Changes may occur after printing. Visit **Medicare.gov** or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

"Medicare & You" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Paid for by the Department of Health & Human Services.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

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CMS Product No. 10050
September 2018

National Medicare Handbook

Moving? Visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If you get RRB benefits, contact the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

¿Necesita usted una copia de este manual en Español?
Llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.

General comments about this handbook are welcome. Email us at **medicareandyou@cms.hhs.gov**. We can't respond to every comment, but we'll consider your feedback when writing future handbooks.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Part D Premium Payment Program Enhanced with Medigap Premium Payment and Medical Out-of-Pocket Assistance

Frequently Asked Questions for current and potential MDPP clients

Program Overview Questions

1. **What is the Medicare Part D Premium Payment (MDPP) Program?**

   The California Department of Public Health (CDPH), Office of AIDS (OA), MDPP Program pays the client's portion of their Medicare Part D insurance premiums for persons living with HIV/AIDS. Premium assistance is offered only to qualified clients who are enrolled in both a Medicare Part D prescription drug plan and the AIDS Drug Assistance Program (ADAP).* As of June 2018, this program has enhanced benefits.

   *See Enrollment Question 1.

2. **What enhanced benefits were added to MDPP?**

   As of June 2018, clients who enroll or are enrolled in OA's MDPP program will also be able to submit outpatient Medical Out-of-Pocket (MOOP) claims for reimbursement. Clients are now also able to request Medigap Plan premium payment assistance through their Enrollment Worker, if enrolled in a Medigap plan.

   *See Medigap Question 4.

3. **As part of the enhanced benefits, will MDPP cover Part B premium payments?**

   No, MDPP will not cover Part B premium payments.

4. **As part of the enhanced benefits, will MDPP cover Part C (Medicare Advantage) premium payments?**

   No, MDPP will not cover Part C premium payments.

Medicare Part D Premium Payment Program Enhanced with Medigap Premium Payment and Medical Out-of-Pocket Assistance

Frequently Asked Questions for current and potential MDPP clients

Medigap Questions

1. **What is a Medigap Plan?**

   Medigap plans, also known as Medicare Supplemental Health Insurance Policies, provide supplemental coverage that cover health care costs such as co-payments, co-insurance, and deductibles, that Medicare Parts A and/or B do not cover.

   Please note: Medigap plan availability varies by zip code and no plan is entirely comprehensive. Clients with Medicare Part D cannot purchase a Medigap policy that has prescription coverage.

   Enrolling in Medigap

   For information on Medigap enrollment, please read Medicare's publication "Choosing a Medigap Policy" at https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf:

   - **Medigap Open Enrollment Period**—A one-time-only, 6-month period when federal law allows you to buy any Medigap policy you want that's sold in your state. It starts in the first month that you're covered under Medicare Part B, and you're 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional Open Enrollment rights under state law.

   - **If you're a person with Medicare under 65 and have a disability or End-Stage Renal Disease**, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65. However, some states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65.

   For more information on Medigap or Medicare Advantage plans, please visit www.medicare.gov or contact the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) at www.aging.ca.gov/hicap/ or call 800-434-0222.

2. **Are Medigap plans the same as Medicare Advantage plans?**

   No, Medigap plans are different from Medicare Advantage plans. A Medigap plan is supplemental insurance which helps cover some costs not covered by Original Medicare, Parts A and B. Medicare Advantage plans are also known as Medicare Part C, a provider network-based alternative to enrolling in Medicare Parts A and B that includes coverage for both inpatient and outpatient services. Clients with Medicare Advantage policies are not eligible to obtain Medigap policies.

For more information on Medigap or Medicare Advantage plans, please visit www.medicare.gov or contact the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) at www.aging.ca.gov/hicap/ or call 800-434-0222.

3. **If I have health insurance through Medicare and Medi-Cal, should I sign up for a Medigap plan?**

   For questions around Medicare and Medigap plans, please visit www.medicare.gov or contact the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) at www.aging.ca.gov/hicap/ or call 800-434-0222.

4. **Can CDPH retroactively pay for Medigap?**

   CDPH will make payments for a client's Medigap policy for the month the MDPP Medigap premium payment application is received by CPDH, assuming the client is already on MDPP. CDPH will not make retro payments for months prior to the application being submitted, i.e. CDPH will not make a payment for June if the application was submitted in July.

5. **Can CDPH make Medigap plan payments for spousal/bundled plans?**

   No. Unlike standard health insurance policies that may cover multiple persons, a Medigap policy covers only one person. If more than one person in the household signs up with the same Medigap insurer (like AARP, Anthem, or Kaiser), the insurer could automatically bundle the policies for billing purposes, causing the client to receive a *combined billing statement*. However, since this is not truly spousal/bundled health insurance, each person will retain a separate Medigap policy. Clients seeking assistance with their Medigap premium must ensure they have a plan billing statement separate from their spouse or other household member. Separate plan billing statement must include individual member ID, premium, and payment remittance address.

Medicare Part D Premium Payment Program Enhanced with Medigap Premium Payment and Medical Out-of-Pocket Assistance

Frequently Asked Questions for current and potential MDPP clients

Enrollment Questions

1. **Who is eligible for MDPP?**

   To be eligible for the MDPP Program, you must meet the following criteria:

   - Be actively enrolled in ADAP
   - Have an active Medicare Part D plan with a discernible Part D monthly premium
   - Not be deemed 100% Low Income Subsidy (LIS) or Extra Help
   - Not be full-scope Medi-Cal

2. **Can "Dual Eligibles" enroll in MDPP?**

   Dual Eligibles, also known as "Medi-Medi Clients", are those who qualify for both Medicare and Medi-Cal. Some Dual Eligibles have a Medi-Cal share of cost, while others, such as those with full-scope Medi-Cal, do not. Clients with a monthly Medicare Part D premium and unmet Medi-Cal share of cost may apply to the MDPP Program, as long as they meet all other Program criteria listed above.

3. **What supporting documentation do I need in order to enroll into MDPP?**

   In order to enroll in MDPP, you must submit a completed Client Attestation Form.

   If you have an active Medigap plan and would like MDPP to provide premium assistance, you must also provide a recent Medigap billing statement that includes client name, client premium amount due*, policy number, and the payment remittance address.

   *For Medigap plans with discount(s), MDPP will pay the net premium for the enrolled client only.

   Please note: MDPP will only accept a *combined Medigap billing statement* as program documentation if all persons on the statement are current MDPP clients.

4. **What if I was deemed 100% Low Income Subsidy (LIS) or Extra Help, but my income has increased, and I am no longer deemed 100% LIS?**

   If you are no longer deemed 100% LIS, you will need to re-apply / re-enroll into MDPP: Please contact your Enrollment Worker.

Medicare Part D Premium Payment Program Enhanced with Medigap Premium Payment and Medical Out-of-Pocket Assistance

Frequently Asked Questions for current and potential MDPP clients

Medical Out-of-Pocket Claims Questions

1. **What are medical out-of-pocket (MOOP) benefits?**

   MOOPs are expenses such as annual deductibles, co-pays, and co-insurance that count towards the insurance plan's out-of-pocket maximum.

2. **How do I access the MOOP benefit?**

   Once you have successfully enrolled in MDPP, you are automatically eligible for MOOP benefits. You will receive an identification (ID) card in the mail from our Medical Benefits Manager, Pool Administrators, Inc. (PAI). Please read all information enclosed with the card carefully, as it includes instructions and forms necessary to submit MOOP claims for reimbursement. You do not need to contact your Enrollment Worker to access this benefit. If you are already an existing MDPP client, you are automatically eligible to submit MOOP claims effective June 1, 2018.

   Please note: Clients who are deemed 100% LIS or have full-scope Medi-Cal are not eligible for the MDPP program, so they are not eligible for the MOOP benefit.

3. **Where can I access the CDPH MOOP Claim Form?**

   The CDPH MOOP Claim Form is available on the CDPH website, www.cdph.ca.gov. In addition, you can also obtain it from your Enrollment Worker or ADAP Advisor.

4. **What are the requirements to file a MOOP claim?**

   In order to file a MOOP claim, you must be enrolled in the MDPP program and have had an outpatient service on or after June 1, 2018. The date of service must also be within both the MDPP program enrollment and Medicare Part D plan start-and-end dates. In order for CDPH to pay the MOOP claim, CDPH must not be the primary payer, your insurance must be billed first. Finally, the service must count towards your out-of-pocket maximum.

5. **How do I file a MOOP claim?**

   In order to submit a MOOP claim, you can complete and submit the CDPH MOOP Claim Form, supporting documentation such as an invoice or receipt, and the Explanation of Benefits (EOB) from the primary insurance plan to PAI at:

   - Fax: (860) 560-8225
   - Email: CDPH_MBM_Fax@pooladmin.com
   - Mail: PAI-CDPH-02, 628 Hebron Ave., Suite 502, Glastonbury, CT 06033

Supporting documentation must include:

- your name
- the date of service
- the type of outpatient medical service received
- the provider's and/or clinic's name
- the out-of-pocket amount
- the amount covered by your insurance

We encourage you to make a copy of the form and supporting documentation for your records prior to submitting claims to PAI.

Please note: Your provider may instead file the MOOP claim on your behalf using the process mentioned above or by calling PAI Customer Service at (877) 495-0990 and establishing electronic claims submission and automated payments. The provider should use payer ID PAI02 when submitting claim forms for MDPP clients.

Communications and ID card Questions

1. **What do I do with my PAI-CDPH ID card?**

   At the time of service, your PAI-CDPH ID card must be presented to your primary care doctor or other medical provider to verify your enrollment in the program. Your provider must contact the CDPH ADAP Call Center at 844-421-7050 to verify enrollment in the program. Reimbursements will be made directly to your medical provider. Please note that the PAI-CDPH ID card is not for medication access; you will need to continue using your Magellan Rx card for prescription benefits.

2. **If I have a question regarding MDPP, who do I contact?**

   You may contact your ADAP Enrollment Worker, an MDPP Advisor, or the ADAP Call Center at 844-421-7050 for any MDPP questions you may have.

3. **How will I know if I am successfully enrolled in MDPP or MDPP with Medigap premium payment assistance?**

   You will receive a letter from PAI after the first premium payment has been made. The letter will identify the start date and premium amount that was paid to the specified provider. You may also contact your Enrollment Worker to confirm. If you are not eligible for the MDPP program, you will receive a denial letter. If you are eligible for MDPP but not Medigap premium payments, you will receive a Medigap denial letter.

SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part III
Medi-Cal

Table of Contents

What documents do I need to apply for Medi-Cal?

If the county is not able to verify your information, you will be notified. If you are notified, the following is a list of acceptable documents:

Category	Documents
Identity of applicant	• Birth certificate • Driver's license • Paycheck • School records • U.S. Passport • U.S. American Indian/Alaska Native Tribal document • U.S. military ID • Fed, State or local ID
Social Security Numbers	• Social Security cards • Award letter • Medicare card
Immigration status	• INS documents (if not born in the US)
Residence	• Driver's license • Check stub • Rent or mortgage receipt • Utility bill • School, Government or any document showing a CA address
Earned income	• Dated check stubs for the last 30 days • Statement from your employer • Copy of last year's tax return • Bank statement showing direct deposit
Other income	• A current benefit check • Copies of child support checks • Alimony checks • Award letter
Resources	• Bank statements showing savings and checking accounts • Mortgage statements • Life insurance policies • Statements of stocks, bonds or certificates of deposit (CDs) • Trust documents
Vehicle registration	• Department of Motor Vehicle registration certificate

How Long Does It Take?

Forty-five (45) days are allowed to process a Medi-Cal application not involving a disability. If you are applying for Medi-Cal based on a disability, your application process may take up to 90 days depending on how quickly you complete the disability information and when your doctors and hospitals submit your medical records. To avoid processing delays, submit all information requested of you as soon as possible. Ask your eligibility worker for help if you cannot get the information. If you have an immediate medical or dental need, such as pregnancy or a severe illness, indicate this need on your application and your application may be processed more quickly.

Additional Proof Needed for Health Coverage

- Information about any job related health insurance available to your family.
- Policy numbers for any current health insurance.

(information gathered from MyBenefitsCalWIN.org)

APPLICATION FOR CALFRESH , CASH AID , AND/OR MEDI-CAL/HEALTH CARE PROGRAMS

If you have a disability or need help with this application, let the County Welfare Department (County) know and someone will help you.

If you prefer to speak, read, or write in a language other than English, the County will get someone to help you at no cost to you.

How do I apply?
Use this application if you are applying for food assistance (CalFresh), cash aid (California Work Opportunity and Responsibility to Kids, Refugee Cash Assistance, General Assistance or General Relief), Medi-Cal and/or other health care programs. If you want to apply for CalFresh only, you can ask the County for the CalFresh only application. CalFresh is a food assistance program to help you with the cost of buying food for your household. If you want to apply for health care only, you can ask the county for a health care only application. Health care includes: low-cost insurance for Medi-Cal; affordable private health insurance; or a tax credit that can help you pay your premiums for health coverage. Do not use this application if you are applying for only health care. Your County may have a separate application for General Assistance or General Relief. Ask your County to be sure.

You can also apply for these programs online by going to http://www.benefitscal.org/.

- Fill out the whole application form, if you can. You must at least give the County your name, address, and signature (question 1 on page 1 of the application) to begin the application process for CalFresh. For cash aid you must fill out questions 1 through 5 on pages 1 and 2 of the application and sign it to begin the application process. For General Assistance or General Relief ask the County which questions must be answered to begin the application process.
- Each program has a symbol (shown at the top of this page) showing what questions pertain to what programs. For cash aid, it is a dollar sign; for CalFresh, it is a shopping cart; and for health coverage, it is an ambulance. For example, if you are not applying for cash aid, you don't need to answer questions marked only with a dollar sign.
- Give the application to the County in person, by mail, by fax or online.
- The day the County receives your signed application starts the time to give you an answer on whether you can get benefits. If you are in an institution, this time starts from the day you leave.

What do I do next?
- Read about your rights and your responsibilities (Program Rules pages) before you sign the application.
- You must have an interview with the County to discuss your application. If you have a disability, other arrangements can be made.
- If you did not fill out all of the application, you can finish it during your interview.
- You will need to give proof of your income, expenses, and other circumstances to see if you are eligible.

How long will it take?
It may take up to 30 days to process your application for CalFresh. For cash aid and Medi-Cal, it may take up to 45 days. Ask the County how to get your benefits or health care right away if you have an emergency.

You may be able to get CalFresh benefits within 3 calendar days if:

- Your household's monthly gross income (income before deductions) is less than $150 and your cash on hand or in checking or savings accounts is not more than $100; or
- Your household's housing costs (rent/mortgage and utilities) are more than your monthly gross income and money in checking or savings; or
- You are a migrant or seasonal farmworker household with less than $100 in checking or savings and 1) your income stopped, or 2) your income has started but you do not expect to get more than $25 in the next 10 days.

For cash aid, you may get immediate assistance if:

- You are homeless or have an eviction notice or a notice to pay rent or move; or
- Your food will run out within three days; or
- Your utilities have been or will be shut off; or
- You don't have sufficient clothing or diapers; or
- You have another kind of emergency important to health and safety.

Informational Page - Please take and keep for your records.

To help the County see if you can get benefits faster, please complete questions 1, 6 through 9, 15, and 24, and give the County proof of your identity (if you have it) with the application. For General Assistance or General Relief, ask the County how long it will take and about any special rules for getting benefits faster.

The County will send you a letter to let you know if your household is approved or denied for the benefits you applied for.

What do I need for my interview?
To avoid delays, bring proof of the following items with you to your interview. Keep your interview even if you do not have the proof. The County may be able to help if you need help getting proof. During the interview, the County will go over the information on the application and will ask you questions to see if you can get benefits and the amount of benefits you can get.

Proof Needed to Get Benefits

- Identification (Driver's License, State ID card, passport).
- Birth certificates for everyone applying for cash aid.
- Proof of where you live (rental agreement, current bill with your address listed).
- Social Security numbers for everyone applying for aid (see note below about certain noncitizens).
- Money in the bank for all the people in your household (recent bank statements).
- Earned income of everyone in your household for the past 30 days (recent pay stubs, a work statement from an employer). **NOTE:** If self-employed, income and expenses or tax records.
- Unearned income (Unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.).
- Lawful immigration status **ONLY** for legal noncitizens applying for benefits (an Alien Registration Card, visa).
  NOTE: Certain noncitizens applying for immigration status based on domestic violence, crime prosecution or trafficking may not need this proof. They also may not need a Social Security Number.

Proof Needed to Get <u>More</u> CalFresh Benefits

- Housing costs (rent receipts, mortgage bills, property tax bill, insurance documents).
- Phone and utility costs.
- Medical expenses for anyone in your household who is elderly (60 and older) or disabled.
- Child and adult care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Child support paid by a person in your household.

Additional Proof Needed for Health Coverage

- Information about any job related health insurance available to your family.
- Policy numbers for any current health insurance.

Additional Proof Needed for Cash Aid

- Proof of immunizations for children six years of age or younger.
- Vehicle registration for vehicles owned by you or someone you are applying for.

What if I am homeless?
Please let the County know right away if you are homeless so they can help you figure out an address to use to accept your application and get notices from the County regarding your case. For CalFresh and cash aid, homeless means you are:

A. Staying in a supervised shelter, halfway house, or similar place.
B. Staying at the home of another person or family for no more than 90 days straight.
C. Sleeping in a place not designed for, or normally used as, a place to sleep (a hallway, a bus station, a lobby, or similar places).

Informational Page - Please take and keep for your records.

RIGHTS AND RESPONSIBILITIES

You have a responsibility to:

- Give the County all information needed to determine your eligibility.
- Give the County proof of the information you have when it is needed.
- Report changes as required. The County will give you information about what, when, and how to report. For CalFresh and cash aid if you don't meet your household's reporting requirements, your case may be closed or your benefits may be lowered or stopped.
- Look for, get, and keep a job or participate in other activities if the County tells you that it is required in your case.
- Fully cooperate with county, state, or federal personnel if your case is selected for review or investigation to ensure that your eligibility and benefit level were correctly figured. Failure to cooperate in these reviews will result in loss of your benefits.
- Pay back any cash aid or CalFresh benefits that you were not eligible to get.

You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Have an interpreter provided by the State at no cost if you need one.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Withdraw your application at any time prior to the County determining eligibility.
- Ask for help to fill out your application or help getting the proof that you need and get an explanation of the rules.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Get cash aid within one day if you qualify for Immediate Need.
- Be interviewed in a reasonable amount of time by the County when you apply and to have your eligibility determined within 30 days for CalFresh or 45 days for cash aid and Medi-Cal.
- Get at least 10 days to give to the County proof that is needed to make a determination of eligibility.
- Get written notice at least 10 days before the County lowers or stops your CalFresh or cash aid benefits.
- Discuss your case with the County and to review your case when you ask to do so.
- Ask for a State hearing within 90 days if you do not agree with the County about your case. If you ask for a hearing before an action on your case takes place, your benefits will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefits change until after the hearing to avoid having to pay back any overpaid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that were cut.
- Ask about your hearing rights or for a legal aid referral at the toll-free phone numbers – **1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.** You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you do not want to go alone.
- Get help from the County to register to vote.
- Report changes that you are not required to report, if it may increase your CalFresh benefits or cash aid.
- Give proof of your household's expenses that may help you get more CalFresh benefits. Not giving proof to the County is the same as saying that you do not have that expense and you will not be able to get more CalFresh benefits.
- Let the County know if you would like someone else to use your CalFresh benefits for your household or help with your CalFresh case (Authorized Representative).

  You are also giving the Medi-Cal agency the right to pursue and get medical support from a spouse or parent. If you think that cooperating to collect medical support will harm you or your children, you can tell the Medi-Cal agency and you may not have to cooperate.

Please take and keep for your records

Program Rules and Penalties

You are committing a crime if you give false or wrong information, or do not give all the information on purpose to try to get CalFresh, cash aid, and Medi-Cal, that you are not eligible to receive, or to help someone else get benefits that they are not eligible to receive. You must pay back any benefits you get that you were not eligible to receive. If you do this on purpose and receive more than $950 in benefits you were not eligible to receive, you can be charged with a felony.

For CalFresh: I understand that if I commit an intentional program violation by doing any of the following:	**I may...**
• hide information or make false statements	• lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me
• use electronic benefit transfer (EBT) cards that belong to someone else or let someone else use my card	• lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me
• use CalFresh benefits to buy alcohol or tobacco	• lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me
• trade, sell, or give away CalFresh benefits or EBT cards	• be fined up to $250,000, imprisoned up to 20 years, or both
• trade CalFresh benefits for controlled substances, such as drugs	• lose CalFresh benefits for 24 months for the first offense • lose CalFresh benefits permanently for the second offense.
• give false information about who I am and where I live so I can get extra CalFresh benefits	• lose CalFresh benefits for 10 years for each offense
• have been convicted of trading or selling CalFresh benefits worth more than $500, or trading CalFresh benefits for firearms, ammunition, or explosives	• lose CalFresh benefits forever

For cash aid I understand that if I...	**I may...**
• am convicted of an intentional program violation	• lose my cash aid
• do not follow cash aid rules	• be fined up to $10,000 and/or sent to jail/prison for 5 years
• am found guilty by a court of law or an administrative hearing of committing certain types of fraud	• lose cash aid for 6 months, 12 months, 2 years, 4 years, 5 years, or forever.

Important Information for Noncitizens

- You can apply for and get CalFresh benefits, cash aid, or health care for people who are eligible, even if your family includes others who are not eligible. For example, immigrant parents may apply for CalFresh benefits, cash aid, or health care for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible.
- Getting food benefits will not affect you or your family's immigration status. Immigration information is private and confidential.
- The immigration status of noncitizens who are eligible and apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for benefits. The County will need to know their income and resource information to correctly determine your household's benefits. The County will not contact USCIS about the people who don't apply for benefits.

Use of Social Security Numbers (SSN)

CalFresh and Cash Aid: Everyone applying for CalFresh benefits or cash aid needs to provide a SSN, if you have one, or proof that you have applied for a SSN (such as a letter from the Social Security office). We can deny you or any member of your household who does not give us a SSN. Some people do not have to give SSNs to get help such as, victims of domestic abuse, crime prosecution witnesses, and trafficking victims.
Health Coverage/Medi-Cal: We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting a SSN, Call 1-800-772-1213 or visit the website: www.socialsecurity.gov

Overissuance

This means you got more CalFresh benefits than you should have. You will have to pay it back even if the county made an error or if it wasn't on purpose. Your benefits may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Please take and keep for your records

Overpayment
This means that you got more cash aid than you should have gotten. Just like with CalFresh benefits, you will have to pay it back even if the County made an error or if it wasn't on purpose. Your cash aid may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Reporting
Every household that gets benefits must report certain changes. Your county will tell you what changes to report, how to report them, and when to report them. Failure to report the changes may result in your benefits being lowered or stopped. You can also report if things happen that may increase your benefits, such as getting less income.

State Hearings
You have the right to a State hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You can request a State hearing within 90 days of the County's action and you must tell why you want a hearing. The approval or denial notice you receive from the County will have information on how to request an appeal. If you ask for a hearing before the action happens, you may be able to keep your cash aid and CalFresh benefits the same until a decision is made.

Privacy Act and Disclosure
You are giving personal information in the application. The County uses the information to see if you are eligible for benefits. If you do not give the information, the County may deny your application. You have a right to review, change, or correct any information that you gave to the County. The County will not show your information or give it to others unless you give them permission or federal and state law allows them to do so. The County will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. The County may share this information with other federal and state agencies for official examination, with law enforcement officials for the purpose of arresting persons fleeing to avoid the law, and with private claims collection agencies for claims collection action. The County may verify immigration status of household members applying for benefits by contacting the USCIS. Information the County gets from these agencies may affect your eligibility and level of benefits.

The County will use the information from your application to check your eligibility for help with paying for health coverage. The County will check your answers using information in state and federal electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, the County may ask you to send proof.

Nondiscrimination
It is the State and County's policy that all people be treated equally, and with respect and dignity. In accordance with federal law and the U.S. Department of Agriculture (USDA) Policy, discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disabilities is strictly prohibited.

To file a complaint of discrimination, either contact your County's Civil Rights Coordinator, or write to or call the USDA or California Department of Social Services (CDSS):

USDA, Director
Office of Civil Rights, Room 326-W
Whitten Building
1400 Independence Ave.
Washington D.C. 20250-9410
1-202-720-5964 (voice and TDD)

CDSS
Civil Rights Bureau
P.O. BOX 944243, M.S. 8-16-70
Sacramento, CA 94244-2430
1-866-741-6241 (Toll-Free)

USDA is an equal opportunity employer.

Work Rules for CalFresh
The county may assign you to a work program. They will tell you if it is voluntary or if you must do the work program. If you have a mandatory work activity and you do not do it, your benefits may be lowered or stopped.

You may not be eligible for CalFresh if you have recently quit a job.

Please take and keep for your records

Work Rules for CalWORKs (Welfare-to-Work)

If you get cash aid, you must participate in Welfare-to-Work (WTW) unless you are exempt. The county will tell you if you are exempt from WTW. If you do not do your assigned activities your cash aid may be lowered or stopped.

CalWORKs - Fingerprinting/Photo Imaging

All eligible adult household members for cash aid must be fingerprinted/photo-imaged. If anyone who is required to cooperate with these rules does not get fingerprinted/photo-imaged, no benefits will be issued to the entire household. The fingerprint/photo images are confidential and can only be used to prevent or prosecute welfare fraud.

How do I get/use my benefits?
CalFresh and Cash Aid:

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to get cash from ATMs or to buy food and/or other items.
- If your EBT card is lost, stolen, destroyed or you think someone may know your PIN number that you don't want to use your benefits call (877) 328-9677 or call the County right away to report it and change your PIN number. Make sure all responsible adults and your authorized representative also know how to report one of these problems right away. Any benefits taken from your account before you report the EBT card or PIN lost or stolen will **NOT** be replaced.
- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like toothpaste, soap, or paper towels).
- CalFresh benefits are accepted at most grocery stores and other places that sell food. Cash aid can be used at most stores and most ATMs. Some ATMs may charge a fee. There may also be a fee if you use an ATM to get cash after three withdrawals. For a list of locations near you that accept EBT, please go to: https://www.ebt.ca.gov or https://www.snapfresh.org. You can also find out where you can get cash without paying a fee.
- CalFresh benefits are only for you and your household members. Your cash aid is only for you and the members of your family who were approved for cash aid. Your cash aid is to help meet the basic needs of your family (housing, food, clothing, etc.). Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.
- Any use of your EBT card by you, a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **NOT** be replaced.

Medi-Cal and Health Care:

- For Medi-Cal, you will receive a Benefits Identification Card (BIC).
  - Sign your BIC when you get it and use it only to get necessary health care services.
  - Never throw your BIC away (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
  - Take the BIC to your medical provider when you or a family member is sick or has an appointment.
  - Take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.
- For other health care programs you will receive a health plan card from your particular carrier.

General Assistance and General Relief:

- General Assistance and General Relief are County run programs for adults without children. The County will tell you about your rights and responsibilities and the program rules if you are applying for one of these programs.

Please take and keep for your records

Please use black or blue ink because it is easy to read and copies best. Please print your answers.
If you need more space to answer a question(s), attach additional sheets of paper to provide the information. Please be sure to identify which question you are writing about on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS)

HOME ADDRESS OR DIRECTIONS TO YOUR HOME	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE

I want to get information about this application by email. ☐ Yes ☐ No

I want to get messages about my case by email. ☐ Yes ☐ No

HOME PHONE	WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS

What programs are you applying for? ☐ CalFresh ☐ Cash Aid ☐ Health Coverage ☐ Other_____

Do you have a disability and need help applying? ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No If **yes,** please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)?_____
What language do you prefer to speak (if not English)?_____

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

Is your household's gross income less than $150 and cash on hand, checking and savings accounts $100 or less?	☐ Yes ☐ No	Have your utilities been shut off or do you have a shut-off notice?	☐ Yes ☐ No
Is your household's combined gross income and liquid resources less than the combined rent/mortgage and utilities?	☐ Yes ☐ No	Will your food run out in 3 days or less?	☐ Yes ☐ No
Is your household a migrant/seasonal farm worker household with liquid resources not exceeding $100?	☐ Yes ☐ No	Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?	☐ Yes ☐ No
Do you have an eviction notice or a notice to pay rent or leave?	☐ Yes ☐ No	Do you need essential clothing, such as diapers or clothing needed for cold weather?	☐ Yes ☐ No

Is anyone pregnant? ☐ Yes ☐ No If yes, did she get a Presumptive Eligibility card? ☐ Yes ☐ No

Does anyone in your household have a personal emergency? ☐ Yes ☐ No If **yes**, check box: ☐ Pregnancy ☐ Immediate Medical Need ☐ Child Abuse ☐ Domestic Abuse ☐ Elder Abuse ☐ Other emergency which threatens health or safety. Explain:

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- Any answers I have given on pages 1 through 17 and appendices A through E of the SAWS 2 Plus are true, correct, and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1).
- I read, or had read to me, the Program Rules and Penalties (Program Rules Pages 2 - 4).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility is fraud and that I may be subject to penalties under federal law if I provide false or untrue information. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits and cash aid.
- I understand that Social Security Numbers or Immigration Status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.
- I am giving the Medi-Cal agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties.

SIGNATURE OF APPLICANT, CARETAKER RELATIVE (OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN) ***If you have an Authorized Representative, please complete Question 2 on the next page.**	DATE
SIGNATURE OF SPOUSE, OTHER PARENT, OTHER AIDED ADULT, OR REGISTERED DOMESTIC PARTNER	DATE

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? ☐ Yes ☐ No

If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME	AUTHORIZED REPRESENTATIVE PHONE NUMBER

Do you want to name someone to receive and spend CalFresh Benefits for your household? ☐ Yes ☐ No

If **yes**, complete the following section:

NAME	PHONE NUMBER

ADDRESS CITY, STATE, ZIP CODE

2a. HEALTH INSURANCE AUTHORIZED REPRESENTATIVES

You can give a trusted person permission to talk about your application for health insurance, see your information, and act for you on things about this part of your application. Do you want to choose an authorized representative for the health insurance part of your application? ☐ Yes ☐ No If yes, fill out the information in Appendix C.

3. Are you or any member of your family American Indian or Alaskan Native? ☐ Yes ☐ No
If **yes**, and applying for health care, please go to Appendix B for additional questions.

RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY	ARE YOU OF HISPANIC, LATINO, OR SPANISH ORIGIN? ☐ Yes ☐ No	IF YOU ARE OF HISPANIC, OR LATINO ORIGIN, DO YOU CONSIDER YOURSELF ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other_____

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed _____

☐ Asian (If checked, please select one or more of the following):

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify)_____

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You will need to have an interview with the County to discuss your application and to receive cash aid or CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. Cash aid applicants must have an in person interview. If you are applying for CalWORKs and CalFresh, your CalFresh interview will be done at the same time as your CalWORKs interview during normal office hours.

☐ Please check this box if you would prefer an in-person interview for CalFresh.

☐ Please check this box if you need other arrangements due to a disability.

5. OTHER PROGRAMS

Has anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Tribal TANF, Medicaid, Supplemental Nutrition Assistance Program [food stamps], General Assistance/General Relief, etc.)? ☐ Yes ☐ No

IF **YES,** WHO?	WHERE *(COUNTY/STATE)*?
IF **YES**, WHO?	WHERE *(COUNTY/STATE)*?

6. HOUSEHOLD'S INFORMATION: ADULTS

Complete the following information for all adults in the home. If applying for health care coverage, also include any adults claimed on your tax return.
If you are applying for cash aid and there is more than one adult in the home who is applying for cash aid or who is the parent of a child applying for aid, please go to Appendix D for additional questions.
For noncitizens you are applying for, please complete additional questions 6e and 6f.

APPLYING FOR BENEFITS *(check each type)*								Marital Status							Only answer the question below for each person applying for benefits.	Social Security number is optional for members not applying for benefits.
CalFresh	*Cash Aid	Medi-Cal Health Care	None	**NAME** (Last, First, Middle Initial)	How is the person related to you?	**DATE OF BIRTH**	**GENDER** (M OR F)	Single	Married	Separated	Divorced	Widowed	Full-Time Student (check if yes)	Disabled (check if yes)	**U.S. CITIZEN** or **NATIONAL** (check Yes or No) **If no, complete question 6e.**	**SOCIAL SECURITY NUMBER**
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	

*** Cash Aid also includes General Assistance and General Relief programs.**

6a. Does everyone listed in question 6 have the same contact information? ☐ **Yes** ☐ **No** **If no, please fill in the person's contact information below. If yes, please skip to the next question.**

NAME (FIRST, MIDDLE, AND LAST)	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
HOME PHONE NUMBER	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS (OPTIONAL)				

NAME (FIRST, MIDDLE, AND LAST)	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
HOME PHONE NUMBER	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS (OPTIONAL)				

6b. HOUSEHOLD'S INFORMATION: CHILDREN

Complete the following information for all children in the home. If applying for health care coverage, also include any children claimed on your tax return.
For noncitizens you are applying for, please complete additional questions 6e and 6f.

APPLYING FOR BENEFITS (check each type): CalFresh	Cash Aid	Medi-Cal Health Care	None	NAME (Last, First, Middle Initial)	How is the person related to you?	DATE OF BIRTH	PLACE OF BIRTH	SEX (M / F)	Check all that applies to one or both of the child's parents: Not in home	Unemployed	Disabled	Deceased	None	Full-Time Student (check if yes)	Shots up to date? (check if yes)	Only answer the question below for each person applying for benefits. U.S. CITIZEN or NATIONAL (check Yes or No) **If no, complete question 6e.**	Social Security number is optional for members not applying for benefits. SOCIAL SECURITY NUMBER
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	

6c. SOCIAL SECURITY INFORMATION

Does everyone applying for aid have a Social Security Number? ☐ Yes ☐ No If **no**, please fill in the information below.
We need the Social Security Number for everyone who is applying for aid. There are some exceptions for people who are victims of domestic violence or other crimes such as human trafficking. If you need help getting a Social Security Number call 1-800-772-1213 or go online to www.socialsecurity.gov.

NAME	REASON FOR NOT HAVING A SOCIAL SECURITY NUMBER	APPLIED FOR SSN
	☐ The person is a child who is less than one year old. ☐ It is against this person's religion. ☐ This person does not qualify for an SSN. ☐ Other ____________________	Has this person applied for a Social Security Number? ☐ Yes ☐ No
	☐ The person is a child who is less than one year old. ☐ It is against this person's religion. ☐ This person does not qualify for an SSN. ☐ Other ____________________	Has this person applied for a Social Security Number? ☐ Yes ☐ No

6d. Has anyone been in the U.S. Military service or are they the spouse, parent or child of a person who was? ☐ Yes ☐ No

If **yes**, please complete the information below. If **no**, please continue to the next question.

Name	U.S. Citizen?	(✔) Status	Honorable Discharge?	Dates of Service
	☐ Yes ☐ No	☐ Active duty ☐ Veteran ☐ Spouse, parent, or child of person in active duty or a veteran	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Active duty ☐ Veteran ☐ Spouse, parent, or child of person in active duty or a veteran	☐ Yes ☐ No	

6e. NONCITIZEN INFORMATION - Please complete for noncitizens you are applying for.

Name	Date entered U.S. (if known)	Does this person have an eligible immigration status? If yes, please provide their immigration document and number.	Has this person lived in the U.S. continuously since 1996?	Is this person a Naturalized Citizen?	Sponsored? (check Yes or No) If yes, complete question 6f
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does anyone listed above have at least 10 years *(40 quarters)* of work history? ☐ Yes ☐ No

If **yes**, who? _____

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa or U-Visa, VAWA petition? ☐ Yes ☐ No

If **yes**, who? _____

Has anyone changed their immigration status in the last 12 months? ☐ Yes ☐ No

If **yes**, please complete the information below.

If **no,** please continue to the next question.

NAME	WHAT CHANGED?	DATE OF CHANGE	ALIEN NUMBER (IF APPLICABLE)
NAME	WHAT CHANGED?	DATE OF CHANGE	ALIEN NUMBER (IF APPLICABLE)

6f. Sponsored Noncitizen Information - Please answer for sponsored noncitizens you are applying for.

Did the sponsor sign an I-864? ☐ Yes ☐ No If **yes**, please answer the rest of the question.
If the sponsor signed an I-134 then **skip** this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No If yes, how much? $ _____

Does the sponsor regularly help with any of the following (check all that apply)?

☐ rent ☐ clothes ☐ food ☐ other_____

SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER
SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER

6g. Does anyone listed in question 6 who is under the age of 21 have a parent who does not live in the home?

☐ Yes ☐ No If **yes**, please list the name of the child(ren) and the name(s) of the parents who do not live in the home.
If **no**, please continue to the next question.

NAME OF CHILD	NAME OF PARENT(S) NOT LIVING IN THE HOME
NAME OF CHILD	NAME OF PARENT(S) NOT LIVING IN THE HOME

6h. Does anyone in question 6 live with at least one child under the age of 19 and are they the main person taking care of the child?

☐ Yes ☐ No If **no**, skip to the next question. **If yes, who?**_____

6i. Does anyone listed in question 6 have a physical, mental, emotional, or developmental disability that causes limitations in activities (such as bathing, dressing, daily chores)? ☐ Yes ☐ No If **yes**, please list the name(s) of the person with the disability. If **no**, please continue to the next question.

Name:_____ Name:_____

6j. Complete for each disabled person listed in question 6.

Name of person	Does this person need help with activities of daily living through personal assistance or a medical facility? ☐ Yes ☐ No If **yes**, explain:
Disability is expected to last: ☐ 30 days or more ☐ 12 months or more	Does this person work and have medical expenses that are needed to help them keep working? For example, a wheelchair, leg braces, etc. ☐ Yes ☐ No If **yes**, please explain.
Does this person need care so that someone else can work or attend school? ☐ Yes ☐ No	Is this person in a medical facility or nursing home? ☐ Yes ☐ No If **yes**, what is the name of the medical facility or nursing home?

Name of person	Does this person need help with activities of daily living through personal assistance or a medical facility? ☐ Yes ☐ No If **yes**, explain:
Disability is expected to last: ☐ 30 days or more ☐ 12 months or more	Does this person work and have medical expenses that are needed to help them keep working? For example, a wheelchair, leg braces, etc. ☐ Yes ☐ No If **yes**, please explain.
Does this person need care so that someone else can work or attend school? ☐ Yes ☐ No	Is this person in a medical facility or nursing home? ☐ Yes ☐ No If **yes**, what is the name of the medical facility or nursing home?

6k. Is there a child or disabled person in the household who needs care from another household member?

☐ Yes ☐ No If **yes**, please explain. If **no**, skip to the next question.

6l. Students
Is anyone who is applying for benefits attending a college or vocational school? ☐ Yes ☐ No
If **yes**, please answer this queston. If **no**, skip to the next question.

Name of Person	Name of School/Training	Enrolled Status (✔ check one)	Working?
		☐ Half-time or more ☐ Less than half-time Number of Units:_____	Average work hours per week: _____
		☐ Half-time or more ☐ Less than half-time Number of Units:_____	Average work hours per week: _____

6m. Is anyone listed in question 6 or 6b pregnant or a teen parent? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Name	Is this person under the age of 20? ☐ Yes ☐ No Is this person a teen parent? ☐ Yes ☐ No	School status if under the age of 20 ☐ Has a high school diploma ☐ Has a GED ☐ Is attending school regularly ☐ Is not attending school regularly (explain why):	Due date (if known)	How many babies are expected with this pregnancy?
Name	Is this person under the age of 20? ☐ Yes ☐ No Is this person a teen parent? ☐ Yes ☐ No	School status if under the age of 20 ☐ Has a high school diploma ☐ Has a GED ☐ Is attending school regularly ☐ Is not attending school regularly (explain why):	Due date (if known)	How many babies are expected with this pregnancy?

6n. Has anyone ever gotten a cash bonus or penalty, or help with child care, transportation or other service from the Cal-Learn Program? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Name	**Where** (County)	Date(s) Received

6o. Was anyone listed in question 6 ever in foster care? ☐ Yes ☐ No
If **yes**, please explain.

Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? ☐ Yes ☐ No
Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? ☐ Yes ☐ No

6p. Is there a foster child currently living in your home who is receiving foster care services? ☐ Yes ☐ No
If **yes**, who?_____
Please answer the following questions about the foster child(ren):

Was this child(ren) placed in your home under a dependency order of the court? ☐ Yes ☐ No
Do you want the foster care child(ren) counted in your CalFresh case? ☐ Yes ☐ No
If **yes**, the foster care income you receive will be counted as unearned income.
If **no**, the foster care income will not be counted as unearned income.

6q. Does everyone listed in question 6 live in California and expect to keep living here? ☐ Yes ☐ No
If **no**, please explain.

6r. Does anyone listed in question 6 plan to leave California for more than 30 days? ☐ Yes ☐ No
If **yes**, please explain.

NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? ☐ YES ☐ NO IF YES, WHEN:
NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? ☐ YES ☐ NO IF YES, WHEN:

7. Unearned Income
Does anyone get income that does not come from work (unearned)? ☐ Yes ☐ No If **yes**, please answer this question.
If **no**, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- ☐ Social Security Disability
- ☐ SSI/SSP
- ☐ Cash aid
- ☐ CalWORKs/TANF/GA/GR/CAPI/RCA
- ☐ Room and board (from a renter)
- ☐ Pension
- ☐ Child/Spousal support
- ☐ Rental/Royalties
- ☐ Social Security retirement or survivors benefits
- ☐ Per capita payments
- ☐ Work study/welfare to work or other program
- ☐ Sales of notes, contracts, trust deeds, promissory notes
- ☐ Veterans education benefits/income
- ☐ Government/railroad disability or retirement
- ☐ Veteran benefits or Military pension
- ☐ Financial aid (school grants/loans/scholarships)
- ☐ Gifts of money or other loans
- ☐ Unemployment Insurance/ State Disability Insurance (SDI)
- ☐ Worker's Compensation
- ☐ Net Farming/Fishing
- ☐ Lottery/gambling winnings
- ☐ Help with rent/food/clothing
- ☐ Insurance or legal settlements
- ☐ Private disability or retirement
- ☐ Dividend and interest income
- ☐ Strike benefits
- ☐ Other_____ _____

Person Getting the Money?	**From Where?**	**How Much?**	**How Often Received?** (once, weekly, monthly, or other)	**Expect to Continue?** (Check **Yes** or **No**)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If this income is not expected to continue, please explain:

8. Earned income

Does anyone get income from a job (earned income)? ☐ Yes ☐ No If **yes**, please answer this question.
If **no**, skip to the next question.
NOTE: If self-employed, fill out question 8a below.
Please list all income **before** taxes or other deductions are taken out (gross income).
Examples of earned income are (these examples can be full-time, temporary seasonal work, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)
- Include any paid jobs the County helped you get.

Person Working	Employer's Name and Address	Employer's Phone Number	Hourly Rate	Average hours per week	How Often Paid? (Once weekly, monthly, other)	Total Gross Earned Income Received This Month?	Expect to Continue? (✔ Check **Yes** or **No**)
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No

If this income is not expected to continue, please explain:

Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? ☐ Yes ☐ No
In the last year? ☐ Yes ☐ No
Did the County help the person get this job? ☐ Yes ☐ No

IF YES, WHO?	DATE OF JOB LOSS, QUIT, OR CHANGE	DATE OF LAST PAY	REASON?

IS ANYONE ON STRIKE?	IF YES, WHO?	DATE WENT ON STRIKE	DATE OF LAST PAY	REASON?
☐ Yes ☐ No				

8a. Self-Employment

Self-employed household members may take actual self-employment expenses (or for CalFresh or cash aid, take a standard 40% deduction off of self-employment income). For cash aid, you may also choose to use a monthly average (yearly business costs divided by 12 months). If you choose actual expenses, you must list your business expenses on a separate sheet of paper.

Person Self-Employed	Business Name	Type of Business	Date Business Started	Gross Monthly Income	Self-Employment Expenses (please ✔ check one)	*Net Monthly Income
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$

* Net monthly income is gross monthly income minus expenses.

9. Other Income

Does anyone get housing or rent, utilities, food or clothing free or in exchange for work? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Item Received	Free	For Work	Who gets the item?	Value	Who gives the item?
Housing or Rent	☐	☐		$	
Utilities	☐	☐		$	
Food	☐	☐		$	
Clothing	☐	☐		$	

10. Yearly Income

Does anyone's total income (unearned, earned, and self employment) change from month to month? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Name of Person	What will be their total income this year?	What will be their total income next year (if you think it will be different)?
	$	$
	$	$

11. Household's Child/Adult Care Expenses (The actual amount of cost incurred if allowing the expenses to potentially be a deduction).

Does anyone pay for care of a child, disabled adult, or other dependent so you or the other person can go to work, school, or look for a job? ☐ Yes ☐ No If **yes**, please answer this question.

If **no**, skip to the next question.

Who gets care?	Who gives care? (name and address of provider)	Amount paid?	How Often Paid? (weekly/monthly, other)
		$	
		$	
		$	
		$	

Does anyone help your household pay all or part of your child/adult care cots listed above? ☐ Yes ☐ No If y**es,** complete below.

Who gets care?	Who helps pay?	Amount paid?	How Often Paid? (weekly/monthly, other)
		$	
		$	

12. Child Support Payments

Is anyone listed in question 6 legally obligated to pay child support, including back child support? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How Often? (weekly/monthly, other)
		$	
		$	

13. Spousal Support/Alimony

Is anyone listed in question 6 legally obligated to pay spousal support/alimony? ☐ Yes ☐ No

If **yes**, please answer the questions below.

If **no**, skip to the next question.

Who pays spousal support/alimony?	Amount paid?	How often? (weekly, bi-weekly. monthly, other)
	$	
	$	

14. Special Needs Expenses

Does anyone have a special medical condition or situation that requires any of the following?

Special diet prescribed by a doctor? ☐ Yes ☐ No

Special phone or other equipment? ☐ Yes ☐ No

Housework (no one in the home can do it)? ☐ Yes ☐ No

Very high use of utilities? ☐ Yes ☐ No

Special laundry service? ☐ Yes ☐ No

Other special need? (specify) ☐ Yes ☐ No

_____

Please list the name of the person with the special need and explain:

_____

15. Household Expenses

Does anyone you purchase and prepare food with get billed for any household expenses? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

NOTE: Do no enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances. It is not necessary to fill in the actual amount owed.

Type of Expenses	Have Expense?	Who Pays?	Amount Owed	How Often Billed? (weekly/monthly)
Rent or house payment	☐ Yes ☐ No		$	
Property taxes and insurance (if billed separate from rent or mortgage)	☐ Yes ☐ No		$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if separate from rent or mortgage)	☐ Yes ☐ No			
Telephone/cell phone	☐ Yes ☐ No			
Homeless Shelter Expense	☐ Yes ☐ No			
Water, sewage, garbage	☐ Yes ☐ No			
Does anyone not in your household help you pay for the expenses listed above? ☐ Yes ☐ No If **yes**, please complete.		Who helps pay?	How much? $	How often paid?

Does your household get, or expect to get any payments from the Low Income Home Energy Assistance Program (LIHEAP)? ☐ Yes ☐ No

16. Medical Expenses:
Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? ☐ Yes ☐ No
If **yes**, please answer this question.
If **no,** skip to the next question.
NOTE: Do not list spouses or children receiving dependent payments for an SSI or disability and blindness recipient. List expenses you expect to have in the near future.
Allowable medical expenses are:

- ☐ Medical or dental care
- ☐ Hospitalization/outpatient treatment/nursing care
- ☐ Prescribed medications
- ☐ Health and Hospitalization insurance policy premiums
- ☐ Medicare premiums (Medi-Cal share of costs, etc.)
- ☐ Dentures, hearing aids and prosthetics
- ☐ Maintaining an attendant necessary due to age, illness, or infirmity
- ☐ The number and cost of meals furnished to an attendant
- ☐ Prescribed over the counter medications
- ☐ Cost of transportation (mileage or fee) and lodging to obtain medical treatment or services
- ☐ Prescribed eye glasses and contact lenses
- ☐ Prescribed medical supplies and equipment
- ☐ Service animals expenses (food, vet bills, etc.)

Name of Elderly/Disabled Person	Amount of Expense	How often paid? (monthly, weekly, other)	What type of expense? (prescriptions, dentures, # of meals for attendant, etc.)	Will the household be reimbursed for any medical expenses? (by Medi-Cal, insurance, family member, etc.)
	$			IF YES, BY WHO: HOW MUCH: $
	$			IF YES, BY WHO: HOW MUCH: $

17. Other Tax-Deductible Expenses
If anyone pays for anything that can be deducted on a federal income tax return, telling us about it here could make the cost of health insurance a little lower. Do not include anything that you already included in self-employment expenses. If you have other deductible expenses, please answer this question. If **no**, skip to the next question.

Type of Expenses	Have Expense?	Who pays?	How often paid? (weekly/monthly)
Alimony	☐ Yes ☐ No		
Student loan interest	☐ Yes ☐ No		
Other deductions (please identify)	☐ Yes ☐ No		

18. Does anyone in question 6 get food from any of the following? ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Communal dining facility for the elderly/disabled
- Food distribution program operated by a Native American reservation
- Other food program

IF YES, WHO?	WHAT PROGRAM?
IF YES, WHO?	WHAT PROGRAM?

19. Does anyone in question 6 live at any of the following? ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Homeless Shelter
- Shelter for battered women
- Reservation for Native Americans
- Drug/Alcohol rehabilitation center
- Correctional facility/Penal institution (Jail or Prison)
- Group living arrangement for the blind/disabled
- Federally subsidized housing
- Psychiatric hospital/mental institution
- Hospital
- Long-Term Care or Board and Care Facility

Person's Name	Name of Institution (Center, Shelter, Facility, etc.)	Expected Date of Release (if applicable)

20. Is anyone getting In-Home Supportive Services (IHSS)? ☐ Yes ☐ No
If **yes**, fill in the information below.

WHO GETS SERVICES?	HOW MUCH DO YOU PAY EACH MONTH FOR THE SERVICES?
	$

21. Does everyone listed in question 6 buy and prepare food with you? ☐ Yes ☐ No
If **no**, list the people who don't buy and prepare food with you.

NAME	NAME
NAME	NAME

21a. Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability?
☐ Yes ☐ No If **yes**, who:_____

22. Answer these questions for anyone who needs health coverage. Is anyone enrolled in health coverage now from the following? ☐ Yes ☐ No
If **yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐ Medicaid/Medi-Cal	☐ Employer Insurance
☐ CHIP	Name of health insurance
☐ Medicare	Policy number:
☐ TRICARE (Don't check if you have direct care or Line of Duty)	Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree health plan? ☐ Yes ☐ No
☐ VA health care programs	Is this a state employee benefit plan? ☐ Yes ☐ No
☐ Peace Corps	☐ Other
	Name of health insurance
	Policy Number:
	Is this plan a limited-benefit plan like a school accident policy? ☐ Yes ☐ No

22a. Is anyone listed on this application offered health care coverage from a job? ☐ Yes ☐ No
If **yes**, you'll need to complete and include Appendix A.

22b. Is anyone's health insurance expected to end or has it ended in the last 90 days? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Insurance Company	Person Insured	Expiration Date	Reason it ended or will end

22c. Does anyone want help for medical bills from the last three months? ☐ Yes ☐ No
If **yes**, who:_____

23. Does anyone listed in question 6 plan to file a federal income tax return next year? ☐ Yes ☐ No
If **yes**, complete the questions below for each tax filer.
If **no**, skip to 23f.

23a. Please complete this section for each person who plans to file a federal income tax return **next year** if you answered **yes** to question 23. You can still apply for health insurance even if you don't file a federal income tax return.

23b. Name of person planning to file a federal income tax return:_____

23c. Will this person file jointly with a spouse? ☐ Yes ☐ No
If **yes**, name of spouse:_____

23d. Will this person claim any dependents on their tax return: ☐ Yes ☐ No
If **yes**, please list the name(s) of the dependents you are claiming:_____

23e. How is the dependent(s) listed in 23d related to the tax filer who will claim them?:_____

23f. To make it easier to determine my eligibility for paying health coverage in future years. I agree to allow you to use income data, including information from tax returns. You will send me a notice, let me make any changes, and I can opt out at any time.
Yes, renew my eligibility automatically for the next (check one): ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
☐ **No**, don't use information from tax returns to renew my coverage.

24. Household's Resources

Does anyone have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)? ☐ Yes ☐ No If y**es**, please answer this question. If **no**, skip to the next question.

Optional for health care; only answer if someone applying is 65 or older or disabled. If applying for cash aid and CalFresh, you must answer the question.

Check each resource listed below that you or anyone in your household has:

- ☐ Bank/Credit Union account (Checking)
- ☐ Bank/Credit Union account (Savings)
- ☐ Safe Deposit box
- ☐ Savings Bond(s)
- ☐ Oil, Mining or Mineral Rights
- ☐ Money Market Account(s)
- ☐ Mutual funds/Trust funds
- ☐ Certificate of Deposit (CD)/IRA
- ☐ Cash on hand
- ☐ Notes, Mortgages, Deeds of Trust
- ☐ Stocks
- ☐ Bonds
- ☐ Uncashed checks
- ☐ Life or Burial insurance
- ☐ Other: _____

If joint account with another person please say so below.

For each box checked above, complete the following information.

In Whose Name is the Resource Listed?	Type of Resource	How Much is it Worth?	Where is the Resource? (include the name of the bank or company where money is held)
		$	
		$	
		$	
		$	

Have you or anyone in your household sold, traded, given away, or transferred a resource in the last thirty (30) months? ☐ Yes ☐ No

WHEN?	WHAT WAS THE RESOURCE?	WHAT WAS IT WORTH?	HOW MUCH DID YOU GET FOR IT
		$	$

If you traded or gave the resource away, please explain:_____

_____

Optional for health care; only answer if someone applying is 65 or older or disabled.

25. Personal Property

Does anyone own any personal or business-related property? ☐ Yes ☐ No
If y**es**, please answer the question. If **no**, skip to the next question.

- ☐ Tools
- ☐ Business inventory
- ☐ Livestock
- ☐ Business equipment
- ☐ Sporting equipment, Guns
- ☐ Non-Motor boats and/or trailers
- ☐ Camper shells
- ☐ Personal tools
- ☐ Jewelry, Artwork, Antiques, Collections, Musical instruments (Piano, Organ, etc.)

Please include the item even if it is jointly owned with someone else. Do not include wedding or engagement rings, family heirlooms, etc. List any other jewelry worth $100 or more and household goods or personal items worth more than $500 per item.

Item	Is it listed for Sale?	Purchase Price or Current Value	Amount Owed
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$

Optional for health care; only answer if someone applying is 65 or older or disabled. If you are applying for cash aid, you must answer the question.

26. Vehicles

Does anyone own, have the use of, or have their name on any registration of any motor vehicle, such as: a car, motorcycle, snowmobile, recreational vehicle (RV), or motorboat, etc., even if it isn't running? ☐ Yes ☐ No

If **yes**, please fill out the information in Appendix E.

27. Does anyone in question 6 own or are they buying a home, land, or property anywhere including in another state or country? ☐ Yes ☐ No If **yes**, please explain.

Optional for health care; only answer if someone applying is 65 or older or disabled.

Who owns or is buying the home/property?	Address of the home/property	Is someone renting the home from the owner?	How much rent does the owner get?		Not living in now but owner expects to move back into the home someday?
		☐ Yes ☐ No	$	☐ Not rented	☐ Yes ☐ No
		☐ Yes ☐ No	$	☐ Not rented	☐ Yes ☐ No

28. Diversion Program

Has anyone received a Diversion cash payment or non-cash services from any county or other state? ☐ Yes ☐ No

If **yes**, please answer the question. If **no**, skip to the next question.

Name	County/State Received From	Amount Received	List of Services Received	Estimated Value of Services	Date Last Received
		$		$	

29. Duplicate Benefits

Have you, or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program) benefits in any State after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

30. Trafficking Benefits

Have you, or any member of your household, ever been convicted of trafficking (allowing use of or selling EBT cards to others) SNAP benefits of $500 or more after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

31. Trading Benefits for Drugs

Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

32. Trading Benefits for Firearms or Explosives

Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition or explosives after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

33. Fraud

Have you or anyone in your household had their cash aid stopped for being found guilty of Welfare Fraud? ☐ Yes ☐ No

If **yes**, who?_____ When?_____

Where?_____

34. Non-Cooperation/Sanctions

Have you or anyone in your household had their cash aid stopped for failure to cooperate with eligibility requirements, work/training sanctions or any other reason? ☐ Yes ☐ No

If **yes**, who?_____ When?_____

Where?_____Why?_____

35. Fleeing Felon

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? ☐ Yes ☐ No

If **yes**, who?_____

36. Probation/Parole Violation

Have you or any member of your household been found by a court of law to be in violation of probation or parole? ☐ Yes ☐ No

If **yes**, who?_____

37. Other Special Needs

Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and/or unusual circumstances, such as a fire, earthquake, or flood? ☐ Yes ☐ No

If **yes**, please explain:

38. Other Services

The following services are available. Your answers to the questions will not affect your eligibility.

A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.

- Do you want more information about CHDP services? ☐ Yes ☐ No
- Do you want CHDP medical services? ☐ Yes ☐ No
- Do you want CHDP dental services? ☐ Yes ☐ No
- Do you need help making appointments or with transportation to CHDP services? ☐ Yes ☐ No

B. Do you want more information about immunization services? ☐ Yes ☐ No

C. If you are pregnant, you can get help finding a doctor, getting healthy foods and other help. Do you want to talk to someone about this help? ☐ Yes ☐ No

D. Are you breastfeeding a child? ☐ Yes ☐ No
If **yes**, have you given birth within the last 12 months? ☐ Yes ☐ No
If you checked yes to 38 C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).

E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unwanted pregnancies and/or have the next child? ☐ Yes ☐ No
If **yes**, call your health care plan or regular doctor. Or, for facts and the location of confidential family-planning clinics, call toll-free 1-800-942-1054.

39. Third Party Liability

Is anyone who is applying for healthcare involved in a worker's compensation claim, lawsuit, or settlement because of an accident or injury? ☐ Yes ☐ No
If **yes**, please tell us who:

_____ _____

_____ _____

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY

IF THE ANSWER IS "YES" TO ANY OF THE QUESTIONS BELOW - EXPEDITE

Is the household's gross income less than $150 and is the total of cash on hand, checking and savings accounts $100 or less? ☐ Yes ☐ No

Is the household's combined gross income and liquid resources less than the combined rent/mortgage and appropriate utility allowance? ☐ Yes ☐ No

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding $100? ☐ Yes ☐ No

Does the CalWORKs Assistance Unit have a pay-or-quit or other eviction notice? ☐ Yes ☐ No

Appendix A HEALTH COVERAGE FROM JOBS

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. If there is more than one person who is offered health coverage from a different employer, you can copy this page and use it for the second person (or as many as you need).
First, tell us about the job (employer) who offers coverage.

1. EMPLOYEE NAME (FIRST NAME, MIDDLE NAME, LAST NAME)	2. EMPLOYEE SOCIAL SECURITY NUMBER — —

EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN) —
5. EMPLOYER ADDRESS		6. EMPLOYER PHONE NUMBER ( )
7. CITY	8. STATE	9. ZIP CODE

10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB?

11. PHONE NUMBER (IF DIFFERENT FROM EMPLOYER'S PHONE NUMBER) ( )	12. EMPLOYER'S EMAIL ADDRESS (EMPLOYER'S REPRESENTATIVE)

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months?

☐ No (stop here for this section of the application)

☐ Yes (continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____
(MM/DD/YYYY)

List the names of anyone else who is eligible or will be eligible for coverage from this job.

Name:_____ Name:_____Name:_____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

14a. Is this a State employee benefit plan? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation (that helps the employee to quit smoking) programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

☐ The employer doesn't offer wellness programs.

16. What change will the employer make for the new plan year (if known)?

☐ Employer will no longer provide health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy):_____

☐ No changes are expected.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Appendix B **QUESTIONS FOR AMERICAN INDIAN AND ALASKAN NATIVE INDIVIDUALS**

Complete this section if you or a family member (spouse and/or dependents) are American Indian or Alaskan Native. Submit this with your application.

Tell us about your American Indian or Alaskan Native family member(s).

American Indians and Alaskan Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay a cost share and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible. If you have more than two people to tell us about, make a copy of this page and attach it. You may also use a separate piece of paper. Just remember to write the question number next to your answer.

		AI/AN Person 1	**AI/AN Person 2**
1.	Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2.	Member of a federally recognized tribe?	☐ Yes If **yes**, tribe name _____ ☐ No	☐ Yes If **yes**, tribe name _____ ☐ No
3.	Has this person ever gotten a service from the Indian Health Service, a tribal health program, or through a referral from one of these programs?	☐ Yes ☐ No If **no**, is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ no	☐ Yes ☐ No If **no**, is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ no
4.	Certain money may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations) • Money from selling things that have cultural significance	☐ Yes - if **yes**, please complete information below: ☐ None to report $_____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____	☐ Yes - if **yes**, please complete information below: ☐ None to report $_____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____

Appendix C ASSISTANCE WITH COMPLETING THIS APPLICATION

If you want someone to be your authorized representative for the health insurance part of this application, please answer the questions on this page. If you're a legally-appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or Suite number

4. City

5. State

6. Zip code

7. Phone number

( )

8. Organization name (if applicable)

9. I.D. Number (if applicable)

By signing you allow this person to get official information about the health insurance part of this application and act for you on all matters with Covered California or your County Human Services Agency. As a reminder you can always change your authorized representative by calling the County or going to the web at www.HealthCare.gov.

10. Your signature

11. Date

For Certified Application Counselors, Navigators, Agents and Brokers Only.

Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. I.D. number (if applicable)

Appendix D

EMPLOYMENT HISTORY

If you are applying for cash aid and have two or more adults in the home who are applying for aid, please fill out the information on this page for each adult. Please tell us about your work history for the past 24 months (two years). If using the paper application and you need more space, copy this page or use a separate piece of paper.

Person1

NAME:

Job 1

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 2

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 3

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Appendix D — EMPLOYMENT HISTORY CONTINUED

If you are applying for cash aid and have two or more adults in the home who are applying for aid, please fill out the information on this page for each adult. Please tell us about your work history for the past 24 months (two years). If using the paper application and you need more space, copy this page or use a separate piece of paper.

Person 2

NAME:

Job 1

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 2

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Job 3

Is this person Native American? ☐ Yes ☐ No

Name of Tribe:_____

Reason for leaving this job?

Name and Address of Employer:

Number of hours worked:

☐ Daily ☐ Weekly ☐ Monthly

Was this your own business (self-employed)?

☐ Yes ☐ No

Dates you worked:

From_____ To_____

How much do you or did you get paid at this job and when? $_____

☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Monthly

Did the County help you get this job?

☐ Yes ☐ No

Appendix E **VEHICLE INFORMATION AND SELF CERTIFICATION OF EQUITY VALUE**

Optional for health care: Only answer if someone applying is age 65 or older or is disabled. If you are applying for cash aid, you MUST answer these questions for each vehicle.

Please provide information for each vehicle that anyone owns, has use of, or has their name on the registration, or even if it is not running. Vehicle means, car (including truck, van, Sport Utility Vehicle [SUV]), motorcycle, motorized scooters, snowmobile, recreational vehicle (RV) or motorboat.

	Vehicle (1)	**Vehicle (2)**	**Vehicle (3)**
Owner of vehicle			
Name of person who uses this vehicle			
Is this vehicle: • used as a home? • used for self-employment, self-support, or business? • needed to transport a disabled household member, • used to get the household's fuel or water?	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes**, you may stop
Is this vehicle used by a child under age 18 to: • go to school? • work? • training? • job search?	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes**, you may stop	☐ Yes ☐ No If **yes,** you may stop
Is this vehicle a gift, donation, or family transfer? You may be asked by the County to provide proof.	☐ Yes ☐ No ☐ Gift ☐ Donation ☐ Family Transfer If **yes**, check the box that applies, attach proof from DMV and stop here. If you do not have proof, ask the county for help.	☐ Yes ☐ No ☐ Gift ☐ Donation ☐ Family Transfer If **yes**, check the box that applies, attach proof from DMV and stop here. If you do not have proof, ask the county for help.	☐ Yes ☐ No ☐ Gift ☐ Donation ☐ Family Transfer If **yes**, check the box that applies, attach proof from DMV and stop here. If you do not have proof, ask the county for help.
Year/Make/Model			
Vehicle License Number			
Estimated value of vehicle (how much your vehicle is worth)? We call this the Fair Market Value.	$ ☐ I don't know/I need help finding out the value	$ ☐ I don't know/I need help finding out the value	$ ☐ I don't know/I need help finding out the value
How I found out the Fair Market Value	☐ For sale ads ☐ Car Dealer ☐ Kelly blue Book ☐ Mechanic ☐ Purchase price ☐ Other:_____	☐ For sale ads ☐ Car Dealer ☐ Kelly blue Book ☐ Mechanic ☐ Purchase price ☐ Other:_____	☐ For sale ads ☐ Car Dealer ☐ Kelly blue Book ☐ Mechanic ☐ Purchase price ☐ Other:_____
How much I owe on the vehicle	$ ☐ I don't know/I need help finding out the amount owed	$ ☐ I don't know/I need help finding out the amount owed	$ ☐ I don't know/I need help finding out the amount owed
What I used to find the amount owed on the vehicle	☐ Last Bill ☐ Lender statement ☐ Estimate ☐ Other:_____	☐ Last Bill ☐ Lender statement ☐ Estimate ☐ Other:_____	☐ Last Bill ☐ Lender statement ☐ Estimate ☐ Other:_____
Is this a leased vehicle?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

APPLICATION FOR CALFRESH BENEFITS

If you have a disability or need help with this application, let the County Welfare Department (County) know and someone will help you.

If you prefer to speak, read, or write in a language other than English, the County will get someone to help you at no cost to you.

How do I apply?
Use this application if you are applying for CalFresh benefits only. CalFresh is a food assistance program to help you with the cost of buying food for your household. If you wish to apply for programs other than CalFresh such as, CalWORKs or Medi-Cal, please ask for an application to apply for other programs. You can also apply for CalFresh or other programs online by going to http://www.benefitscal.org/. You can see if you may be eligible by going to http://www.cdss.ca.gov/foodstamps/PG849.htm.

- Fill out the whole application form, if you can. You must at least give the County your name, address, and signature (question 1 on page 1) to begin the application process.
- Give the application to the County in person, by mail, by fax, or online.
- The day the County receives your signed application starts the time to give you an answer on whether you can get benefits. If you are in an institution, this time starts from the day you leave.

What do I do next?

- Read about your rights and your responsibilities (Program Rules pages 1 through 5) before you sign the application.
- You must have an interview with the County to discuss your application. Most interviews are done by phone, but it can be done in person at the County office or other place arranged with the County. If you have a disability, other arrangements can be made.
- If you did not fill out all of the application, you can finish it during your interview.
- You will need to give proof of your income, expenses, and other circumstances to see if you are eligible.

How long will it take?
It may take up to 30 days to process your application. You may be able to get benefits within 3 calendar days, if you meet one of the Expedited Service criteria:

- Your household's monthly gross income (income before deductions) is less than $150 and your cash on hand or in checking or savings accounts is $100 or less; or
- Your household's housing costs (rent/mortgage and utilities) are more than your monthly gross income and cash on hand or in checking or savings accounts; or
- You are a migrant or seasonal farmworker household with less than $100 in checking or savings and 1) your income stopped, or 2) your income has started but you do not expect to get more than $25 in the next 10 days.

To help the County see if you can get benefits in three days, please answer questions 1, 6 through 8, 11, and 16, and give the County proof of your identify (if you have it) with the application.

The County will send you a letter to let you know if your household is approved or denied CalFresh benefits.

Agency Conference
Agency conference is a process that provides the household the right to request a meeting with an eligibility supervisor (this meeting may be attended by an eligibility worker and an authorized representative) to

informally resolve any dispute as to whether the household meets Expedited Service criteria.

The agency conference shall be scheduled within two working days of the request, unless the household requests that it be scheduled later or states that they do not wish to have an agency conference.

What do I need for my interview?

To avoid delays, bring proof of the following with you to your interview. Keep your interview even if you do not have the proof. The County may be able to help if you need help getting proof. During the interview, the County will go over the information on the application and will ask you questions to see if you can get CalFresh benefits and the amount of benefits you can get.

Proof Needed to Get Benefits

- Identification (Driver's License, State ID card, passport).
- Where you live (a rental agreement, current bill with your address listed).
- Social Security Numbers (see note below about certain noncitizens).
- Money in the bank for all the people in your household (recent bank statements).
- Earned income of everyone in your household for the past 30 days (recent pay stubs, a work statement from an employer). **NOTE:** If self-employed, income and expense or tax records.
- Unearned income (Unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.).
- Lawful immigration status **ONLY** for noncitizens applying for benefits (an Alien Registration Card, visa). **NOTE:** Certain noncitizens applying for immigration status based on domestic violence, crime prosecution or trafficking may not need this proof. They also may not need a Social Security Number.

Proof Needed to Get More CalFresh Benefits

- Housing costs (rent receipts, mortgage bills, property tax bill, insurance documents).
- Phone and utility costs.
- Medical expenses for anyone in your household who is elderly (60 and older) or disabled.
- Child and adult care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Child support paid by a person in your household.

How do I get/use my CalFresh benefits?

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to use your card.
- If your EBT card is lost, stolen, or destroyed, or you think someone may know your PIN number that you don't want to use your benefits call (877) 328-9677 or call the County right away. Make sure all responsible adults and your authorized representative also know how to report one of these problems right away. If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will not be replaced.
- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like toothpaste, soap, or paper towels).
- CalFresh benefits are accepted at most grocery stores and other places that sell food. For a list of locations near you that accept EBT please go to: https://www.ebt.ca.gov or https://www.snapfresh.org.
- CalFresh benefits are only for you and your household members. Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.

What if I am homeless?

Please let the County know right away if you are homeless so they can help you figure out an address to use to accept your application and get notices from the County regarding your case. For CalFresh, homeless means you are:

A. Staying in a supervised shelter, halfway house, or similar place.
B. Staying at the home of another person or family for no more than 90 days straight.
C. Sleeping in a place not designed for, or normally used as, a place to sleep (e.g., a hallway, a bus station, a lobby, or similar places).

Informational Page - Please take and keep for your records.

RIGHTS AND RESPONSIBILITIES

You have a responsibility to:

- Give the County all information needed to determine your eligibility.
- Give the County proof of the information you have when it is needed.
- Report changes as required. The County will give you information about what, when, and how to report. If you don't meet your household's reporting requirements your case will be closed or your CalFresh benefits may be lowered or stopped.
- Look for, get, and keep a job or participate in other activities if the County tells you that it is required in your case.
- Fully cooperate with County, State, or federal personnel if your case is selected for review or investigation to ensure that your eligibility and benefit level were correctly figured. Failure to cooperate in these reviews will result in loss of your benefits.
- Pay back any CalFresh benefits that you were not eligible to get.

You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Have an interpreter provided by the State at no cost if you need one.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Withdraw your application at any time prior to the County determining eligibility.
- Ask for help to fill out your application for CalFresh and get an explanation of the rules.
- Ask for help to get proof that is needed.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Be interviewed in a reasonable amount of time by the County when you apply and to have your eligibility determined within 30 days.
- Get at least 10 days to give the County proof that is needed to make a determination of eligibility.
- Get written notice at least 10 days before the County lowers or stops your CalFresh benefits.
- Discuss your case with the County and to review your case when you ask to do so.
- Ask for a State hearing within 90 days if you do not agree with the County about your CalFresh case. If you ask for a hearing before an action on your CalFresh case takes place, your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefits change until after the hearing to avoid having to pay back any over paid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that were cut.
- Ask about your hearing rights or for a legal aid referral at the toll-free phone number – **1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.** You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you do not want to go alone.
- Get assistance from the County to register to vote.
- Report changes that you are not required to report, if it may increase your CalFresh benefits.
- Give proof of your household's expenses that may help you get more CalFresh benefits. Not giving proof to the County is the same as saying that you do not have that expense and you will not be able to get more CalFresh benefits.
- Let the County know if you would like someone else to use your CalFresh benefits for your household or help with your CalFresh case (Authorized Representative).

Please take and keep for your records

Program Rules and Penalties

You are committing a crime if you give false or wrong information, or do not give all the information on purpose to try to get CalFresh benefits that you are not eligible to receive, or to help someone else get benefits that they are not eligible to receive. You must pay back any benefits you get that you were not eligible to receive.

Program Violations **For CalFresh: I understand I may have committed an intentional program violation if I do any of the following:**	**Penalties** **I may:**
• Hide information or make false statements • Use Electronic Benefit Transfer (EBT) cards that belong to someone else or let someone else use my card • Use CalFresh benefits to buy alcohol or tobacco • Trade, buy, sell, steal or give away CalFresh benefits or EBT cards, or attempt to trade, buy, sell, steal or give away CalFresh benefits or EBT cards • Try to get dual benefits, for example, apply in two or more different counties or states at the same time • Submit false documents for children or adult household members who are not eligible or who do not exist • Violate conditions of my probation or parole • Flee after a felony conviction • Purchase (buy) a product with CalFresh benefits that has a return deposit, intentionally (on purpose) throw away the contents and return the container for the deposit amount or attempt to return the container for the deposit amount • Buy a product with CalFresh benefits and intentionally resell it for cash or anything other than eligible food	• Lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me • Lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me • Lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me • Be fined up to $250,000.00, imprisoned up to 20 years or both
• Trade CalFresh benefits or attempt to trade CalFresh benefits for: cash, firearms, non-eligible goods or controlled substances such as drugs	• Lose CalFresh benefits for 24 months for the first offense • Lose CalFresh benefits permanently for the second offense
• Give false information about who I am and where I live so I can get extra CalFresh benefits	• Lose CalFresh benefits for 10 years for each offense
• Have been convicted of trading, selling or attempting to trade CalFresh benefits worth more than $500, or trading or attempting to trade CalFresh benefits for firearms, ammunition or explosives	• Lose CalFresh benefits permanently

Please take and keep for your records

Important Information for Noncitizens

- You can apply for and get CalFresh benefits for people who are eligible, even if your family includes others who are not eligible. For example, immigrant parents may apply for CalFresh benefits for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible.
- Getting food benefits will not affect you or your family's immigration status. Immigration information is private and confidential.
- The immigration status of noncitizens who are eligible and apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for CalFresh benefits. The County will need to know their income and resource information to correctly determine your household's benefits. The County will not contact USCIS about the people who don't apply for CalFresh benefits.

Privacy Act and Disclosure: You are giving personal information in the application. The County uses the information to see if you are eligible for benefits. If you do not give the requested information, the County may deny your application. You have the right to review, change, or correct any information that you gave to the County. The County will not show your information or give it to others unless you give them permission or federal and state law allows them to do so. 273.2(b)(4) *Privacy Act statement.* As a County agency, we must notify all households applying and being recertified for CalFresh benefits of the following:

(i) The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the CalFresh Program. We will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will also be used to monitor compliance with program regulations and for program management.

(ii) This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

(iii) If a CalFresh claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

(iv) Providing the requested information including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of CalFresh benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

The County may verify immigration status of household members applying for benefits by contacting the USCIS. Information the County gets from these agencies may affect your eligibility and level of benefits.

The County will check your answers using information in state and federal electronic databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a **consumer reporting agency**. If the information does not match, the County may ask you to send proof.

Please take and keep for your records

Use of Social Security Numbers (SSN)

Everyone applying for CalFresh benefits needs to provide a SSN, if they have one, or proof that they have applied for a SSN (such as a letter from the Social Security Office). The County may deny CalFresh benefits for you or any member of your household who does not give us a SSN. Some people do not have to give SSN's to get help such as, victims of domestic abuse, crime prosecution witnesses, and trafficking victims.

Overissuance

This means you got more CalFresh benefits than you should have. You will have to pay it back even if the County made an error or if it wasn't on purpose. Your benefits may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Reporting

Every household that gets CalFresh benefits must report certain changes. Your County will tell you what changes to report, how to report them, and when to report them. Failure to report the changes may result in your CalFresh benefits being lowered or stopped. You can also report if things happen that may increase your benefits, such as getting less income.

State Hearing

You have the right to a State hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You can request a State hearing within 90 days of the County's action and you must tell why you want a hearing. The approval or denial notice you receive from the County will have information on how to request a State hearing. If you ask for a hearing before the action happens, you may be able to keep your CalFresh benefits the same until a decision is made.

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD 3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or contact your County's Civil Rights Coordinator, or write a letter addressed to USDA and provide in the letter all of the information requested in the form or write to California Department of Social Services (CDSS) address below. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

CDSS
Civil Rights Bureau
P.O.BOX 944243, M.S. 8-16-70
Sacramento, CA 94244-2430
1-866-741-6241 (Toll Free)

This institution is an equal opportunity provider.

Please take and keep for your records

Case File Reviews

Your case may be selected for additional review to ensure that your eligibility was correctly figured. You must cooperate fully with the County, State, or federal personnel in any investigation or review, including a quality control review. Failure to cooperate in these reviews could result in loss of your benefits.

Work Rules for CalFresh

The County may assign you to a work program. They will tell you if it is voluntary or if you must do the work program. If you have a mandatory work activity and you do not do it, your benefits may be lowered or stopped. You may not be eligible for CalFresh if you have recently quit a job without a good reason.

EBT Usage

Any benefit taken from your account before you, another household member, or your authorized representative report the EBT card or PIN has been lost or stolen will **not** be replaced.

Any use of your EBT card by you, a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **not** be replaced.

If you do not report that another person you do not want to spend your benefits has your PIN and you do not get your PIN changed, any benefits used will **not** be replaced.

Please take and keep for your records

NOTES

Please use black or blue ink because it is easy to read and copies best. Please print your answers.
If you need more space to answer a question(s), use page 10 "Additional Writing Space" section and attach additional sheets of paper if needed to provide the information. Please be sure to identify which question you are writing about in the extra space or on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS)

HOME ADDRESS OR DIRECTIONS TO YOUR HOME	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

CONTACT AUTHORIZATION

Please give the county the best contact information to reach you. This will help in processing your application. By providing your contact information below, you are authorizing the county to contact you by phone, email or text, or to leave a phone message regarding your application.

HOME PHONE	CELL PHONE	CHECK BOX FOR TEXT
		☐
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS	

Are you homeless? ☐ Yes ☐ No If **yes,** please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)?_____
What language do you prefer to speak (if not English)?_____

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

	(PLEASE CHECK ONE)
Do you have a disability and need help with applying?	☐ Yes ☐ No
Are you interested in applying for Medi-Cal? If you answer **yes** the County will use your answers to find out if you can get Medi-Cal.	☐ Yes ☐ No
Is your household's monthly gross income less than $150 and cash on hand, or in checking and savings accounts is $100 or less?	☐ Yes ☐ No
Is your household's combined monthly gross income and cash on hand or in checking and savings accounts is less than the combined cost of rent/mortgage and utilities?	☐ Yes ☐ No
Is your household a migrant/seasonal farm worker household with liquid resources not exceeding $100 and either your income stopped or you will not get more than $25 in the next 10 days?	☐ Yes ☐ No

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- My answers to the questions are true and complete to the best of my knowledge.
- Any answers I may give for my application process will be true and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1) for the CalFresh Program.
- I read, or had read to me, the CalFresh Program Rules and Penalties (Program Rules Page 2).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility for CalFresh is fraud. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits.
- I understand that Social Security Numbers or immigration status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.

SIGNATURE OF APPLICANT(OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN)	DATE

***If you have an Authorized Representative please complete question 2 on the next page.**

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME:	AUTHORIZED REPRESENTATIVE PHONE NUMBER:

Do you want to name someone to receive and spend CalFresh benefits for your household? (Please Check One) ☐ Yes ☐ No

If **yes**, complete the following section:

NAME:	PHONE NUMBER:

ADDRESS: CITY STATE ZIP CODE

3. RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY

Are you Hispanic or Latino? (Please Check One)
☐ Yes ☐ No

If you are of Hispanic or Latino origin, do you consider yourself:
☐ Mexican ☐ Puerto Rican ☐ Cuban
☐ Other_____

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed _____

☐ Asian (If checked, please select one or more of the following):

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify)_____

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You or another adult member in your household will need to have an interview with the County to discuss your application and to receive CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. In-person interviews will only happen during the County's normal office hours.

☐ Please check this box if you would prefer an in-person interview.

☐ Please check this box if you need other arrangements due to a disability.

Please check the boxes below for your preferred day and time for an interview:

Day: ☐ Today ☐ Next available day ☐ Any day ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time: ☐ Early morning ☐ Mid-morning ☐ Afternoon ☐ Late afternoon ☐ Anytime

5. OTHER PROGRAMS

Have you or anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Medicaid, Supplemental Nutrition Assistance Program [CalFresh], General Assistance (GA)/General Relief (GR), etc.)? (Please Check One) ☐ Yes ☐ No

IF **YES,** WHO?	WHERE (COUNTY/STATE)?
IF **YES**, WHO?	WHERE (COUNTY/STATE)?

6a. HOUSEHOLD'S INFORMATION

Complete the following information for all persons in the home that you buy and prepare food with, including you. **If applying for noncitizens, please complete question 6b and 6c. If not, go to question 6d.**

Social Security number is optional for members not applying for benefits. You must answer the questions below for each person applying for benefits.

APPLYING FOR BENEFITS (✔ check Yes or No)	**NAME** (Last, First, Middle Initial)	How is the person related to you?	**DATE OF BIRTH**	**GENDER** (M OR F)	**U.S. CITIZEN** or **NATIONAL** (✔ check Yes or No) If **no**, complete question 6b below	**SOCIAL SECURITY NUMBER**
☐ Yes ☐ No		**SELF**			☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	
☐ Yes ☐ No					☐ Yes ☐ No	

Please list the names of anyone who lives with you that does not buy and prepare food with you:

NAME	NAME
NAME	NAME

6b. NONCITIZEN INFORMATION - Complete for those listed in question 6a above who are not citizens and are applying for aid.

Name	**Date of Entry into U.S.** (if known)	**Give one of the following** (if known)**: Passport Number, Alien Registration Number, etc.**	**Sponsored?** (✔ check Yes or No) If **yes,** complete question 6c below:
		DOCUMENT TYPE:_____ DOCUMENT NUMBER:_____	☐ Yes ☐ No
		DOCUMENT TYPE:_____ DOCUMENT NUMBER:_____	☐ Yes ☐ No
		DOCUMENT TYPE:_____ DOCUMENT NUMBER:_____	☐ Yes ☐ No

(PLEASE CHECK ONE)

Does anyone listed above have at least 10 years (40 quarters) of work history or military service in the USA? ☐ Yes ☐ No
If **yes**, who?_____

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa, U-Visa or VAWA status? ☐ Yes ☐ No
If **yes**, who?_____

6c. SPONSORED NONCITIZEN INFORMATION - Complete for those listed in question 6b above who are sponsored noncitizens and are applying for aid.

Did the sponsor sign an I-864? ☐ Yes ☐ No If **yes**, please answer the rest of the question. If the sponsor signed an I-134 then skip this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No If **yes**, how much? $_____

Does the sponsor regularly help with any of the following (check all that apply)?
☐ rent ☐ clothes ☐ food ☐ other_____

SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER
SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER

6d. Students

Is anyone who is applying for benefits including you attending a college or vocational school? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

Name of Person	Name of School/Training	Enrolled Status (✔ check one)	Are They Working?
		☐ Half-time or more ☐ Less than half-time Number of units:_____	Average work hours per week:_____
		☐ Half-time or more ☐ Less than half-time Number of units:_____	Average work hours per week:_____

6e. Is there a foster child living in your home? ☐ Yes ☐ No If **yes**, who?_____

Please answer the following questions about the child(ren):

Was this child(ren) placed in your home under a dependence order of the court? (Please Check One) ☐ Yes ☐ No

Do you want the foster care child(ren) counted in your CalFresh case? (Please Check One) ☐ Yes ☐ No

If **yes**, the foster care income you receive will be counted as unearned income.

If **no**, the foster care income will not be counted as unearned income.

7. Unearned Income

Do you or anyone you buy and prepare food with get income that does not come from a job (unearned)? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- ☐ Social Security
- ☐ SSI/SSP
- ☐ Cash aid
- ☐ CalWORKs/TANF/GA/GR/CAPI
- ☐ Room and board (from your renter)
- ☐ Pension
- ☐ Child/Spousal support
- ☐ Government/railroad disability or retirement
- ☐ Veteran benefits, or Military pension
- ☐ Financial aid (school grants/loans/ scholarships)
- ☐ Gift of money
- ☐ Unemployment Insurance/ State Disability Insurance (SDI)
- ☐ Worker's compensation
- ☐ Lottery/gambling winnings
- ☐ Help with rent/food/clothing
- ☐ Insurance or legal settlements
- ☐ Private disability or retirement
- ☐ Strike benefits
- ☐ Other_____

_____

Person getting the money?	From where?	How much?	How often received? (once, weekly, monthly, or other)	Expect to continue? (✔ Check Yes or No)
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No

If this income is not expected to continue, please explain:

8. Earned income

Do you or anyone you buy and prepare food with get income from a job (earned income)? (Please Check One) ☐ Yes ☐ No

If **yes**, please answer this question. If **no**, skip to the question 9.

NOTE: If self-employed fill out question 8a.

Please list all income **before** taxes or other deductions are taken out (gross income).

Examples of earned income are (these examples can be full-time, temporary, seasonal, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)

Person working	Employer's name and address	Employer's phone number	Hourly rate	Average hours per week	How often paid? (Once, weekly, monthly, other)	Total gross earned income received this month	Expect to continue? (✔ Check Yes or No)
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No

If this income is not expected to continue, please explain:

Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? (Please Check One) ☐ Yes ☐ No

IF **YES**, WHO?	DATE OF JOB LOSS, QUIT, OR CHANGE	DATE OF LAST PAY

REASON?

Is anyone on strike? (Please Check One) ☐ Yes ☐ No

IF **YES**, WHO?	DATE WENT ON STRIKE	DATE OF LAST PAY

REASON?

8a. Self-Employment

Self-employed household members may deduct actual self-employment expenses or take a standard 40% deduction off of self-employment income. If you choose actual expenses, you will need to give the County proof of the expenses.

Person self-employed	Date business started	Type of business and name	Gross monthly income	Self-employment expenses (please ✔ check one)
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____
			$	☐ 40% flat rate ☐ Actual expenses $ _____

9. Household's Child/Adult Care Expenses

Do you or anyone you buy and prepare food with pay for the care of a child, disabled adult, or other dependent so you or the other person can go to work, school, training, or look for a job? (Please Check One) ☐ Yes ☐ No

If **yes,** please answer this question. If **no,** skip to the next question.

Who gets care?	Who gives care? (name and address of provider)	Amount paid?	How often paid? (weekly/monthly, other)
		$	
		$	
		$	
		$	

Does anyone help your household pay all or part of your child/adult care costs listed above? ☐ Yes ☐ No If **yes**, complete below:

Who gets care?	Who helps pay?	Amount paid?	How often paid? (weekly/monthly, other)
		$	
		$	

10. Child Support Payments

Are you or anyone you buy and prepare food with legally obligated to pay child support, including back child support?

☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How often paid (weekly/monthly, other)
		$	
		$	

11. Household Expenses

Are you or anyone you buy and prepare food with responsible for any household expenses? ☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

NOTE: Do not enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances and you do not need to fill in the actual amount owed.

Type of Expenses	Have Expense? (Please Check One)	Who pays?	Amount Owed	How often billed? (weekly/monthly, other)
Rent or house payment	☐ Yes ☐ No		$	
Property taxes and insurance (if billed separately from rent or mortgage)	☐ Yes ☐ No		$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if billed separately from rent or mortgage)	☐ Yes ☐ No			
Telephone/cell phone	☐ Yes ☐ No			
Homeless Shelter Expense	☐ Yes ☐ No			
Water, sewage, garbage	☐ Yes ☐ No			
Does anyone <u>not</u> in your household help you pay for the expenses listed above? (Please Check One) ☐ Yes ☐ No If **yes**, please complete.		**Who helps pay?**	**How much?** $	**How often paid?**

Does your household receive, or expect to receive, payment from the Low Income Home Energy Assistance Program (LIHEAP)? (Please Check One) ☐ Yes ☐ No

12. Medical Expenses:
Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? ☐ Yes ☐ No If **yes**, please answer this question. If **no,** skip to the next question.
NOTE: Do not list spouses or children receiving dependent payments for an SSI or disability and blindness recipient.
List expenses you expect to have in the near future.

Allowable medical expenses are: (Check all that apply)

- ☐ Medical or dental care
- ☐ Hospitalization/outpatient treatment/nursing care
- ☐ Prescribed medications
- ☐ Health and Hospitalization insurance policy premiums
- ☐ Medicare premiums (Medi-Cal share of costs, etc.)
- ☐ Dentures, hearing aids and prosthetics
- ☐ Maintaining an attendant necessary due to age, illness, or infirmity
- ☐ The number and cost of meals furnished to an attendant
- ☐ Prescribed over the counter medications
- ☐ Cost of transportation (mileage or fee) and lodging to obtain medical treatment or services
- ☐ Prescribed eye glasses and contact lenses
- ☐ Prescribed medical supplies and equipment
- ☐ Service animals expenses (food, vet bills, etc.)

Name of elderly/disabled person	**Amount of expense**	**How often paid?** (monthly, weekly, other)	**What type of expense?** (prescriptions, dentures, number of meals for attendant, etc.)	**Will the household be reimbursed for any medical expenses?** (by Medi-Cal, insurance, family member, etc.)
	$			IF **YES,** BY WHO: HOW MUCH: $
	$			IF **YES,** BY WHO: HOW MUCH: $
	$			IF **YES,** BY WHO: HOW MUCH: $
	$			IF **YES,** BY WHO: HOW MUCH: $

13. Does anyone who is applying for benefits, including you, get food from any of the following? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Communal dining facility for the elderly/disabled
- Food distribution program operated by a Native American reservation
- Other food program

IF **YES,** WHO?	WHERE?
IF **YES,** WHO?	WHERE?

14. Does anyone who is applying for benefits, including you, live at any of the following? (Please Check One) ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Homeless Shelter
- Shelter for battered women
- Reservation for Native Americans
- Drug/Alcohol rehabilitation center
- Correctional facility/Penal institution *(Jail or Prison)*
- Group living arrangement for the blind/disabled
- Federally subsidized housing
- Psychiatric hospital/mental institution
- Hospital
- Long-Term Care or Board and Care Facility

Person's Name	**Name of Institution** (center, shelter, facility, etc.)	**Expected Date of Release** (if applicable)

15. Are you or anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? (Please Check One) ☐ Yes ☐ No

IF **YES,** WHO?

16. Household's Resources

Do you or anyone you buy and prepare food with have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)? ☐ Yes ☐ No If y**es**, please answer this question. If **no**, skip to the next question.

Check all that apply:

- ☐ Bank/Credit Union account (Checking)
- ☐ Bank/Credit Union account (Saving)
- ☐ Safe Deposit box
- ☐ Savings Bond(s)
- ☐ Money Market Account
- ☐ Mutual Funds
- ☐ Certificate of Deposit (CD)
- ☐ Cash on hand
- ☐ Stocks
- ☐ Bonds
- ☐ Other: _____

If joint account with another person please say so below.

For each box checked above, complete the following information.

In whose name is the resource listed?	What type of resource?	How much is it worth?	Where is the resource? (include the name of the bank or company where money is held)
		$	
		$	
		$	
		$	

Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months?

(Please Check One) ☐ Yes ☐ No

17. Duplicate Benefits

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program, known as CalFresh in California) benefits in any state after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

18. Trafficking (trading or selling) of Benefits

Have you or any member of your household ever been convicted of trafficking (trading or selling EBT cards to others) SNAP benefits of $500 or more after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

19. Trading Benefits for Drugs

Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

20. Trading Benefits for Firearms or Explosives

Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition, or explosives after September 22, 1996? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

21. Fleeing Felon

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

22. Probation/Parole Violation

Have you or any member of your household been found by a court of law to be in violation of probation or parole? (Please Check One) ☐ Yes ☐ No

If **yes**, who?_____

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY

IF THE ANSWER IS YES TO ANY OF THE QUESTIONS BELOW - EXPEDITE

Is the household's gross income less than $150 and cash on hand, or in checking and savings accounts $100 or less? ☐ Yes ☐ No

Is the household's combined gross income and cash on hand or on checking and savings accounts less than the combined rent/mortgage and appropriate utility allowance? ☐ Yes ☐ No

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding $100 and does not expect to receive more than $25 in next 10 days? ☐ Yes ☐ No

MEDI-CAL ANNUAL REDETERMINATION FORM

You must fill out this form and return it to the county to keep your Medi-Cal!

Case Number *(optional)*	**Social Security Number** *(optional)*	
Print Your Full Name *(if you have not moved, put address label here if one is provided)*	**Birth Date** *(optional)* **(mm/dd/yyyy)**	
Current Street Address, Apartment Number ❑ *(check here if address is new)*	**City/State**	**Zip Code**
Mailing Address *(if different from above)*	**City/State**	**Zip Code**

Use ink and **PRINT** your answers. Make sure you sign and date the form. Use the postage paid envelope to return it. If you need more space, attach a separate sheet to this form. If you have any questions or need help filling out this form, call your worker at the telephone number listed on the Annual Redetermination Notice.

Section 1. Income

(a) Do you or any family member in the home get money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts, or interest or dividends? ❑ Yes ❑ No

If yes, complete below and list each source of income on a separate line.

Attach most recent pay stubs showing income before taxes or deductions, benefit or award letters, checks received or signed statement from employer, or last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person with Income *(include first and last name)*	**Source of Income**	**Income Amount** *(before any deductions)*	**How Often Paid** *(weekly, monthly, twice a month)*	**Hours Worked** *(per week or month)*

(b) Do you or any family member in the home get rent, utilities, food, or clothing entirely free? ❑ Yes ❑ No

If yes, who? _____

What was free? _____

(c) Was the free rent, utilities, food, or clothing received in exchange for work done? ❑ Yes ❑ No

Section 2. Expenses and Deductions

Do you or any family member in the home pay for child or adult care, health insurance or Medicare premiums, court-ordered child support or alimony, or educational expenses? ❑ Yes ❑ No

If yes, complete below and list each expense/deduction on a separate line.

Attach proof of expenses/deductions.

Name of Person with Expense/Deduction *(include first and last name)*	**Type of Expense or Deduction**	**Amount of Payment**	**Paid to Whom**	**How Often Paid** *(weekly, monthly, twice a month)*

Section 3. Other Health Insurance

(a) Did you or any family member have a change in, or get new health, dental, vision, or Medicare coverage or insurance within the last 12 months? ❑ Yes ❑ No

If yes, who has the coverage/insurance? _____

Which type of coverage/insurance? _____

(b) Is any family member living in the home receiving kidney dialysis-related services? ❑ Yes ❑ No

If yes, who? _____

(c) Has any family member living in the home received an organ transplant within the last 2 years? ❑ Yes ❑ No

If yes, who? _____

Section 4. Living Situation

(a) Did anyone move into or out of your home, move in with someone else, get married, or have a baby within the last 12 months? *(Examples: newborn, child, or adult moved in or out of the home, absent parent returns home.)* ❑ Yes ❑ No

If yes, complete below:

Name *(include first and last name)*	**Relationship to You**	**What Changed?**	**Date Changed**

(b) Does anyone in the home want Medi-Cal who is not already receiving it? ❑ Yes ❑ No

If yes, who? _____

(c) If a new baby is in home, where was the baby's place of birth? _____ (City) | _____ (State) | _____ (Country)

Section 4. Living Situation *continued*

(d) Did anyone in the home get inpatient care in a nursing facility or medical institution? ❑ Yes ❑ No

If yes, who? _____

(e) Is anyone in the home pregnant? ❑ Yes ❑ No

If yes, who? _____

Number of babies expected _____ Due date: _____

Section 5. Real or Personal Property

(a) Indicate the total amount of cash and uncashed checks held by any family member in the home $ _____

(b) Does anyone have a checking or savings account, life insurance, long-term care insurance, motor vehicle, court-ordered settlement or judgement, stocks, bonds, retirement funds, trusts where money or property is held for the benefit of any family member in the home, real estate, motor vehicles for a business, business accounts or property, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), or oil or mineral rights? ❑ Yes ❑ No

(c) Did you or any family member in the home sell or give away any money or property in the past 12 months, or have any of the items listed in this section been spent or used as security for medical costs? ❑ Yes ❑ No

Note: If you have answered "yes" to questions (b) or (c), you will also have to fill out a property supplement form, submit the form to the county and provide verification.

Section 6. Immigration or Citizenship Status Change

Has there been a change in immigration or citizenship status for anyone in the home that has Medi-Cal or wants Medi-Cal within the last 12 months? *(If your immigration status has changed, you might qualify for full scope Medi-Cal benefits.)* ❑ Yes ❑ No

If yes, list the name(s) below and send proof of new status.

Name of Person *(include first and last name)*	**Status Change** *(send proof of status)*

Section 7. Blindness/Disability/Incapacity

(a) Do you or any family member in the home have a physical or emotional condition that makes it difficult to work, take care of personal needs, or take care of your children? ❑ Yes ❑ No

If yes, who? _____

(b) Was the physical, mental, or health condition a result of an injury or accident? ❑ Yes ❑ No

If yes, explain _____

_____

Section 8. Other Health Program Information and Referrals

(a) Check this box if you do **not** want your child's information shared with the low-cost Healthy Families Program if your child gets Medi-Cal with a share of cost. ❑

(b) Do you want information on the no-cost health program for children under 21 *(Child Health and Disability Prevention Program, also known as CHDP?)* ❑ Yes ❑ No

(c) Do you want information on the no-cost supplemental food program for pregnant or breast feeding women and children under 5 *(Women, Infants, and Children Program, also known as WIC)?* ❑ Yes ❑ No

(d) Do you want information on the Personal Care Services Program, an in-home care program for aged, blind, or disabled persons (also known as In-Home Supportive Services)? ❑ Yes ❑ No

Section 9. Signature and Certification

Person completing this form must read and sign below.

➤ I have received and read a copy of the *Important Information for Persons Requesting Medi-Cal* form (MC 219).

➤ I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219 form.

➤ I certify that I will report all income, property, and/or other changes that may affect Medi-Cal eligibility within ten days of the change.

➤ I understand that all of the statements, including benefit and income information, that I have made on this form, may be subject to investigation and verification.

➤ I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	**Date**

Daytime or Message Telephone Number	**Home Telephone Number** ❑ *(check here if new number)*

Signature of Witness *(if signed by a mark),* **Interpreter or Person Assisting**

— County Use Only —

Referrals

❑ HF ❑ WIC
❑ CHDP ❑ PCSP

Follow-up Forms

❑ MC 13 ❑ MC 210 PS ❑ Other:
❑ DDSD Packet

Case name: _____

Worker's name: _____

Worker's telephone number: _____

PROPERTY SUPPLEMENT

STOP: If you are applying for no-cost Medi-Cal only for ***children under age 19*** and/or ***pregnant women*** applying only for pregnancy-related services, you do not need to complete this form. You may be contacted later if necessary.

GO: If you are applying for full-coverage Medi-Cal for a family including adults, please complete this form and be sure to list all your property. The county worker will determine which properties are important to your application. If you have any questions, please contact your worker. **Note:** Owning a home does not make you ineligible for Medi-Cal.

Mark the box under **YES** or **NO** for each item held in the name of, or held for the benefit of any family member in the home. Please follow the instruction below each question.

	YES	NO	ITEM
1.	☐	☐	Shares of stock or mutual funds. *If yes, please provide a copy of the stock or mutual fund certificates indicating the number of shares.*
2.	☐	☐	Individual Retirement Accounts (IRAs), Keoghs, or work-related pension funds. *If yes, please provide the most recent statements from your employer, financial institution, or brokerage indicating the amount of principal and interest you are receiving or the cash value (after penalties for early withdrawal).*
3.	☐	☐	Annuities, burial trusts, burial contracts or burial insurance, trusts or agreements where money or property is held for the benefit of any family member in the home, blocked accounts, court-ordered settlements, judgments, orders for support, prenuptial and post-nuptial agreements, promissory notes, mortgages, deeds of trust, etc. *If yes, please provide copies of the policies, contracts, trusts, purchase agreements, court orders, account documents showing investments and distributions.*
4.	☐	☐	Business accounts and property. *If yes, please provide tax returns, invoices, receipts, licenses, profit and loss statements, etc.*
5.	☐	☐	House, condominium, ranch, land, mobile home, or life estate that is your home that you live in, or that is your former home and is lived in by your spouse, child under 21, disabled son or daughter, dependent relative, or a sibling who lived in the property continuously and provided care for one year which enabled you to remain in the home rather than a nursing facility. *If yes, please list address of property here:* _____ *No verification is required.*
6.			If you own a home or former home and you are absent for any reason (including admission into long-term care) but intend to return home someday, please indicate below. **NOTE:** The word "intend" means "desire or wish" to return home even though you may not be physically or mentally able to do so.

☐ Yes, I intend to return home someday.
☐ No, I do not intend to return home someday.
Please list the address of the property here: _____
*No verification is required if you answered that you do intend to return home someday. If you answered that you do **NOT** intend to return someday, please submit a copy of the most recent tax assessment. If you choose to, you may provide an appraisal from a qualified real estate appraiser and that value will be used if it is lower.*

7. ☐ ☐ Other real estate, condominiums, buildings, mobile homes, life estates, time shares, oil and mineral rights.
If yes, please provide copies of the mortgage papers, most recent tax assessment, registration, or ownership documents.

8. ☐ ☐ Motorcycles, trailers, boats, or other motorized vehicles that are not used by you as a home.
Please provide a copy of the ownership documents or most recent registrations, purchase agreements, sales receipts, or estimates of value from a qualified source. On the submitted verification for each item, indicate if the item is used:
- *on the job (such as a taxi);*
- *to travel long distances to work (such as a truck used by a contractor working out of town);*
- *to carry the main supply of fuel or water for your home;*
- *to transport a disabled or incapacitated family member living in the home or if it is business property.*

9 . ☐ ☐ Jewelry (not wedding rings, engagement rings, or heirlooms) worth more than $100.00.
If yes, please provide copies of sales receipts, appraisals, estimates of value or insurance documents.

10. ☐ ☐ Any other real or personal property, assets, or resources valued at $500 or more.
If yes, send copies verifying the property and its worth.

11. ☐ ☐ Has anyone spent or used any of the items listed above in payment for, or as security for medical services?
If yes, please explain below and attach verifications.

1 through 10. ***If you owe money on any of the items listed above, or if any of the items listed above have liens against them, please provide copies of the lien, loan, or security documents.***

12. ☐ ☐ Did you, or any family member in the home, sell or give away any money or property in the past
- 36 months (or 60 months if the transfer was made to or from a trust or agreement for holding money or property for the benefit of someone) if you are applying for Medi-Cal; or
- 12 months if you are currently receiving Medi-Cal?

If yes, please explain in the "Additional Information" section at the end of this form and attach verifications.

The following questions apply only to those individuals who are already receiving Medi-Cal.

13. ☐ ☐ Does any family member in the home have a checking account or savings account?
If yes, send copies of account statements showing current balances in the accounts.

14. ☐ ☐ Does anyone have a court-ordered settlement or judgment?
If yes, send copies of all court orders, documents, and agreements. If copies have already been provided to your worker, you do not need to provide them again.

15. ☐ ☐ Does anyone have life insurance or long-term care insurance?
If yes, send copies of your policies, contracts, and purchase agreements. If copies have already been provided to your worker, you do not need to provide them again. If your policy is a certified California Partnership for Long-term Care policy, send a copy of your most recent benefit statement.

Additional information:

MEDI-CAL CONTACT UPDATE

Please fill in numbers 1 through 4, and sign number 5 below:

1. New Contact Information	2. Old Contact Information
Name (print)	Name (print)
Address (number, street, apt.)	Address (number, street, apt.)
City State ZIP code	City State ZIP code
Mailing address (if different from above)	Mailing address (if different from above)
City State ZIP code	City State ZIP code
Telephone number ( )	Telephone number ( )

3. Your Health Plan Information	4. Personal Information
Health plan name (print)	Your date of birth
Your health plan number	Your Beneficiary Identification Card (BIC) number

PLEASE READ THE FOLLOWING BEFORE SIGNING BELOW:

You can help us keep your Medi-Cal contact information current by completing, signing, and turning in this form. It allows your managed care plan to share with your county Medi-Cal office any **name, address,** and/or **telephone number** changes you make. This form will help in making sure that you receive the most current information about your Medi-Cal benefits.

The county Medi-Cal office may not be able to update your Medi-Cal case file with your **name, address,** and **telephone number** change if this form is not completed and signed by you. **Don't forget** that Medi-Cal rules require you to report a change of address to the county Medi-Cal office within ten days.

5. PLEASE PRINT YOUR NAME, SIGN, AND DATE IN THE AUTHORIZATION BOX BELOW:

I, *(print name)* _____, give permission for the county Medi-Cal office to update my Medi-Cal case file and those of my family members with any changes in information regarding my **name, address,** and/or **telephone number** that I report to my managed care plan. I understand that I will need to complete a new form every time I have a change to my **name, address,** and/or **telephone number.**

_____ _____

Signature Date

COUNTY INFORMATION *(to be filled in by county staff)*

Case number	Worker name	Worker number	Worker telephone number ( )

SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part IV
ADAP/ OA-HIPP

Table of Contents

Employer Based Health Insurance Premium Payment (EB-HIPP)
Program Frequently Asked Questions (FAQs)

This FAQ is for potential EB-HIPP Clients

Program Overview Questions

1) What is EB-HIPP?

California Department of Public Health (CDPH), Center for Infectious Diseases (CID), Office of AIDS (OA) has created a program that pays an ADAP client's portion of their employer based insurance premiums who have elected to participate in the EB-HIPP program and meets the program requirements.

2) Who is eligible for EB-HIPP?

To be eligible for EB-HIPP clients must meet the following criteria:

- Be enrolled in ADAP
- Enrolled in employer based insurance
  - Client must be employed by the employer in order to participate in the EB-HIPP program
- Employer agrees to participate in the EB-HIPP program
- Completed participation agreement form is completed by client and employer
- Employment verified with paystub (paystub must be within the last 3 months)
- EB-HIPP must pay the client's portion of their premium in order for the client to receive MOOP benefits

3) What services are covered under EB-HIPP?

EB-HIPP pays the client's portion of their employer based insurance premiums. EB-HIPP will pay medical and dental premiums. If a vision premium is included in the medical or dental premium, the client will have their vision premium subsidized EB-HIPP pays client's Medical Out-of-Pocket (MOOP) expenses for outpatient services.

Confidentiality Questions

4) Will my health information be shared with my employer? No, your health information will not be disclosed.

5) **What communication will occur between my employer and CDPH?** Client should be aware that Pool Administrators Inc. (PAI) is the contracted vendor for the State of California and may contact the client's employer to get updated premium and payment information. The information will be considered confidential, but may be exchanged with the employer as necessary to determine client's eligibility and for the purpose of administering the program.

6) Can my employer ask PAI for information about the EB-HIPP program, such as why I qualify for this program?
Yes, but PAI will only release information that pertains to your insurance, premium payments, or personal information that identifies you in our database (i.e. date of birth, name, Social Security Number). In addition, the EB-HIPP program is confidential and will not disclose program information to your employer in order to protect your confidentiality. Your employer should refrain from asking you why you qualify for the EB-HIPP State-administered program as a participant's qualifications for and enrollment in the program is confidential under California privacy laws.

Enrollment Questions

7) What supporting documentation do I need in order to enroll into EB-HIPP? ADAP clients must submit the following documentation to their Enrollment Worker or CDPH

- Participation Agreement Form - completed by client and employer
- Employment paystub – dated within the last 3 months
- Client Attestation Form (CDPH 8723)

8) Where can I access the Participation Agreement Form?

You may contact your ADAP Enrollment Worker, an ADAP Advisor, or the ADAP Call-Center to obtain the Participation Agreement Form.

9) What happens if I no longer work at the company listed on the Participation Agreement Form?

You will be required to resubmit the Participation Agreement Form, Client Attestation, and employer paystub dated within the last 3 months. The forms can be submitted to your Enrollment Worker or CDPH.

10) What happens if the information on the Participation Agreement Form changes after it has been submitted (i.e. employer address, premium amounts, payment period)?

If the information on the Participation Agreement Form changes (i.e. employer address, premium amounts, payment period) once the form has been submitted, please have your employer re-complete form and return it back to you. The updated form will then need to be submitted to your Enrollment Worker or to CDPH.

Re-Certification/Re-Enrollment

11) What is the re-enrollment timeline for EB-HIPP?

Re-enrollment for EB-HIPP will align with your ADAP re-enrollment date.

12) Will I need to re-submit all EB-HIPP supporting documentation at re-enrollment?

If your insurance premium or employer has not changed, you will only need to submit the following documents:

- Paystub (must be within last 3 months)
- Client Attestation

If your insurance premium or employer has changed, you will be required to submit the following documents:

- Paystub (must be within last 3 months)
- Client Attestation
- Completed Participation Agreement Form

13) What is the re-certification timeline for EB-HIPP?

Re-certification for EB-HIPP will align with your ADAP recertification date.

14) Will I need to re-submit all EB-HIPP supporting documentation at recertification?

- If the employer and insurance premium remains the same, the client does not need to provide supporting documentation for EB-HIPP (SVF will need to be submitted to extend ADAP eligibility via mail or at an authorized ADAP Enrollment Site)
- If there are changes to the employer, employer's information, and/or premium amount, the client must have their employer re-fill and submit the Participation Agreement Form with updated information in order for ADAP to continue making accurate payments. In addition, the client will be required to submit a new ADAP Client Attestation Form (CDPH Form 8723) and paystub dated within the last 3 months.

Communications

15) If I have a question regarding EB-HIPP, who can I contact?
You may contact your ADAP Enrollment Worker, an ADAP Advisor, or the ADAP Call-Center for any EB-HIPP questions you may have.

16) Once I am enrolled into the EB-HIPP Program, will my employer and I be notified?
PAI will send a letter to your employer notifying of them of your enrollment into the EB-HIPP Program. In addition, your Enrollment Worker will receive an email notifying them of your enrollment into the EB-HIPP Program. Your ADAP Enrollment Worker will be responsible for notifying you of your enrollment.

17) If my EB-HIPP application is denied, will I be notified?
Your ADAP Enrollment Worker will be notified if your EB-HIPP application is denied. The reason for the denial will also be provided in the notification. Please work with ADAP Enrollment Worker for a resolution.

18) Will my employer be notified if I lapse and get dis-enrolled from the EB-HIPP Program?
Yes, PAI will send a notification to your employer regarding your dis-enrollment from the EB-HIPP Program.

AETC AIDS Education & Training Center Pacific

CDPH

Quick Clinical Guide: HIV PrEP Pre-Exposure Prophylaxis

Updated March 2019

Daily emtricitabine/tenofovir DF (Truvada®) is safe and effective for significantly reducing the risk of HIV infection in sexually active individuals (including adolescents) and people who inject drugs (PWID) when used consistently. This document is a brief "how-to guide," including medication coverage options for California state, and links to patient assistance programs for low-income patients. For resources and referrals, go to **PleasePrEPMe.org**. All web links are clickable in this document.

1. Identify patients who may benefit from PrEP

HIV-negative individuals, including adolescents, men who have sex with men (MSM), cis- and transgender women, who may benefit from PrEP include:

- People who ask for PrEP
- People with HIV-positive partners
- People with sexual exposures including: condomless anal sex, multiple sex partners, sex partners at high risk for HIV, or transactional sex (such as sex for money, drugs or housing)
- People who have had a bacterial sexually transmitted infection (STI)
- People who inject drugs (PWID) and people who use stimulants, such as methamphetamine, during sex

2. Discuss PrEP with your patient

Be present and listen. Ask about interest in and readiness for PrEP:

- What do you know about PrEP? Do you know anyone on PrEP?
- What makes you want to start PrEP? What do you hope PrEP will do for you?
- What barriers do you foresee? How long do you foresee being on PrEP?

Let them know what to expect and about the potential risks and benefits of PrEP. Important points include:

Potential side effects	• **Nausea or abdominal discomfort (~10%)**, which usually resolves in a few weeks • **Mild kidney dysfunction (<1%)**, which improves upon discontinuation of Truvada® • **Slightly decreased bone density**, but no increased risk of fractures • Many people on PrEP experience no side effects
Adherence	Adherence is correlated with higher effectiveness. Tailor adherence strategies to patient needs and lifestyle (pillbox, phone or online reminders, cell phone alarms, etc.). Many people who inject drugs are capable of adhering to PrEP. • For rectal exposures, no transmissions were seen in patients with detectable drug blood levels equivalent to ≥4 doses/week. Feminizing hormones may reduce tenofovir levels. For transgender women on hormones with rectal exposures, daily doses may be more important. • For vaginal/front exposures, no transmissions were seen in patients with detectable drug blood levels equivalent to 6-7 doses/week.
Risk of Resistance	Resistance to HIV medications can occur if acute HIV is not identified quickly while on PrEP. A negative HIV test result should be documented before initiating PrEP and every 3 months thereafter. The patient should report immediately to clinic if they develop symptoms compatible with acute HIV infection (fever with sore throat, rash, or headache).
Time to protection	**Time to protection** varies by site of exposure • Approximately 7 daily doses after starting PrEP in rectal tissue • Approximately 20 daily doses in cervico-vaginal tissue • Approximately 20 daily doses for blood exposures for people who inject drugs

3. Take a medical, sexual, substance use history and review of symptoms.

Check for:

- HIV exposures in the prior 3 days; if present, offer three-drug post-exposure prophylaxis (PEP).
- Recent symptoms of a mono-like illness (fever with sore throat, rash or headache): if present, test for acute HIV (HIV RNA PCR and HIV 4th generation Ag/Ab test) and consider deferring PrEP until test results are back.
- Any history of renal or liver disease, or osteoporosis: if present, use caution or avoid using tenofovir.
- Willingness and ability to 1) take a medication every day, and 2) return for regular appointments and labs while taking PrEP.

4. Assess how your patient will pay for PrEP

■ Insured patients

- Many private insurers cover PrEP but may require prior authorization (PA). Approval for coverage typically requires documentation of all of the following:
  - » Patient has been determined to be at high risk for HIV infection
  - » Patient has received counseling on safer sex practices and HIV infection risk reduction
  - » Patient has no clinical symptoms consistent with acute viral infection
  - » Patient has no recent (<1 month) suspected HIV exposures
  - » Patient has a confirmed negative HIV status within the past week
- Medi-Cal does not require a prior authorization for PrEP. We recommend writing a note to the pharmacy to "bill to the State Medi-Cal HIV carve-out" instead of the managed-care plan to help ensure Medi-Cal coverage.
- For adolescents, the Medi-Cal Minor Consent Program can help pay for PrEP/PEP and keep the services confidential.
- ICD-10 codes for PrEP include:
  - » **Z20.6:** Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
  - » **Z20.2** Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
  - » **Z71.7** Human Immunodeficiency Virus (HIV) counseling
  - » Other codes are on p.42 of the **CDC Clinician Supplement: tinyurl.com/CDCPrEPsupp2017**
- If patient needs help with co-pays, Gilead (maker of Truvada®) has a co-pay assistance program for up to $7,200 annually: gileadadvancingaccess.com or **877-505-6986**
- Other payment assistance programs are listed on the **Fair Pricing Coalition website: tinyurl.com/FPCcopays**
- The **California PrEP Assistance Program (PrEP-AP)** helps low income [≤ 500% Federal Poverty Line (FPL)] insured patients pay for PrEP-related out-of-pocket costs, such as medical visits and labs, and also assists with Truvada® co-payments after the $7,200 Gilead benefit is exhausted: **tinyurl.com/prepap**

■ Uninsured patients

- The **Gilead Advancing Access** PrEP medication assistance program will provide monthly Truvada® deliveries to the patient or clinic at no cost for those without prescription coverage and who meet income guidelines (≤ 500% FPL).
  - » Call **800-226-2056** for inquiries or to apply by phone, Monday-Friday, 6am-5pm PST
  - » Fax the completed application and proof of income to 855-330-5478: tinyurl.com/GileadEnrollment or services.gileadhiv.com/content/pdf/gilead_enrollment_form.pdf
  - » If approved, one bottle (30-day supply) will be shipped to the clinic in 3-14 days; or for quicker pickup at any non-Kaiser pharmacy, provide an ID, bin, group, or PCN number (provided by Gilead).
  - » A Gilead representative will call the provider before the 2nd bottle is sent to confirm refill if continuing to ship toclinic. Otherwise, refills can be coordinated with retail pharmacy of choice.
  - » Patients must re-apply (i.e. resubmit proof of eligibility) every 12 months.
  - » U.S. and undocumented residents are eligible. SSN is not required. Proofs of income include: W2, 1040 tax return, 2 pay stubs from the last 90 days or letter stating monthly income. Letter may also state residence address. Letter must be signed and dated, but does not need to be notarized.
- The **California PrEP-AP (tinyurl.com/prepap)** serves uninsured low-income patients (<500% FPL) as a payer of last resort for PrEP-related medical costs (e.g. labs, visits, STI treatment) and must be used in conjunction with Gilead Patient Assistance Program.

5. Obtain baseline testing

HIV test: HIV antibody test (4th gen Ag/Ab recommended) +/- HIV RNA test	All patients need a negative HIV antibody test (4th generation Ag/Ab recommended) prior to initiation of PrEP. In patients with acute HIV symptoms or who report a possible HIV exposure in the last month, test with both an HIV RNA PCR and HIV 4th generation Ag/Ab test. If the patient has HIV infection, refer them to an HIV care provider; Truvada® alone is inadequate therapy for HIV infection.
Serum Creatinine (e.g. as part of a basic or complete metabolic panel)	Estimated GFR or CrCl by serum labs should be ≥60 ml/min (Cockcroft-Gault) to safely use tenofovir DF. An online calculator can be found here: **tinyurl.com/CrClcalculator**
Hepatitis B surface antigen (HBsAg)	Truvada® is active against hepatitis B virus (HBV). Patients with chronic HBV can use Truvada® for PrEP but should have liver function tests monitored regularly during PrEP use and after discontinuing PrEP; hepatitis can flare if Truvada® is discontinued. Patients who are HBsAg negative should be offered HBV vaccination if not previously infected or immunized.
Hepatitis C antibody	Determine baseline hepatitis C infection status and obtain repeat testing at least yearly among PWID and others with ongoing risks of exposure.
STIs (based on patient sexual practices)	Test patients on PrEP for syphilis and for urethral, rectal, and pharyngeal GC and CT based on reported exposure routes (not based on gender/sexuality) every 3 months.
Pregnancy test (when appropriate)	People able to become pregnant (reproductive-age cis women, some transgender men) should receive a pregnancy test and have contraception plans reviewed. In patients trying to conceive, PrEP should be coordinated with prenatal care with attention to the patient's reproductive and breastfeeding plans. Perinatal HIV/AIDS consultation is available 24/7 at **888-448-8765.**

6. Initiate PrEP

If there are no contraindications and the patient wants to use PrEP, PrEP can be initiated.

- **Same-day PrEP prescriptions are encouraged when possible.** The California Office of AIDS and Pacific AIDS Education and Training Center strongly encourage writing a prescription and starting PrEP on the same day a patient comes in for consultation when:
  - the patient has a negative HIV test within the last 2 weeks and no HIV exposures since this test
  - all laboratory testing is obtained that day, and
  - the patient has no symptoms of acute HIV infection.

  If it has been more than 2 weeks since baseline labs were obtained, repeat an HIV test and start PrEP the same-day while awaiting results of the repeat HIV test.
- **To transition from PEP to PrEP**, check an HIV 4th gen Ag/Ab test while on week 4 of PEP and prescribe PrEP so they can start PrEP as soon as they are done with PEP. Confirm that the HIV testing done during week 4 of PEP is negative.

Prescribe Truvada®
Tenofovir DF 300 mg + Emtricitabine 200 mg: 1 pill PO once daily
30-day supply with 0-2 refills for first dispensation.

Do not use Descovy® (emtricitabine/tenofovir AF) for PrEP.
Although currently being studied, it has not been approved by the FDA for PrEP.

- Provide adherence counseling and anticipatory guidance about common side effects. Discuss patient strategies for daily adherence.
- Counsel patients on risk reduction and using condoms–in addition to PrEP–to decrease risk of STIs and provide additional HIV risk reduction.

7. Monitor and provide ongoing support for patients using PrEP

Timeframe	Action
30 days after initiation • In-person follow-up visit highly recommended for patients <24 years old or those who may have difficulties with adherence • A phone call is a reasonable alternative for other patients	• Assess for: » Side effects and patient interest in continuing. » Adherence: link to a daily habit, set reminders, reinforce importance of daily use, and address any challenges the patient has faced. » Ongoing risk and provide risk reduction counseling. » Signs and symptoms of acute HIV infection. • Prescribe additional 60-day supply with no refills.
Every 3 months • Labs • Visit • Refills	• At visit: adherence and risk reduction counseling. • HIV test: 4th generation antigen/antibody test preferred. • Serum Creatinine: stop if eGFR declines or <60 ml/min. • STI screening for syphilis and for urethral, rectal, and pharyngeal GC and CT based on reported exposure routes (not based on gender/sexuality). • Pregnancy test for appropriate patients. • Prescribe 90-day supply if HIV test negative at each visit.
Every 12 months or more often based on assessed risk	• Hepatitis C antibody, particularly for MSM and PWID.

8. What if my patient tests positive for HIV while on PrEP?

a. Discontinue Truvada® to avoid development of HIV resistance

b. Start patient on HIV treatment as soon as possible in accordance with **HIV Treatment Guidelines (tinyurl.com/HIVTreatmentGuidelines)**, and/or refer to an HIV provider ASAP. For questions and support, call the **National HIV Clinicians Consultation Center: 800-933-4313**.

c. Order HIV genotype and document results

d. Report the test result to your local health department

Have questions?

The national HIV PrEPLine for clinicians provides guidance on PrEP:
855-448-7737, 8am – 3pm PST

Go to **PleasePrEPMe** for a location-responsive California PrEP provider directory, online chat navigation in English/Spanish, and many resource pages including for patients, providers, youth, trans and non-trans women: **pleaseprepme.org**

Further information about PrEP can be found at:

- **Project Inform PrEP Navigator Manual: pleaseprepme.org/prepnavigatormanual**
- **CDC website: cdc.gov/hiv/risk/prep/index.html**
- **San Francisco City Clinic's website: sfcityclinic.org/services/prep.asp**
- **Project Inform provider, staff, and patient resources: projectinform.org/prep**

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Feedback/questions: **paetc@ucsf.edu**

SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part V
Immigration

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

May 21, 2018

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 18-09
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: OVERVIEW OF THE CALIFORNIA HEALTHCARE, ELIGIBILITY, ENROLLMENT AND RETENTION SYSTEM CHANGE REQUEST 69974 ON IMMIGRANT ELIGIBILITY

The purpose of this letter is to provide counties with information about the implementation of California Healthcare, Eligibility, Enrollment, and Retention System (CalHEERS) Change Request (CR) 69974. CR 69974 makes additional enhancements to CalHEERS functionality relating to determination of eligibility based on immigration status implemented in Release 17.9 on September 25, 2017.

CalHEERS Changes Implemented by CR 69974

The CalHEERS system has been updated to:

- Require an individual to attest to their immigration status and document type on the application portal
- Include an expanded and updated immigration status drop-down menu to the application portal[1]
- Make all immigration document entry fields optional throughout the application portal

[1] This expanded and updated menu includes 47 immigration status options. It will enable non-citizen applicants to attest to their immigration status. The menu includes statuses for Qualified Non-Citizens, Lawfully Present immigrants, PRUCOL immigrants, and for the Trafficking or Crime Victims Assistance program. The menu also includes an option for "Document or Status Not Listed".

- Grant full scope Medi-Cal to otherwise eligible Qualified Non-Citizens based on attestation with subsequent verification or with real-time verification

- Grant conditional full scope Medi-Cal to otherwise eligible state-funded Permanently Residing in the United States Under Color of Law (PRUCOL) without requesting verification from the Verify Lawful Presence service (VLP) provided through the Federal Data Services Hub.

- Grant full scope Medi-Cal to otherwise eligible Lawfully Present immigrants who are under the age of 21 or pregnant based on attestation with subsequent verification or real-time verification

- Grant restricted scope Medi-Cal to eligible Lawfully Present immigrants who are over the age of 21 or not pregnant

- Grant restricted scope Medi-Cal to an eligible individual who selects "document or status not listed" on both the immigration status drop-down menu and the immigration document drop-down menu

- Request Grant Date from VLP only when required for Qualified Non-Citizens

- Allow counties to administratively verify the immigration status of an applicant/beneficiary

- Allow counties to administratively verify PRUCOL status

- Update the electronic health information transfer (eHIT) schema to include all immigration statuses from the immigration status drop-down menu and all documents from the document drop-down menu in CalHEERS

- Send updated Citizen/Alien indicators to the Medi-Cal Eligibility Data System (MEDS) when the system has sufficient information to do so.

CalHEERS Portal Changes

Immigration Status Drop-Down Menu – The immigration status drop-down menu for an individual to select their immigration status has been updated. Prior to this change request, the immigration status drop-down menu on the CalHEERS portal only displayed immigration statuses that were Lawfully Present. If an individual selected none of those statuses, a second menu provided a list of PRUCOL immigration statuses

(with the exception of the last PRUCOL category on the MC 13) for selection. With the implementation of CR 69974, the immigration status drop-down menu now displays 47 immigration statuses including a “My Document or Status is not Listed” option.

Immigration Document Drop-Down Menu – The document drop-down menu has been updated to separate the "Cuban/Haitian Entrant, Document indicating withholding of removal" document option into two separate documents on the portal. The two new options are “Document indicating Cuban/Haitian Entrant” and “Document indicating withholding of removal”.

Immigration Document Information Fields – The document information fields are now all optional fields. Prior to this change request if an individual selected a document from the document drop-down menu, most of the fields for inputting document information were mandatory and could not be bypassed. With this change request, all of the document information fields are now optional. This update allows an individual to attest to having a document and to be provided with a “Reasonable Opportunity Period” (ROP) to provide the document or any necessary document information.

Qualified Non-Citizen Radio Button – The "Are you a Qualified Non-Citizen" radio button has been removed from the Household Member Page. The intent of this data collection was to ensure individuals who attested to being a Qualified Non-Citizen received full scope Medi-Cal benefits. With the implementation of this change request, an individual can attest to being a Qualified Non-Citizen by selecting their specific immigration status. Therefore, there is no need to collect duplicative information with the use of this button.

eHIT Changes

Grant Date – CalHEERS will receive the grant date for Qualified Non-Citizens who are subject to the five year bar through the VLP Hub and pass this information to the Statewide Automated Welfare System (SAWS) through eHIT.

Immigration Status Information – CalHEERS will send SAWS an individual’s immigration status information and corresponding verification information via eHIT. CalHEERS will provide the VLP Response, when available, to SAWS via eHIT.

Immigration Document Information – The eHIT schema is updated to include all of the documents from the portal document drop-down menu. The eHIT schema now includes the documents “Document indicating Cuban/Haitian Entrant” and “Document indicating withholding of removal” instead of the single document of “Cuban/Haitian Entrant, Document indicating withholding of removal.” In addition, the eHIT schema will also

include “Document or Status not Listed.” To ensure that immigrants may attest to their immigration status without providing a document at the time of application, the “Document Type” field is optional in the eHIT schema.

Qualified Non-Citizen Indicator – The Qualified Non-Citizen indicator has been removed from eHIT.

Immigration Status Verification Information – The CalHEERS system includes four immigration status verification inputs used to provide information necessary for verification of immigration status: Lawful Presence, Qualified Non-Citizen, Five Year Bar Applies/Five Year Bar Met, and PRUCOL. Instead of passing/failing each of these indicators based on the immigration status verification, the new “immigration category verification” field has been added to eHIT. The “immigration category verification” field is a Yes/No indicator that the eligibility worker will send along with the immigration status and/or document that verifies whether or not an immigration status sufficient for Medi-Cal eligibility has been verified. When SAWS sends a “Y” for the immigration category verification field, with the immigration status, CalHEERS will input the four verification attributes based on the table provided by the Department of Health Care Services (see Table 1).

PRUCOL Last Category – The eHIT schema includes the functionality for counties to pass the last PRUCOL category to CalHEERS. This will be necessary when an immigrant claims the appropriate PRUCOL category on the MC 13 Statement of Citizenship, Alienage, and Immigration Status form as explained below.

Grant Date and Entry Date

In accordance with current Medi-Cal policy, the "INS-ENTRY-DATE" field must be used to provide the Grant Date for Qualified Non-Citizens subject to the five-year bar. For some other Qualified Non-Citizens, that field is used for the individual’s Date of Entry into the United States. To more accurately reflect the use of this field for those two different dates, the "INS-ENTRY-DATE" field name will be changed to “ENTRY/GRANT DATE” in MEDS. The change to the name of the "INS-ENTRY-DATE" field will be reflected in the appropriate MEDS screens, in MEDS transactions that include this field, and in the MEDS Manual. There is no change to the policy regarding when to use Grant Date versus Date of Entry in that field.

In accordance with ACWDL 98-55, for Qualified Non-Citizens who are subject to the five year bar, the date in MEDS should be the Grant Date. For Medi-Cal cases that have been administratively verified as Yes (Y) but also are in one of the four immigration statuses subject to the five-year bar on federal funding for full scope Medi-Cal,

CalHEERS will trigger a call to the VLP Hub for the Grant Date. For Medi-Cal cases that have been administratively verified by the county, CalHEERS will store the grant date and use the SAWS administrative verification of immigration for the eligibility determination. Counties must ensure that the Grant Date returned by the VLP hub call is sent to the Date of Entry/Grant Date field in MEDS.

Qualified Non-Citizens who are subject to the five year bar are:

- Lawful Permanent Residents
- Conditional Entrant granted before April 1980
- Paroled into the United States for one year or more
- Battered non-citizen, or parent or child of battered non-citizen

NOTE: Other Qualified Non-Citizens (including, but not limited to refugees and asylees) are exempt from the five year bar, so the Grant Date is not needed. Lawful permanent residents who are veterans, or the spouse or child of a veteran, are also exempt from the five-year bar. In accordance with current policy, Qualified Non-Citizens who are exempt from the five-year bar because they are a veteran (or because they are the spouse or child of a veteran) must have the appropriate code (4, 5, or 6) in the Alien Eligibility Code field in MEDS.

Medi-Cal Coverage for Qualified Non-Citizens

In California, Qualified Non-Citizens receive full scope Medi-Cal benefits regardless of their five-year bar status, if otherwise eligible. Lawfully Present children under the age of 21 and Lawfully Present pregnant women are entitled to receive full scope or pregnancy related Medi-Cal benefits. Children and pregnant women who are “Qualified Non-Citizens” will be mapped using the existing immigration status coding methodology in MEDS. However it is still required to map all Medi-Cal eligible individuals using the Citizen/Alien Indicator Code and the Alien Eligibility Code. All Medi-Cal records for eligible individuals must include information in the Citizen/Alien Indicator Code field and the Alien Eligibility Code field (when necessary) in MEDS.

Medi-Cal Coverage for Lawfully Present Immigrants

The Children’s Health Insurance Program Reauthorization Act of 2009, among its many other provisions, gave states the option to provide Medi-Cal benefits to eligible children (under the age of 21) and pregnant women who are “lawfully residing” in the United States as defined for Medi-Cal eligibility purposes.

The implementation of this SPA allows counties to grant full scope Medi-Cal eligibility (or pregnancy related benefits if appropriate) to "Lawfully Present" immigrants. Restricted scope Medi-Cal shall continue to be granted to otherwise eligible "Lawfully Present" immigrants who are 21 or older and not pregnant. The CalHEERS system has been automated to allow an individual to attest specifically to an immigration status that is defined as Lawfully Present. The statuses that are now implemented on the CalHEERS portal are:

- Pending application for Creation of Record of Lawful Admission for Permanent Residence, with Employment Authorization
- Granted withholding of removal under the Convention against Torture – CAT
- Granted Student Visa (e.g. F or M visa)
- Granted Work Visa (e.g. H-1, J-1, O, R, P visa)
- Granted Visitor Visa (e.g. B visa)[2]
- Lawful Temporary Resident (special agricultural workers, or certain immigrants admitted into the U.S. before 1982)
- Granted Temporary Protected Status (TPS), or pending applicants for TPS (pending applicants must have Employment Authorization)
- Family Unity Beneficiary
- Granted Deferred Enforced Departure
- Resident of American Samoa
- Citizen of Micronesia, the Marshall Islands, or Palau
- Administrative order staying removal issued by the Department of Homeland Security

[2] Visitor visa information provided for Medi-Cal applicants and beneficiaries must be verified through the VLP hub for Lawful Presence. If a visa holder is 19 years of age or older and VLP hub verification indicates the individual is not lawfully present, the county must review the record to determine the appropriate level of benefits.

- Pending application for legalization under Immigration Reform and Control Act - IRCA, with Employment Authorization

- Pending application for asylum with Employment Authorization or is under the age of 14 and has had a pending application for asylum for at least 180 days

- Pending application for withholding of removal with Employment Authorization, or is under the age of 14 and has had a pending application for withholding of removal for at least 180 days

- Pending application for legalization under the LIFE Act, with Employment Authorization

- Pending application for suspension of deportation, or cancellation of removal or special rule cancellation of removal, with Employment Authorization

- Pending application for Special Immigrant Juvenile Status

Lawfully Present immigrants are mapped using the Citizen/Alien indicator "2" in MEDS. All Medi-Cal records for eligible individuals must include information in the Citizen/Alien Indicator Code field and the Alien Eligibility Code field (when necessary) in MEDS.

Once a Lawfully Present immigrant is no longer under the age of 21 or pregnant, their eligibility must be re-evaluated, and if applicable, reduced with proper notice from full scope to the benefits they are entitled to.

Short-Term Visa Holders and California Residency

Per ACWDL 98-48, short-term visa holders can meet California residency requirements if a preponderance of the credible evidence supports a claim of California residency. If after reviewing all the available evidence, a county determines that a person with a short-term visa is a resident of California, the basis for that finding must be documented in the case file.

Providing Full Scope Benefits for State Funded Immigrants

The following state-funded PRUCOL immigration statuses from the updated drop-down menu in CalHEERS and eHIT will continue to receive full scope Medi-Cal benefits if they meet all eligibility requirements:

- A non-citizen who has a pending application for adjustment to Lawful Permanent Resident (LPR) status, without Employment Authorization
- Granted Deferred Action for Childhood Arrivals – (DACA)
- Granted Order of Supervision, without Employment Authorization
- An immigrant who entered and has continuously resided in the United States since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident (eligible as a Registry immigrant).
- Granted voluntary departure and awaiting issuance of a visa
- A non-citizen on whose behalf an immediate relative petition (I-130) has been approved and who is entitled to voluntary departure
- Taking steps to apply for a T visa or for certification by the Office of Refugee Resettlement
- Filed for a U visa

Because these statuses are for state funded immigrants, verification of status will not go through the VLP Hub. Counties should continue to verify the immigration status of individuals who claim these statuses. Once the immigration status is verified, the county eligibility worker should administratively verify the immigration status and send a "Y" through eHIT for the individual to receive full scope Medi-Cal. If the county eligibility worker cannot verify the specific immigration status, but the SAWS system has verification that an individual is eligible for full scope Medi-Cal benefits under PRUCOL, the eligibility worker should select the last PRUCOL category to get the individual full scope Medi-Cal.

Administrative Verification of Immigration Status

ACWDL 16-21 provided a table, "Summary of Immigration Statuses Listed in CalHEERS Immigration Status Drop-Down Menu," that showed which of the immigration statuses included in the immigration status drop-down menu in CalHEERS were Qualified Non-Citizens, Lawfully Present, and PRUCOL with the implementation of CalHEERS CR 32277. The purpose of this chart was for it to be used as a tool by county eligibility workers when it was necessary to administratively verify immigration statuses. With the implementation of CR 69974 there are now 47 immigration statuses

an individual can select from the portal. It is no longer necessary for the county eligibility worker to provide each category with a pass or fail as they were instructed to do in ACWDL 16-21. With the implementation of CR 69974, the four verification inputs of an individual's immigration status: Lawful Presence, Qualified Non-Citizen, Five Year Bar Applies/Five Year Bar Met, and PRUCOL will be mapped by CalHEERS based on the immigration status that is verified.

On the CalHEERS portal if an individual selects "Document or Status Not Listed" for both the immigration status and document, CalHEERS will grant restricted scope Medi-Cal. The same logic will be used when immigration status and document is sent to CalHEERS through eHIT, including a "blank" for immigration status and a "blank" for document. By sending a "blank" for both the immigration status and document, CalHEERS will grant restricted scope eligibility for Medi-Cal and ineligibility for Covered California.

NOTE: Counties should send an applicant the MC 13 when the individual selects "Document or status not listed" from both the immigration document and the immigration status drop-down menus.

Administrative Verification of Documents

If there is no immigration status selected and the individual attests to a document on the portal, CalHEERS will grant conditional eligibility. If there is enough information provided in the optional fields, a VLP hub call will be made. If there is not enough information provided in the optional fields a VLP hub call will not be made and conditional eligibility will be granted and the eligibility worker shall collect the necessary information to verify eligibility.

Reducing Benefits after 90- Day "Reasonable Opportunity Period" (ROP)

Consistent with current policy, an applicant attesting to U.S citizenship/satisfactory immigration status shall be granted full scope Medi-Cal benefits without delay, if otherwise eligible, pending verification of their status. If otherwise eligible, applicants are granted full scope Med-Cal during the 90-day ROP to give them an opportunity to provide documents (if needed) or to have their citizenship/satisfactory immigration status verified. In the event that an applicant submits documents during the ROP that support a full scope status, full scope Medi-Cal benefits shall continue until and unless there is final determination that the individual does not have satisfactory immigration status. Full scope Medi-Cal that was granted conditionally must be reduced with proper notice if documentation of citizenship/satisfactory immigration status is not provided

during the 90-day ROP or a final determination is made that the individual does not have satisfactory immigration status. To manually initiate this change in CalHEERS if not already triggered by SAWS, county eligibility workers should change the Manual Verifications of Lawful Presence, Qualified Non-Citizen, Five Year Bar Applies/Five Year Bar Met, and PRUCOL to "Fail."

Verification of the Last PRUCOL Category

The eHIT schema prior to the implementation of CR 69974 did not include the functionality to administratively verify the last PRUCOL category on the MC 13. This category is for immigrants who claim to be "[a]n alien, not in one of the above categories, who can show that: (1) Immigration and Naturalization Service (INS) knows he/she is in the United States; and (2) INS does not intend to deport him/her, either because of the person's status category or individual circumstances."

With the implementation of CR 69974, the eHIT schema now includes "PRUCOL Last Category." It is no longer required for an eligibility worker to administratively fail "Lawful Presence" and pass "PRUCOL" on the administrative verification page in CalHEERS. If an individual provides a signed MC 13 declaring the last category, the eligibility worker should pass the verification of "PRUCOL Last Category" (Yes/No) via eHIT. The verification of "PRUCOL Last Category" can only be sent as a "Y" if there is a signed MC 13. Please note that this new category is specific to individuals who claim that they are: "An alien, not in one of the above categories, who can show that: (1) INS knows he/she is in the United States; and (2) INS does not intend to deport him/her, either because of the person's status category or individual circumstances." The verification of "PRUCOL" is for all other PRUCOL categories and therefore does not need to be administratively passed when administratively verifying "PRUCOL Last Category."

If you have any questions, or if we can provide further information, please contact Amar Singh at (916) 327-6670 or by email at Amar.Singh@dhcs.ca.gov.

ORIGINIAL SIGNED BY

Sandra Williams, Chief
Medi-Cal Eligibility Division

Enclosures

Table 1: Summary of Immigration Statuses Listed in CalHEERS Immigration Status Drop-Down Menu

Immigration Status	Lawfully Present	Qualified Non-Citizen	5-Year Bar Applies	PRUCOL	Citizen/ Alien Indicator	Alien Eligibility Code
Lawful Permanent Resident (LPR/Green Card holder)	Yes	Yes	Yes (If not a veteran or spouse or child of a veteran)	No	K	If 4, 5 or 6, the LPR is a veteran or spouse or child of veteran exempt from 5-year bar.
A non-citizen with an approved visa petition, who has a pending application for adjustment to LPR status	Yes	No	No	Yes	2	*
A non-citizen, without a visa petition, who has a pending application for adjustment to LPR Status, with Employment Authorization	Yes	No	No	Yes	2	*
A non-citizen who has a pending application for adjustment to LPR status, without Employment Authorization	No	No	No	Yes	S	*
Refugee	Yes	Yes	No – Exempt	No	R	N/A
Asylee	Yes	Yes	No – Exempt	No	L or Z	N/A
Cuban/Haitian Entrant	Yes	Yes	No – Exempt	No	8	N/A
Amerasian Immigrant	Yes	Yes	No – Exempt	No	E	N/A
Granted withholding of deportation or removal	Yes	Yes	No - Exempt	No	D	N/A
Granted a stay of deportation	Yes	No	No	Yes	2	*
Granted suspension of deportation whose departure USCIS does not contemplate enforcing	Yes	No	No	Yes	2	*
Conditional Entrant granted before April 1980	Yes	Yes	Yes	No	C	N/A
Paroled into the United States for one year or more	Yes	Yes	Yes	No	W	N/A

Immigration Status	Lawfully Present	Qualified Non-Citizen	5-Year Bar Applies	PRUCOL	Citizen/ Alien Indicator	Alien Eligibility Code
Paroled into the United States for less than one year	Yes	No	No	Yes	Y	*
Battered non-citizen, or parent or child of battered non-citizen	Yes	Yes	Yes	No	Varies	9 (indicates battered immigrant/ Qualified Non-Citizen)
Granted Deferred Action (but not under Deferred Action for Childhood Arrivals - DACA)	Yes	No	No	Yes	2	*
Granted Deferred Action for Childhood Arrivals – (DACA)	No	No	No	Yes	S	*
Granted Order of Supervision, with Employment Authorization	Yes	No	No	Yes	2	*
Granted Order of Supervision, without Employment Authorization	No	No	No	Yes	S	*
An immigrant who entered and has continuously resided in the United States since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident (eligible as a Registry immigrant)	No	No	No	Yes	S	*
Registry applicant, with Employment Authorization	Yes	No	No	Yes	2	*
Pending application for Creation of Record of Lawful Admission for Permanent Residence, with Employment Authorization	Yes	No	No	No	2	*
Granted voluntary departure and awaiting issuance of a visa	No	No	No	Yes	S	*
A non-citizen on whose behalf an immediate relative petition (I-130) has been approved and who is entitled to voluntary departure	No	No	No	Yes	S	*

Immigration Status	Lawfully Present	Qualified Non-Citizen	5-Year Bar Applies	PRUCOL	Citizen/ Alien Indicator	Alien Eligibility Code
Granted withholding of removal under the Convention against Torture – CAT	Yes	No	No	No	2	*
Granted a Victim of Trafficking visa (T visa), or spouse, child, sibling, or parent	Yes	No	No	No	O (Treat as Refugee)	N/A
Pending application for a Victim of Trafficking visa (T visa), or spouse, child, sibling, or parent	Yes	No	No	No-- TCVAP	2	*
Taking steps to apply for a T visa or for certification by the Office of Refugee Resettlement	No	No	No	No-- TCVAP	Varies	W
Granted U visa Granted U non-immigrant visa	Yes	No	No	No-- TCVAP	V	Y
Filed for a U visa	No	No	No	No-- TCVAP	Varies	X
Granted Student Visa (e.g. F or M visa) Student Visa – Granted a student visa (e.g. F or M visa)	Yes	No	No	No	V	*
Granted Work Visa (e.g. H-1, J-1, O, R, P visa) Work Visa – Granted a work visa (e.g. H-1, J-1, O, R, P visa)	Yes	No	No	No	V	*
Granted Visitor Visa (e.g. B visa) Visitor Visa – Granted a visitor visa (e.g. B visa)	Yes	No	No	No	V	*
Lawful Temporary Resident (special agricultural workers, or certain immigrants admitted into the U.S. before 1982)	Yes	No	No	No	2	*
Granted Temporary Protected Status (TPS), or pending applicants for TPS (pending applicants must have Employment Authorization)	Yes	No	No	No	2	*
Family Unity Beneficiary	Yes	No	No	No	2	*
Granted Deferred Enforced Departure	Yes	No	No	No	2	*
Resident of American Samoa	Yes	No	No	No	2	*
Citizen of Micronesia, the Marshall Islands, or Palau	Yes	No	No	No	2	*

Immigration Status	Lawfully Present	Qualified Non-Citizen	5-Year Bar Applies	PRUCOL	Citizen/ Alien Indicator	Alien Eligibility Code
Citizens of Micronesia, the Marshall Islands, and Palau						
Administrative order staying removal issued by the Department of Homeland Security	Yes	No	No	No	2	*
Pending application for legalization under Immigration Reform and Control Act - IRCA, with Employment Authorization	Yes	No	No	No	2	*
Pending application for asylum with Employment Authorization or is under the age of 14 and has had a pending application for asylum for at least 180 days	Yes	No	No	No	2	*
Pending application for withholding of removal with Employment Authorization, or is under the age of 14 and has had a pending application for withholding of removal for at least 180 days	Yes	No	No	No	2	*
Pending application for legalization under the LIFE Act, with Employment Authorization	Yes	No	No	No	2	*
Pending application for suspension of deportation, or cancellation of removal or special rule cancellation of removal, with Employment Authorization	Yes	No	No	No	2	*
Pending application for Special Immigrant Juvenile Status	Yes	No	No	No	2	*
Document or Status Not Listed	No	No	No	No	U	*

* The Alien Eligibility Code for these immigration statuses can be blank. However, if there is an Alien Eligibility Code of “9” it indicates that the individual is a battered immigrant and therefore a Qualified Non-Citizen who is subject to the five year bar.

Documents Typically Used by Lawfully Present Immigrants

Last revised JULY 2016

STATUS	TYPICAL DOCUMENTS
Lawful Permanent Resident (LPR)	• "Green card" (Form I-551) or earlier versions: I-151, AR-2 and AR-3; • Reentry permit (I-327); • Foreign passport stamped to show temporary evidence of LPR or "I-551" status; • Receipt from USCIS (U.S. Citizenship and Immigration Services) indicating that an I-90 application to replace LPR card has been filed; • Memorandum of Creation of Lawful Permanent Residence with approval stamp (I-181); • I-94 or I-94A with stamp indicating admission for lawful permanent residence; • Order issued by the INS/DHS (Immigration and Naturalization Service/Dept. of Homeland Security), an immigration judge, the BIA (Board of Immigration Appeals), or a federal court granting registry, suspension of deportation, cancellation of removal, or adjustment of status; *or* • Any verification from the INS, DHS, or other authoritative document.
Amerasian LPR NOTE: The codes listed here pertain only to the particular Vietnamese Amerasians who qualify for the "Refugee Exemption."	• Any of the LPR documents listed above with one of the following codes: AM-1, AM-2, AM-3, AM-6, AM-7, or AM-8; *or* • Any verification from the INS, DHS, or other authoritative document.
Applicant for Adjustment to LPR Status	• Receipt or notice showing filing or pending status of Form I-485 Application to Register Permanent Residence or Adjust Status; • Form I-797 ASC Appointment Notice with Case Type "I-485 Application to Register Permanent Residence or Adjust Status"; • Form I-688B or I-766 employment authorization document (EAD) coded 274a.12(c)(9) or C9 or C9P; • I-797 receipt for Application for Employment Authorization based on C09; • I-512 authorization for parole, indicating applicant for adjustment of status; *or* • Any verification from the INS, DHS, or other authoritative document.

List of Abbreviations . . . . Page 5

This table lists the categories of non–U.S. citizens who are recognized as "lawfully present" in the United States for various purposes. For more information, contact Linton Joaquin, NILC general counsel, at joaquin@nilc.org.

LOS ANGELES (Headquarters)
3450 Wilshire Blvd. #108 – 62
Los Angeles, CA 90010
213 639-3900
213 639-3911 fax

NATIONAL IMMIGRATION LAW CENTER

WASHINGTON, DC
1121 14th Street, NW, Ste. 200
Washington, DC 20005
202 216-0261
202 216-0266 fax

STATUS	TYPICAL DOCUMENTS
Refugee	• Form I-94 or I-94A Arrival/Departure Record or passport stamped "refugee" or "§ 207"; • Form I-688B or I-766 EAD coded 274a.12(a)(3) or A3; or (a)(4) or "A4" (paroled as a refugee); • Refugee travel document (I-571); *or* • Any verification from the INS, DHS or other authoritative document. NOTE: If adjusted to LPR status, I-551 may be coded R8-6, RE-6, RE-7, RE-8, or RE-9.
Conditional Entrant	• Form I-94, I-94A, or other document indicating status as "conditional entrant," "Seventh Preference," § 203(a)(7), or P7; *or* • Any verification from the INS, DHS, or other authoritative document.
Asylee	• Form I-94, I-94A, or passport stamped "asylee" or "§ 208"; • Order granting asylum issued by the INS, DHS, an immigration judge, the BIA, or a federal court; • Form I-688B or I-766 EAD coded 274a.12(a)(5) or A5; • Refugee travel document (I-571); *or* • Any verification from the INS, DHS, or other authoritative document. NOTE: If adjusted to LPR status, I-551 may be coded AS-6, AS-7, or AS-8.
Granted Withholding of Deportation or Withholding of Removal	• Order granting withholding of deportation or removal issued by the INS, DHS, an immigration judge, the BIA, or a federal court; • Form I-688B or I-766 EAD coded 274a.12(a)(10) or A10; *or* • Any verification from the INS, DHS, or other authoritative document.
Granted Withholding of Deportation/Removal under the Convention Against Torture (CAT)	• Order granting withholding of deportation or removal under CAT, issued by an immigration judge, the BIA, or a federal court; • Form I-688B or I-766 EAD coded 274a.12(a)(10) or A10; *or* • Any verification from the INS, DHS, or other authoritative document
Applicant for Asylum or Withholding of Deportation/Removal, including Applicant for Withholding of Deportation/ Removal under CAT	• Receipt or notice showing filing or pending status of Form I-589 Application for Asylum and Withholding or CAT; • Form I-688B or I-766 EAD coded 274a.12(c)(8) or C8; *or* • Any verification from the INS, DHS, or other authoritative document.
Cuban or Haitian Entrant	• Form I-94 with a stamp indicating "Cuban/Haitian entrant" (this may be rare, as it has not been used since 1980) or any other notation indicating "parole," any documents indicating pending exclusion or deportation proceedings; • Any documents indicating a pending asylum application, including a receipt from an INS Asylum Office indicating filing of Form I-589 application for asylum; • Form I-688B or I-766 EAD coded 274a.12(c)(8) or C8, or 274a.12(c)(11) or C11; *or* • Any verification from the INS, DHS, or other authoritative document. NOTE: Individuals who have adjusted to LPR status may have I-551 cards or temporary I-551 stamps in foreign passports coded CAA66, CB1, CB2, CB6, CB7, CH6, CNP, CU6, CU7, CU8, CU9, CUO, CUP, NC6, NC7, NC8, NC9, HA6, HA7, HA8, HA9, HB6, HB7, HB8, HB9, HC6, HC7, HC8, HC9, HD6, HD7, HD8, HD9, HE6, HE7, HE8, HE9. In addition, Cubans or

STATUS	TYPICAL DOCUMENTS
	Haitians with the codes LB1, LB2, LB6, or LB7 may also qualify. These codes were used for individuals granted LPR status under any of the 1986 legalization provisions including Cuban/Haitian entrants.
Paroled into the U.S.	• Form I-94 or I-94A indicating "parole" or "PIP" or "212(d)(5)," or other language indicating parole status; • Form I-688B or I-766 EAD coded 274a.12(a)(4), 274a.12(c)(11), A4, or C11; *or* • Any verification from the INS, DHS, or other authoritative document. NOTE: If subsequently adjusted to LPR status, may have I-551 card (for Lautenberg parolees, these may be coded LA).
Granted Temporary Protected Status (TPS)	• Form I-688B or I-766 EAD coded 274a.12(a)(12) or A12; • Form I-797 Notice of Action showing grant of TPS status; *or* • Any verification from the INS, DHS, or other authoritative document.
Applicant for TPS	• Receipt or notice showing filing or pending status of Form I-821 (Application for Temporary Protected Status); • Form I-688B or I-766 EAD coded 274a.12(c)(19) or C19; *or* • Any verification from the INS, DHS, or other authoritative document.
Granted Deferred Enforced Departure (DED)	• Form I-688B or I-766 EAD coded 274a.12(a)(11) or A11; *or* • Any verification from the INS, DHS, or other authoritative document.
Granted Deferred Action	• Form I-797 Notice of Action or other form showing approval of deferred action status; • Form I-688B or I-766 EAD coded 274a.12(c)(14) or C14, (c)(33) or C33; *or* • Any verification from the INS, DHS, or other authoritative document.
Applicant for Special Immigrant Juvenile Status	• Form I-797 Notice of Action Special Immigrant Juvenile Receipt Notice; • Form I-797 Notice of Action Special Immigrant Juvenile Approval Notice; • Form I-797 Welcome Notice/Approval of I-485, "Other Basis of Adjustment SL6"; • I-551 coded "SL6"; or • Any verification from the INS, DHS, or other authoritative document.
"Qualified" Domestic Violence Survivor Must have a pending petition for an immigrant visa, either filed by a spouse or a self-petition under the Violence Against Women Act (VAWA), or an application for suspension of deportation or cancellation of removal. The petition or application must either be approved or, if not yet approved, must present a prima facie case.	• Receipt or other proof of filing I-130 (visa petition) under immediate relative (IR) or 2nd family preference (P-2) showing status as a spouse or child; • Form I-360 (application to qualify as abused spouse, child, or parent under the VAWA); • Form I-797 Notice of Action referencing pending I-130 or I-360 or finding establishment of a prima facie case; • Receipt or other proof of filing I-485Application for Adjustment of Status on basis of an immediate relative or family 2nd preference petition or VAWA application; • Any documents indicating a pending suspension of deportation or cancellation of removal case, including a receipt from an immigration court indicating filing of Form EOIR-40 (Application for Suspension of Deportation) or EOIR-42 (Application for Cancellation of Removal); • Form I-688B or I-766 EAD coded 274a.12(a)(10) or A10 (applicant for suspension of deportation) or 274a.12(c)(14) or C14 (individual granted deferred action status);

STATUS	TYPICAL DOCUMENTS
	• Form I-688B or I-766 EAD coded 274.a.12(c)(9) or C9 (applicant for adjustment) or 274a.12(c)(10) or C10 (applicant for suspension of deportation) or 274a.12(c)(14) or C14 (individual granted deferred action status) or C31 (individual with approved VAWA self-petition); *or* • Any verification from the INS, DHS, or other authoritative document.
Victim of Trafficking	• Certification from U.S. Dept. of Health and Human Services (HHS) Office of Refugee Resettlement (ORR); • ORR eligibility letter (if under 18); • Certification status verified through HHS Trafficking Verification Line 202-401-5510 or 866-401-5510 ; • I-914 (T status application); • I-766 coded (a)(16); • Form I-797 approval notice for "CP" (continued presence); • Form I-797 indicating approval of T-1 Status; • *Bona fide* case determination on a T status application; *or* • Form I-797 "Extension of T or U Nonimmigrant Status"; • I-512 authorization for parole, indicating T-1 status; • I-551 coded ST6; *or* • Any verification from HHS, INS, DHS, or other authoritative document.
Derivative Beneficiary of Trafficking Survivor	• Proof of approved I-914A petition (derivative T status); • I-94 or passport stamped T-2, T-3, T-4, or T-5; • Form I-797 Notice of Action indicating approval of T-2, T-3, T-4 or T-5 status; • I-766 EAD coded (c)(25) or C25; • Form I-797 "Extension of T or U Nonimmigrant Status"; • I-512 authorization for parole, indicating T-2, T-3, T-4 or T-5 status; • I-551 card coded ST7, ST8, ST9, or ST0; *or* • Any verification from HHS, INS, DHS, or other authoritative document.
Nonimmigrant	• Form I-94 or I-94A Arrival/Departure Record or passport indicating admission to U.S. with nonimmigrant visa; • Receipt for Form I-102 Application for Replacement/Initial Nonimmigrant Arrival-Departure Document; • I-797 approving application to extend/change nonimmigrant status; • I-797 approving application for S, T, U, or V nonimmigrant status; • Form I-688B or I-766 EAD or other INS/DHS document indicating nonimmigrant status; *or* • Any verification from the INS, DHS, or other authoritative document.
Citizen of Micronesia, the Marshall Islands, and Palau	• Form I-94 or passport noted as "CFA/RMI" or "CFA/FSM" or "CFA/PAL"; • Form I-688B or I-766 coded (a)(8) or A8; *or* • Any verification from the INS, DHS, or other authoritative document.
Lawful Temporary Resident	• Form I-688 Temporary Resident Card; • Form I-688A EAD; • Form I-688B or I-766 EAD coded 274a.12(a)(2) or A2; *or with other evidence indicating eligibility under INA §§210 or 245A* ; • Form I-698 Application to Adjust from Temporary to Permanent Residence under INA § 245A; *or* • Any verification from the INS, DHS, or other authoritative document.

STATUS	TYPICAL DOCUMENTS
Applicant for Legalization under IRCA or the LIFE Act	• Form I-688B or I-766 EAD coded 274a.12(c)(20), (c)(22), or (c)(24) or C20, C22 or C24; • Form I-687 Application for Temporary Residence under INA § 245A; • Passport, with stamp or writing by INS/DHS officer, indicating pending §245 application; *or* • Any verification from the INS, DHS, or other authoritative document.
Family Unity	• Form I-797 Notice of Action showing approval of I-817 Application for Family Unity; • Form I-688B or I-766 EAD coded 274a.12(a)(13) or A13; *or* • Any verification from the INS, DHS, or other authoritative document.
Applicant for Cancellation of Removal or Suspension of Deportation	• Receipt or notice showing filing Form EOIR-40 (Application for Suspension of Deportation), EOIR-42 (Application for Cancellation of Removal), or I-881 (Application for Suspension of Deportation or Special Rule Cancellation of Removal); • I-256A (former suspension application); • Form I-688B or I-766 EAD coded 274a.12(c)(10) or C10; *or* • Any verification from the INS, DHS, or other authoritative document.
Order of Supervision	• Notice or form showing release under order of supervision; • Form I-688B or I-766 EAD coded 274a.12(c)(18) or C18; *or* • Any verification from the INS, DHS, or other authoritative document.
Registry Applicant	• Receipt or notice showing filing Form I-485 Application to Register Permanent Resident or Adjust Status; • Form I-688B or I-766 EAD coded 274a.12(c)(16) or C16; *or* • Any verification from the INS, DHS or other authoritative document.
Stay of Removal	• Administrative or court order granting stay of removal issued by the Department of Homeland Security, an immigration judge, the Board of Immigration Appeals, or a court. • Any verification from the INS, DHS, or other authoritative document.

FOR MORE INFORMATION, CONTACT

Linton Joaquin, NILC General Counsel, joaquin@nilc.org

Abbreviations

BIA - Board of Immigration Appeals
CAT - Convention Against Torture
CMS - Centers for Medicare and Medicaid Services
CP – continued presence
DHS - U.S. Dept. of Homeland Security
EAD - employment authorization document
EOIR - Executive Office for Immigration Review
HHS - U.S. Dept. of Health and Human Services
INS - Immigration and Naturalization Service
IR - immediate relative
LPR - lawful permanent resident
ORR - Office of Refugee Resettlement
USCIS - U.S. Citizenship and Immigration Services
VAWA - Violence Against Women Act

STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS

Print name of applicant (the applicant is the person who want s Medi-Cal)	Date
Print name of person acting for applicant	Relationship to applicant

SECTION A: MEDI-CAL BENEFITS TO CITIZENS AND ALIENS

Citizens and nationals of the United States who meet all eligibility requirements may receive full Medi-Cal benefits.

Aliens who meet all eligibility requirements may receive either full Medi-Cal benefits (if they are in a satisfactory immigration status) or restricted benefits limited to emergency and pregnancy-related services (if they are not in a satisfactory immigration st atus).

Satisfactory immigration status and full Medi-Cal benefit s for aliens: Federal and state law provide that *full* Medi-Cal benefits may be received only by aliens who are in a satisfactory immigration status and who meet all eligibility requirements **including California residency**. Aliens are in a satisfactory immigration status if they are amnesty aliens with valid and current lawful temporary resident cards (I-688) or lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). T**he 16 PRUCOL categories are listed in SECTION B, question 5 below.**

Documented aliens not in a satisfactory immigration status who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Undocumented aliens who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Citizenship/immigration status information: Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential and cannot be used by the INS for immigration enforcement unless you are committing fraud.

Alien status documents and verification requirements: Aliens who claim to be in a satisfactory immigration status (SIS) for Medi-Cal purposes must present INS documents that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in an SIS, but who cannot obtain an INS document or replacement receipt (for example, aliens in the last PRUCOL category indicated in SECTION B below) should submit other evidence establishing their immigration status. INS documents will be verified by the INS. Aliens who do not have these documents with them, or who have unreadable documents, may bring us receipts which show that they have applied for replacements. Aliens will have 30 days to do this, or until their Medi-Cal application is ruled on, whichever is longer. If the alien is otherwise eligible, Medi-Cal will be issued during this period and while the submitted documentation is being verified by the INS. If none of the documents contains the applicant's photograph, they must show us an identity document which establishes that the applicant is the person named in the documents.

Social Security number requirement: Every person requesting Medi-Cal who has a Social Security number is asked to provide it to the county welfare department. U.S. citizens, U.S. nationals, and aliens claiming to be in a satisfactory immigration status who do not have a Social Security number must apply for one and provide it to the county welfare department. Aliens in satisfactory immigration status for Medi-Cal purposes who need help applying for a Social Security number should ask their eligibility worker for assistance. Aliens who are not in a satisfactory immigration status and who do not have a Social Security number can still get restricted Medi-Cal if they meet all eligibility requirements.

SECTION B: CITIZENSHIP/IMMIGRATION STATUS DECLARATION

1. Is the applicant a citizen or national of the United States? ❒ Yes ❒ No

   If the applicant is a citizen or a national of the United States, where was he/she born? _____
   (city, state)

   IF YOU ARE A CITIZEN OR NATIONAL OF THE UNITED STATES, GO DIRECTLY TO SECTION D. IF YOU ARE AN ALIEN, PLEASE ANSWER QUESTIONS 2, 3, AND 4 BELOW (AND QUESTION 5 IF YOU CLAIM TO BE PRUCOL) THEN COMPLETE SECTIONS C AND D. **IF YOU ANSWER "NO" TO QUESTIONS 2, 3, OR 4 BECAUSE THOSE CATEGORIES DO NOT APPLY TO YOU, YOUR ANSWER IS CONFIDENTIAL. THIS INFORMATION CAN ONLY BE USED FOR MEDI-CAL PURPOSES AND CANNOT BE USED BY THE INS FOR IMMIGRATION ENFORCEMENT UNLESS YOU ARE COMMITTING FRAUD.**

2. Is the applicant an amnesty alien with a valid and current I-688? ❒ Yes ❒ No
3. Is the applicant a lawful permanent resident? ❒ Yes ❒ No
4. Is the applicant a PRUCOL alien? ❒ Yes ❒ No

IMPORTANT: All PRUCOL aliens must indicate their specific PRUCOL status in question 5.

5. If the applicant would qualify for Medi-Cal benefits as a PRUCOL alien, indicate the status category which entitles him/her to that classification:

   ❒ A conditional entrant admitted to the United States before April 1, 1980

   ❒ An alien paroled into the United States, including Cuban/Haitian entrants

- ❒ An alien subject to an Order of Supervision
- ❒ An alien granted an indefinite stay of deportation
- ❒ An alien granted an indefinite voluntary departure
- ❒ An alien on whose behalf an immediate relative petition (INS Form I-130) has been approved and who is entitled to voluntary departure
- ❒ An alien who has properly filed an application for lawful permanent resident status
- ❒ An alien granted a stay of deportation for a specified period
- ❒ An alien granted asylum
- ❒ A refugee admitted to the United States since April 1, 1980
- ❒ An alien granted voluntary departure who is awaiting issuance of a visa
- ❒ An alien in deferred action status
- ❒ An alien who entered and has continuously resided in the United States since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry Alien)
- ❒ An alien granted a suspension of deportation whose departure INS does not contemplate enforcing
- ❒ An alien granted withholding of deportation pursuant to INA Section 243(h)
- ❒ An alien, not in one of the above categories, who can show that: (1) INS knows he/she is in the United States; and (2) INS does not intend to deport him/her, either because of the person's status category or individual circumstances

SECTION C: VERIFICATION OF IMMIGRATION STATUS (FOR ALIENS WHO CLAIM SATISFACTORY IMMIGRATION STATUS)

IMPORTANT: Complete this section only if you answered "yes" to questions 2, 3, or 4 in SECTION B on the front of this form.

1. Alien Registration number and/or Alien Admission number (INS Form I-94): _____
2. Date the applicant first entered the United States: _____
3. Applicant's name when he/she first entered the United States: _____
4. Of what country is the applicant a citizen: _____
5. Where was the applicant born: _____

SECTION D: SOCIAL SECURITY NUMBER

Does the applicant have a Social Security number (SSN)? (Aliens who are not in a satisfactory immigration status, and who do not have an SSN, can still get restricted Medi-Cal if they meet all eligibility requirements.)

- ❒ Yes, the applicant's Social Security number is: _____
- ❒ No

SECTION E:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Applicant signature	Date
Signature of person acting for applicant	Date

FOR COUNTY USE ONLY

EW number: _____ County: _____ Date: _____

Action taken:

- ❒ None necessary.
- ❒ SAVE primary verification performed. Date: _____
- ❒ Document Verification Request (INS Form G-845) and copies of documentation of satisfactory immigration status sent to INS. Date: _____
- ❒ Full Medi-Cal benefits were granted pending verification of immigration status.
- ❒ Copies of alien status documents are in the case file.
- ❒ Person referred to INS to obtain replacement documents. Date: _____

COUNTY DETERMINATION OF THE APPROPRIATE LEVEL OF MEDI-CAL BENEFITS.

Based on the information provided on this form:

- ❒ The above named applicant is a U.S. citizen or national, or an alien, who, if otherwise eligible, would receive **FULL** Medi-Cal benefits.
- ❒ The above named applicant is an alien, who, if otherwise eligible, would receive **RESTRICTED** Medi-Cal benefits.

SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part VI
San Francisco Health Care Options

Table of Contents

SF HIV CARE OPTIONS

A guide to clinics, providers, and the healthcare coverage they accept.

HIVReConnect
Increasing retention and re-engagement

Clinic-Based Care Options

HIV Clinics often offer "wrap around" care with Primary Care Physicians, RNs, Social Workers, Benefits Coordinators and other services

CLINIC NAME	BENEFITS INFO
Positive Health Program at Ward 86 💊 SF General Hospital, 995 Potrero Ave., Bldg. 80, Fl 6 (415) 206-2400, option 3 (new patient appointments)	• Medi-Cal: SF Health Plan (23421) • Medicare • Healthy San Francisco; uninsured on sliding scale
Sister Mary Philippa Health Center Saint Mary's Hospital, 2235 Hayes Street, Fl 5 Leah Kramer, LCSW (415) 750-5923 Andre Robertson, MPA (415) 750-5918	• Covered CA: Blue Shield of CA • Medi-Cal: Anthem Blue Cross (H2P367) • Medicare & some private insurance plans • Healthy San Francisco
UCSF 360 Wellness Center 💊 350 Parnassus Ave., Ste. 908 (415) 353-2119, option 1 (new patient appointments)	• CoveredCA: Blue Shield of CA • Medi-Cal: SF Health Plan (24102) Anthem Blue Cross (H2E087) • Medicare & many private insurance plans
General HIV Clinic with specialty programs for Woman, Transgender Women, Men of Color, 50+ Silver Project	
Clinica Esperanza 💊 Mission Neighborhood Health Ctr, 240 Shotwell St. *Se habla español* Robert Maldonado (415) 552-1013, x2234	• Covered CA: Blue Shield of CA • Medi-Cal: SF Health Plan (21047) Anthem Blue Cross (XKI000) • Medicare & some private insurance plans • Healthy San Francisco; uninsured on sliding scale
While the clinic specializes in services for the Spanish-speaking, Latino community and all communities are welcomed. Evening Hours: Tu, Wed, Th, noon-9:00pm; Daytime: Mo and Fri, 9:00-6:00pm	
Kaiser 💊 2238 Geary Blvd., 4 West – Geary Campus 1600 Owens, 4th Floor – Mission Bay Campus (415) 833-4638 – HIV Clinic Intake Line	• Covered CA: Kaiser • Medi-Cal: ***Only*** if you've been a Kaiser member within the prior 6-months; enroll in SF Health Plan then call SFHP to request Kaiser enrollment • Medicare & private Kaiser plans
HealthRight 360 💊 **Integrated Care Ctr:** 1563 Mission St. (415) 746-1940 **Lyon Martin:** 1735 Mission St. (415) 565-7667	• Medi-Cal: SF Health Plan (Mission 22677; Market 21844) Anthem Blue Cross (Mission XX4; Market XXM) • Medicare • Healthy San Francisco
San Francisco City Clinic 💊 356 7th St. (between Folsom & Harrison) *Se habla español*	• Uninsured • Not currently in care
Not in care? Without a local provider? Out of meds? Call Andy Scheer, Social Worker at City Clinic: (415) 487-5511 Easy entry into care, help with insurance and wrap-around benefits (ADAP, HIPP) and linkage to medical homes.	

HIV Benefits: **tiny.cc/SFHIVBenefits** | HIV Navigation: **tiny.cc/SFHIVNavigation** | HIV Care: **tiny.cc/SFHIVCare**

This guide is not an exhaustive list of clinics or providers, nor is it an endorsement of these entities.
Care is also available at Native American Health Center, South of Market Health Center, and St. Anthony's among others.

💊 = Can also help with PrEP

Direct updates: Andy Scheer, LCSW at SF City Clinic (Andy.Scheer@sfdph.org) | **UPDATED: 9/4/19**

CLINIC NAME	BENEFITS INFO
SF Community Health Center 730 Polk St., 4th floor 1800 Market, 4th floor (415) 292-3400	• Medi-Cal: SF Health Plan (25353); Anthem Blue Cross (G1H009) • Medicare • Some private insurance plans; uninsured on sliding scale
AIDS Healthcare Foundation 518-A Castro St. (415) 552-2814	• Covered CA: Blue Shield of CA • Medi-Cal: Anthem Blue Cross (call for clinic code) • Medicare & many private insurance policies • Uninsured on sliding scale
NOTE: The SF clinic is *only* open on Wednesdays & Fridays; the pharmacy in SF is open daily (except Sunday)	
Veterans Administration Ft. Miley: 4150 Clement St., Bldg 203, Ward 1B Downtown: 401 3rd (at Harrison) Elda Kong, NP (415) 221-4810, x23942	• VA Health Care System benefits recipients only
SFDPH Clinics w/ HIV Primary Care Call the SFDPH New Patient Appointment Unit to connect to the clinics listed below. (415) 364-7942	• Medi-Cal: *SF Health Plan (see below for clinic codes)* • Medicare • Healthy San Francisco
• Castro-Mission (21041) • Family Health (21044) • General Medical Clinic (21045)	• Maxine Hall (21046) • Silver Avenue (21053)
• Southeast Health Center (21056) • Tom Waddell (21667)	
SFDPH Youth-focused HIV Primary Care For clients 12 to 24 years of age, regardless of insurance status	• Medi-Cal: *SF Health Plan (see below for clinic codes)* • Healthy San Francisco • Uninsured
• Cole St. (22095) 555 Cole St. (415) 751-8181	• Larkin/Michael Baxter (22096) 134 Golden Gate (415) 673-0911 x259
• Larkin/ACAC (22096) 129 Hyde St. (415) 749-6977	

Private Practice Doctors

Medicare and private insurance—including Covered CA plans—often accepted, but usually not Medi-Cal; call to inquire which plans and if accepting new patients

- Charles Moser, MD
- Gary Feldman, MD
- Mark Illeman, NP
- Virginia Cafaro, MD
- Shawn Hassler, MD
- Lisa Sterman, MD
- Jeffrey Manese, PA
- Mark Higgins, MD
- William Kapla, MD
- Carl Stein, PA
- One Medical Group *Castro, South Park, Embarcadero Center, Mission Valencia*

Paying for Care

Covered California (800) 300-1506 | CoveredCA.com
Medi-Cal 1440 Harrison St. | (415) 863-9882 | MyBenefitsCalWin.com

Medi-Cal Expansion may cover meds & care if household income is at or below 138% of MAGI* FPL

- **2019 138% FPL MAGI***: household size of 1 = $17,236/year or $1,436/month | of 2 = $23,336/year or $1,945/month
- Managed Care Plans in SF: **SF Health Plan** (800) 288-5555 | **Anthem Blue Cross** (800) 407-4627 **Health Care Options** (800) 430-4263 call to enroll/change your plan, or call SF Health Plan or Anthem directly

CA Office of AIDS programs help cover costs for meds & care if household MAGI* FPL is 138% – 500%

- **2019 500% FPL MAGI*:** for 1 = $62,450 | for 2 = $84,550 | for 3 = $106,650 | for 4 = $128,750
- **ADAP** (tiny.cc/ADAP) covers costs of HIV & related medications for uninsured *and* insured enrollees
- **OA-HIPP** (tiny.cc/OAHIPP) pays private insurance premiums (e.g. Covered CA, COBRA) and some co-pays
- **EB-HIPP** (tiny.cc/EBHIPP) pays client's portion of employer-based insurance and some co-pays
- **Medicare Part D Premium Payment** (tiny.cc/MDPP) pays Medicare Part D and MediGap plan premiums

***MAGI = Modified Adjusted Gross Income**; more info: Google "UC Berkeley Labor Center MAGI" or "IRS Topic 403"

= Can also help with PrEP

Direct updates: Andy Scheer, LCSW at SF City Clinic (Andy.Scheer@sfdph.org) | **UPDATED: 9/4/19**

SF HIV NAVIGATION OPTIONS

HIVReConnect
Increasing retention and re-engagement

Side A navigation services help connect people to **ANY** clinic or provider in San Francisco.

NAVIGATION PROGRAM	HIV+ CLIENT FOCUS	HEALTHCARE ACCEPTED	NOTES
LINCS Navigation City Clinic, 356 7th St. Drop in or call Midori Hiyagon (415) 487-5520	All HIV+ people, especially: • Gay & Bi Men • Transgender & Gender non-conforming • Women • Clients w/complex needs	• No insurance restrictions • Can help establish health care coverage	• Se habla Español • HIV Care Navigation and linkage to PrEP & PEP prescription and navigation services at SF City Clinic are also available
SF AIDS Foundation 1035 Market St. 470 Castro St. (@ 18th) assist4hiv@sfaf.org (415) 602-9676 or (415) 487-3000 ask for the HIV Navigator	All HIV+ people, especially: • Gay & Bi Men • Drug Users • Transgender & Gender non-conforming • HIV & Hep C co-infected • Undocumented	• No insurance restrictions • Can help establish health care coverage	• Se habla Español • Short- & long-term case management available • PrEP & PEP prescription and navigation available
Glide 330 Ellis St. (@ Jones) Amber Taylor (415) 674-6168	All HIV+ people, especially: • Drug Users • HIV & Hep C co-infected • Transgender & Gender non-conforming	• No insurance restrictions • Can help establish health care coverage • Glide/HealthRight 360 insurance: Medi-Cal, Medicare, Healthy SF	• Can link HIV- partners to PrEP • Direct connection with Glide/HealthRight 360 Clinic and can link clients to other clinics as well
Shanti 730 Polk St. (@ Ellis) Jordan Ackerly (415) 271-0279	All HIV+ people, especially: • Women • Drug Users • HIV & Hep C co-infected	• No insurance restrictions • Can help establish health care coverage	• Emotional & practical support provided • Hep C mono-infected served • Narcan distribution site
St. James Infirmary 730 Polk St. (@ Ellis) Ask for the Care Navigator (415) 554-8494	• Current & Former sex workers • Drug Users • Transgender & Gender non-conforming	• No insurance restrictions • Can help establish health care coverage	• Short & Long-term case management available • No HIV primary care on site • Sex Workers clinic: Wednesdays, 5:30-9 PM • Transgender clinic: Thursdays, 1-4 PM

Additional Resources: These are not Navigation programs, but can connect patients to care.

Early CARE Program: Rapid Entry/Re-entry into care for uninsured, out of care clients. SF City Clinic, 356 7th St.
Andy Scheer, LCSW (415) 487-5511

PHAST Program: Rapid Entry/Re-entry into care. Ward 86 @ Zuckerberg SF General, 995 Potrero Ave.
Sandra Torres (415) 206-2419; Miguel Ibarra, (415) 206-2411 Lizzy Lynch, RN (415) 206-2458

HIV Integrated Services (via Jail Health): Case management for people in or just out of jail.
Irma Parada (415) 581-3141

Need help picking the right HIV Navigation support? Contact Midori Hiyagon: (415) 487-5520, Midori.Hiyagon@sfdph.org

Direct updates: Andy Scheer, LCSW at SF City Clinic (Andy.Scheer@sfdph.org) | **UPDATED: 7/6/19**

Side B navigation services help connect people to **SPECIFIC** clinics or providers in San Francisco.

AGENCIES & NAVIGATORS	HIV+ CLIENT FOCUS	HEALTHCARE ACCEPTED	NOTES
LINCS Navigation @ Ward 86 City Clinic, 356 7th St. Drop in or call Midori Hiyagon (415) 487-5520	All HIV+ people, especially: • Gay & Bi Men • Transgender & Gender non-conforming • Women	• Patients with: Medi-Cal, Medicare, or Healthy SF • Can help establish health care coverage	• Se habla Español • PrEP & PEP prescription and navigation services available
TACE @ SF Community Health Center 730 Polk St. (@ Ellis) (415) 292-3420 Ask for the HIV Navigator	All HIV+ people, especially: • Transgender & Gender non-conforming • Homeless clients	• Patients must have: Medi-Cal, Medicare, or Healthy SF • Can help establish health care coverage	• Short & Long-term case management available with case managers & peer navigators • OK to drop-in to start care: Mon to Fri, 9-noon • TransAccess drop-in: Thursdays, 9-noon
Clínica Esperanza Mission Neighborhood Health Center 240 Shotwell St. (@ 16th) Robert Maldonado (415) 552-1013 x2234	All HIV+ people, especially: • Latino community • Mono-lingual Spanish-speakers	• Patients with: Medi-Cal, Medicare, Covered CA, or Healthy SF • Some private insurance plans accepted • Can help establish health care coverage	• Se habla Español • PrEP & PEP prescription and navigation services available
UCSF 360 Wellness Center 350 Parnassus Ave., Ste 908 **Women's HIV Program** Beth Chiarelli (415) 353-2417 **General HIV Clinic** Andrew Abundiz (415) 353-3496	All HIV+ people, especially: • Gay & Bi Men • Men of Color • Transgender & Gender non-conforming • Women • Clients w/complex needs	• Patients with: Medi-Cal, Medicare or Covered CA • Many private insurance plans accepted • Can help establish health care coverage	• PrEP & PEP prescription and navigation available • Specialty clinics: Men of Color, 50+ silver project, Transgender women / women
Southeast Health Center 2401 Keith St. Gwen Smith (415) 671-7057	All HIV+ people, especially: • Post-incarceration clients • Current SE Health Center clients	• Patients must have: Medi-Cal, Medicare, or Healthy SF • Can help establish health care coverage	• Short- & long-term case management available • Medication adherence counseling and mental health therapy available

What is HIV Navigation?

HIV Navigation is a service to assist out-of-care, HIV+ clients re/connect with HIV care and treatment. Navigators can help clients access insurance, benefits, and other support services based on their individual needs. They usually offer mobile services in the community for a limited period of time.

Who is considered "Out-of-care" for HIV?

- No visits with an HIV medical provider in the past 6 months **and/or** no appointments scheduled
- Not taking HIV meds (ART) **or** taking them inconsistently

Benefits: **tiny.cc/SFHIVBenefits** | Navigation: **tiny.cc/SFHIVNavigation** | Care: **tiny.cc/SFHIVCare**

Need help picking the right HIV Navigation support? Contact Midori Hiyagon: (415) 487-5520, Midori.Hiyagon@sfdph.org

Direct updates: Andy Scheer, LCSW at SF City Clinic (Andy.Scheer@sfdph.org) | **UPDATED: 7/6/19**

GETTING TO ZERO SAN FRANCISCO

SAN FRANCISCO AIDS FOUNDATION

PrEP Facts

There is an exciting new development in HIV prevention that puts another tool in the hands of HIV-negative people. It's called pre-exposure prophylaxis (PrEP), and we think you should know about it!

Use this brochure to learn more about PrEP and figure out whether this HIV prevention strategy may be useful for you or someone you know.

In San Francisco, those who are at higher risk of HIV exposure include gay and bisexual men, people who inject drugs, and transgender women.

If you determine PrEP is right for you, this brochure can serve double duty with helpful information to show your medical provider to ensure they're just as informed as you are.

For more information, visit PrEPfacts.org.

Contents

What is PrEP?

PrEP is an HIV prevention strategy in which HIV-negative people take anti-HIV medications before coming into contact with HIV to reduce their risk of becoming infected.

PrEP protects against HIV infection much like a malaria pill protects against malaria or a birth control pill protects against pregnancy.

PrEP is different from post-exposure prophylaxis (PEP). PEP is taken within 72 hours *after* HIV exposure and involves a month-long course of anti-HIV medications. If PrEP protects against HIV infection like the birth control pill for pregnancy, think of PEP like the morning-after pill.

PrEP does not protect against other sexually transmitted infections (STIs) or pregnancy and is not a cure for HIV.

Medications & Effectiveness

The FDA approved Truvada for PrEP in July of 2012. The medication has been used as part of combination therapy to treat HIV-positive people since 2004, but this is the first time it's been approved for HIV prevention. Currently, it's the only pill approved for this use.

Truvada combines two anti-HIV medications—Viread (tenofovir disoproxil fumarate or TDF) and Emtriva (emtricitabine or FTC)—into one pill. A prescription consists of 1 pill daily. A 30- to 90-day supply is usually prescribed at a time.

The FDA reviewed the results of several clinical studies, including iPrEX, which followed nearly 2,500, sexually active, HIV-negative gay and bi men and trans women for nearly two years. Participants were assigned to take either Truvada for PrEP or a sugar pill (placebo). All received safer sex counseling, condoms, and regular HIV and STI testing.

Results showed that people who took Truvada every day reduced their HIV risk by more than 90%.

According to data analyses from the iPrEx study that found PrEP to be effective:

- **7 PrEP pills per week, protection estimated at 99%.**
- **4 PrEP pills per week, protection estimated at 96%.**
- **2 PrEP pills per week, protection estimated at 76%.**

It is important to take Truvada consistently every day. It is not meant to be used sporadically or only before or only after sex. When starting, it takes up to seven days of taking daily Truvada for PrEP to reach high levels of HIV protection. If a daily dose is missed, the level of HIV protection may decrease.

Side Effects

There is the possibility of experiencing mild nausea, headaches, or weight loss for the first 4–8 weeks of taking Truvada for PrEP. For most people in studies, these side effects went away on their own after the first few weeks of treatment or when medication was stopped.

More serious side effects, related to kidney and bone mineral density issues, are rare. Some people can have mild increases in serum creatinine (an indicator of kidney health) while on Truvada. Blood tests for creatinine monitoring will be ordered by your doctor. If present, both kidney and bone mineral density issues go away once the drug is stopped.

By the Numbers:

- **1 in 10 will have nausea**
- **1 in 100 will experience decreasing bone mineral density issues**
- **1 in 200 will have kidney problems**

Truvada for PrEP is not known to interact with alcohol or recreational drugs, most medications for depression, hormonal birth control, or hormonal therapy, and is not known to have sexual performance side effects.

There is significant data on the safety of Truvada for HIV-positive people and it is deemed safe for long-term use. Long-term side effects on HIV-negative people are unknown. Safety for infants exposed to Truvada for PrEP during pregnancy or breastfeeding has not yet been determined.

Cost & Availability

- You will need to visit a health center that provides primary care services.
- Truvada for PrEP is available by prescription from doctors, nurse practitioners, and/or physician assistants.
- You will need to talk with a medical provider about your sexual health when you ask for Truvada for PrEP.
- Your medical provider may need to get pre-authorization to give you a prescription; it may include lab tests and/or filling out paperwork.
- You will most likely not be able to walk away with medication at initial visit.
- Most private health insurance plans, as well as Medicaid, cover the cost of Truvada for PrEP.
- When you are calculating your health costs for PrEP, remember that it involves more than just the drug itself. You will need to account for frequent visits and lab tests.

- Brand drug copay/coinsurance (per month)
- Primary care visit copay (at least 3–4 times per year)
- Lab testing copay, supplies, and services (per visit)

How Much Does The Drug Cost?

Truvada is a brand-name drug and no generic version is currently available in the U.S.

- **Without insurance:** As much as $1,800 a month.
- **With Medi-Cal, Medicaid and/or Medicare:** Coverage varies from state to state; talk with a benefits counselor.
- **With insurance:** Costs vary depending on your insurer's standard copay/coinsurance associated with brand-name drugs. Contact your insurance company directly for pricing.

IMPORTANT: If you are an uninsured California resident in need of affordable health insurance, the deadline to sign up for 2014 coverage is March 31, 2014. For more info, call (800) 300-1506 or visit www.coveredca.com.

- **With Covered California:** Between $15–$700 per month depending on which level you choose with copays and deductibles.
  - **Bronze Plan:** $50/brand copay after $5,000 deductible for both medical and drugs where you pay 40% of health expenses. WARNING: Unaffordable; *do not enroll in this tier if you plan on starting PrEP.*
  - **Silver Plan:** $50/brand copay after $250 brand drug deductible where you pay 30% of health expenses.
  - **Gold Plan:** $50/brand copay, no deductible.
  - **Platinum Plan:** $15/brand copay, no deductible.

If you are an uninsured San Francisco resident who does not qualify for Medi-Cal or Covered California and your income is less than $54,000 (500% federal poverty level), then consider Healthy San Francisco to increase your access to health services. It is not health insurance. For more info, call ***(415) 615-4555*** *or visit* ***www.healthysanfrancisco.org.***

- **With Healthy San Francisco (HSF):** Between $0–$25 through San Francisco Department of Public Health depending on income; prices vary through HSF Medical Homes by clinic. You may be asked to enroll in Gilead Sciences' Medication Assistance Program (see below) to reduce your out-of-pocket costs.

Payment Assistance:

- **Gilead's Medication Assistance Program (MAP) for PrEP**: If you do not have health insurance, then apply for this program to see if you are financially eligible to get Truvada for PrEP for free. You must not have health insurance and income verification is required. Your medical provider needs to submit an application form. If approved, your medication will be dispensed to your medical provider directly. For more info, call **1-855-330-5479** or visit **www.truvada.com.**
- **Gilead's Co-Payment Assistance Program (CAP):** If you have health insurance, save up to $200 per month on your Truvada copays. There is no income restriction for eligibility. Your medical provider or pharmacy can submit the application form. Once approved, you will be given a card and medication will be dispensed to your preferred pharmacy. For more info, all **1-877-505-6986** or visit **www.truvada.com.**
- Gilead's MAP and CAP both use same application form: **https://start.truvada.com/Content/pdf/Medication_Assistance_Program.pdf**
- If you are enrolled in Medicaid or Medicare or have coverage for prescription drugs under any other public program or other third party payer, then you are not eligible for Gilead's MAP and CAP.
- Since Truvada for PrEP is for HIV-negative people, you are not eligible for AIDS Drug Assistance Programs (ADAPs). ADAP is a prescription drug assistance program for people living with HIV, funded by federal and state goverments.

If your medical provider is uncomfortable prescribing Truvada for PrEP:

- Show them this brochure!
- Pull up the CDC's interim PrEP guidance on your phone/computer to show them.
- Ask to be referred to an HIV specialist, visit an LGBT-friendly organization, or ask for a medical provider reference from an AIDS services organization.

If you are running into problems getting a prescription for PrEP, please contact us at feedback@sfaf.org to help troubleshoot.

How Does PrEP Work?

Truvada for PrEP works by blocking an enzyme called HIV reverse transcriptase. This prevents HIV from making more copies of itself and establishing infection in the body.

Truvada for PrEP is taken once a day as an oral pill. It can be taken with or without food. It's helpful to take it at the same time every day to establish a regular routine and ensure doses are not missed. Maximum protection comes from taking the pill every day.

Drug Resistance

Before you begin using Truvada for PrEP, it is essential to ensure that you are HIV negative by getting an HIV test before starting the drug. It's important to specifically test for HIV antibodies as well as testing for very recent or acute HIV infection. Depending on the type of testing available where you access PrEP, there may be a delay in your being prescribed PrEP. You will also need to be tested for HIV regularly while taking the drug.

Truvada for PrEP is not sufficient on its own for treating HIV; if you are infected with HIV and take PrEP, or if you take PrEP inconsistently and become infected, the virus could become resistant to the two drugs in the Truvada pill. This may limit your options for HIV treatment.

If you are found to be HIV positive, your doctor will tell you to stop taking Truvada for PrEP to avoid drug resistance. To note, if you are also infected with hepatitis B virus (HBV) and stop taking Truvada for PrEP, your hepatitis may suddenly get worse. You will need to work with your doctor to monitor your health.

Should Condoms Still Be Worn?

Condoms have been and continue to be an effective tool in reducing HIV risk. They are also the only tool that protects against both HIV and certain STIs and prevents pregnancy when used correctly and consistently.

For people who do not use condoms every time they have sex, PrEP provides an effective layer of protection against HIV. The choice to use PrEP, like the choice to use condoms, is a personal decision. The important thing is to find an HIV prevention strategy that fits your needs and meets your sexual health goals.

How Long Can I Take PrEP?

Truvada for PrEP can be discontinued whenever the protection it offers is no longer necessary.

PrEP may make sense for you at different points in your life—for example, when you are in a relationship with a partner who is HIV positive, when you are having sex without condoms with partners who may have HIV, or if you are in a situation in which you can't negotiate condom use with a partner.

If your risk for HIV or your preferences change, you might consider other HIV prevention strategies. It's important to consult your doctor when stopping or starting Truvada for PrEP.

Who Should Consider PrEP?

If you are HIV negative and can answer "yes" to any of the questions below, Truvada for PrEP might be an HIV prevention strategy to consider:

- ❑ **Do you use condoms sometimes or not at all?**
- ❑ **Have you had STIs in your butt in the past 6 months?**
- ❑ **Have you had STIs in your vagina in the past 6 months?**
- ❑ **Do you bottom?**
- ❑ **Have you taken post-exposure prophylaxis (PEP) in the past year?**
- ❑ **Are you in a relationship with an HIV-positive partner?**
- ❑ **Are you having anal and/or vaginal sex with more than one partner and use condoms sometimes or not at all?**
- ❑ **Are you having sex with someone whose HIV status you don't know?**
- ❑ **Are you potentially exposed to HIV though injection drug use?**
- ❑ **Have you used stimulants, poppers, cocaine, meth, ecstasy, or GHB in the last 3–6 months?**
- ❑ **If you are a woman, are you trying to safely have a child with an HIV-positive partner?**

What Does Taking Truvada for PrEP Involve?

Taking Truvada for PrEP is more than just taking a pill every day; it also means frequent medical provider visits.

If you're considering taking Truvada for PrEP, the following checklist can serve as a guide to help you and your medical provider discuss and understand what is involved, and to decide together if this will be a useful HIV prevention strategy for you.

Before Starting

- Talk about why you're interested in taking Truvada for PrEP.
- Review potential side effects, HIV risk reduction practices, and the importance of adherence *(taking the pill consistently)*.
- Take an HIV test.
- Test for hepatitis B.
- Test for kidney health.
- Test for STIs like syphilis, gonorrhea, and chlamydia.
- If applicable, discuss whether you are pregnant or planning to become pregnant, or breastfeeding.

Every 1-3 Months

- Review potential side effects, HIV risk reduction practices, and the importance of adherence.
- Re-test for HIV.
- Re-test for changes in kidney health.
- Talk about any STI symptoms. *(Re-test every 3–6 months even if no symptoms are present.)*
- If applicable, test for pregnancy.

Stopping PrEP

- Stopping PrEP includes testing for HIV and choosing an alternative HIV prevention strategy. If possible, you should continue Truvada for 4 weeks after your last significant exposure to HIV.
- Truvada must be discontinued following a positive HIV test result.
- If you test HIV positive, it is important to get into care for HIV as soon as possible.
- If you test HIV positive and also have hepatitis B, your hepatitis may suddenly get worse when you stop PrEP. Work with your doctor to monitor your health.

How often you meet for testing and monitoring is a decision best made between you and your medical provider. There may be more visits in the beginning for side effects and adherence monitoring, but less frequently after the first few months.

For your health and safety, it is essential that you start Truvada for PrEP with a medical provider and not share HIV medications with HIV-positive or HIV-negative friends.

Notes for Medical Providers

Medical providers should refer to the above guide with the following additional considerations. For guidance documents from Gilead, please visit **truvadapreprems.com.**

Before Starting

- Talk about why the potential client is interested in taking Truvada for PrEP.
- Review potential side effects, safer sex/injection practices, and the importance of medication adherence.
- Clients should be tested for HIV. If possible, consider using a test that can detect acute HIV infection *(e.g., an HIV RNA or a 4th-generation HIV Ag/Ab test)*. An HIV-negative result must be documented.
  - Clients should be educated about the symptoms of an acute seroconversion reaction and advised to seek medical attention immediately.
- Kidney function should be checked using renal safety labs.
- Calculated creatinine clearance should be confirmed at ≥60 mL per minute via Cockcroft-Gault formula. You can use this calculator to determine CrCl:(Reference **http://medscape.com/calculator/creatinine-clearance-cockcroft-gault**)
- Test client for syphilis, gonorrhea/chlamydia (oral, rectal, urethral), and hepatitis B (vaccinate if needed).
  - Truvada for PrEP is active against hepatitis B and helps treat clients with chronic hepatitis B. Adherence is critical for these clients as drug-resistant hepatitis B can occur. If hepatitis B is diagnosed, Truvada for treatment of hepatitis B, as well as HIV prevention, can be considered.
  - Patients with hepatitis B who stop Truvada can experience hepatitis flares. It's important to monitor liver function in patients with hepatitis B who are taking Truvada, including after the medication is stopped.

- Discuss the risks/benefits of taking Truvada for PrEP during pregnancy and/or breastfeeding. Medical providers with pregnant clients on PrEP are encouraged to prospectively and anonymously submit information to the Antiretroviral Use in Pregnancy Registry at **apregistry.com** and call Gilead at **1-800-258-4263**.

Every 1-3 months

- Discuss side effects and adherence. (If client is adherent in months 1–3, consider quarterly follow-ups.)
- Discuss HIV risk reduction practices and include condom distribution and education in every visit.
- Re-test client for HIV and document result.
- Re-test for kidney function. (If kidney function is stable, testing every 3–6 months is adequate.)
- Assess for STI symptoms. (Re-test every 3–6 months even if asymptomatic.)
- Re-assess client's pregnancy status/plans.
- Prescription should be renewed after client re-tests HIV negative and re-assess if prescription is working for client.

Discontinuation

- Test client for HIV:
  - If positive, document results of resistance testing and establish a linkage to care.
  - If negative, establish linkage to risk reduction support services if necessary.
- If client is positive for hepatitis B:
  - Consider an alternative medicine for treatment.
  - Liver function (AST, ALT, bilirubin) should be closely monitored as hepatitis B flares can occur.

Medical Provider Billing Codes

Currently, there are no official ICD-9 or ICD-10 codes specifically for PrEP. These billing codes were compiled from various medical providers across the country who are prescribing Truvada for PrEP to their clients.

Common PrEP-Related Billing Codes

ICD-9	Description
V69.2	High-risk sexual behavior
V01.79	Exposure to other viral diseases
ICD-10	**Description**
Z72.5	High-risk sexual behavior
Z20.82	Contact with and (suspected) exposure to other viral communicable diseases
CPT	**Description**
99401	Preventive counseling (15 minutes)
99402	Preventive counseling (30 minutes)
99403	Preventive counseling (45 minutes)
99404	Preventive counseling (60 minutes)

Other PrEP-Related Billing Codes

ICD-9	Description
V01	Contact with or exposure to communicable diseases
V15.85	Exposure to potentially hazardous body fluid
E920.5	Needlestick
V01.8	Exposure to other communicable diseases
V01.9	Contact with or exposure to unspecified communicable disease
V07.8	Other specified prophylactic measure
V58.83	Encounter for therapeutic drug monitoring
V07.9	Unspecified prophylactic measure
42	Human immunodeficiency virus illness or disease with symptoms
V08	Human immunodeficiency virus infection, asymptomatic
70.3	Hepatitis, viral, type B (acute) without hepatic coma
V02.61	Hepatitis, viral, type B carrier status
70.32	Hepatitis, viral, type B, chronic
70.31	Hepatitis, viral, type B, delta

ICD-10	Description
Z20	Contact with and (suspected) exposure to communicable diseases
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Z20.5	Contact with and (suspected) exposure to viral hepatitis
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus (HIV)
Z77.21	Contact with and (suspected) exposure to potentially hazardous body fluids
W46	Contact with hypodermic needle: "the appropriate 7th character is to be added to each code from category W46" A- initial encounter, D- subsequent encounter, S-sequela
W46.0	Contact with hypodermic needle (hypodermic needle stick NOS)
W46.1	Contact with contaminated hypodermic needle
Z20.8	Contact with and (suspected) exposure to other communicable diseases
Z20.81	Contact with and (suspected) exposure to other bacterial communicable diseases
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
Z79	Long term (current) drug therapy. Includes long term (current) drug use for prophylactic purposes
Z51.89	Encounter for other specified aftercare
Z51.81	Therapeutic drug level monitoring
Z79.899	Other long term (current) drug therapy
B20	Human immunodeficiency virus (HIV) disease. Includes: AIDS; AIDS-related complex (ARC); HIV infection, symptomatic
Z21	Asymptomatic human immunodeficiency virus (HIV) infection status
B16.9	Acute hepatitis B without delta-agent and without hepatic coma
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B17.0	Acute delta-(super) infection of hepatitis B carrier
Z22.51	Carrier of viral hepatitis B
B18.0	Chronic viral hepatitis B with delta-agent
B18.1	Chronic viral hepatitis B without delta-agent

ICD-10	Description
B16.0	Acute hepatitis B with delta-agent with hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
Z00.0	Encounter for general adult medical examination
Z01.812	Encounter for preprocedural laboratory examination (blood and urine tests prior to treatment or procedure)
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.4	Encounter for screening for human immunodeficiency virus (HIV)
Z11.59	Encounter for screening for other viral diseases
Z11.8	Encounter for screening for other infectious and parasitic diseases
Z13.89	Encounter for screening for other disorder (encounter for screening for genitourinary disorders)
Z13.9	Encounter for screening unspecified
Z32.0	Encounter for pregnancy test
Z70.0	Counseling related to sexual attitude
Z70.1	Counseling related to patient's sexual behavior and orientation
Z70.3	Counseling related to sexual behavior and orientation of third party (child, partner, spouse)
Z72.51	High-risk heterosexual behavior
Z72.52	High-risk homosexual behavior
Z72.53	High-risk bisexual behavior

References & Resources

Information about PrEP

- PrEPfacts.org
- projectinform.org/prep
- prepwatch.org
- myprepexperience.blogspot.com
- frontiersla.com/mylifeonprep
- whatisprep.org

Gilead Sciences

- Website: start.truvada.com
- Patient Assistance Program: truvada.com/truvada-patient-assistance
- Guidance Documents: truvadapreprems.com

CDC Interim PrEP Guidance for Providers
cdc.gov/hiv/prevention/research/prep/

Heterosexuals:
cdc.gov/mmwr/preview/mmwrhtml/mm6131a2.htm

Men who have sex with men:
cdc.gov/mmwr/preview/mmwrhtml/mm6003a1.htm

Injection drug users:
cdc.gov/mmwr/preview/mmwrhtml/mm6223a2.htm

New York State's PrEP Guidance:
hivguidelines.org/prep

National HIV/AIDS Clinician's Consultation Center
Warmline: 800-933-3413 (providers only)
Perinatal HIV Hotline: 888-448-8765

Who We Are

This project is a collaboration of San Francisco AIDS Foundation, San Francisco Department of Public Health, Project Inform, Be The Generation Bridge, and other local health agencies, community-based providers, and PrEP advocates, with support from Gilead Sciences.

If you have feeback about this brochure, please email us at feedback@sfaf.org.

SAN FRANCISCO AIDS FOUNDATION

LEARN MORE AT
PrepFacts.org

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Printed February 2014

SF HIV FOG
Open Enrollment
Boot Camp V

Monday, October 7, 2019

UCSF Mission Bay
550 16th Street
San Francisco

Resource Guide

Part VII
Miscellaneous Information

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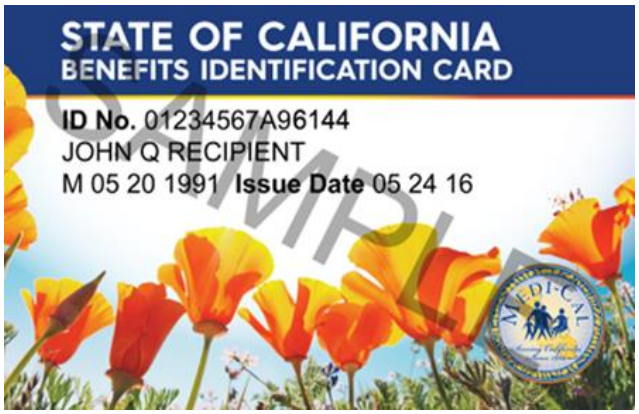
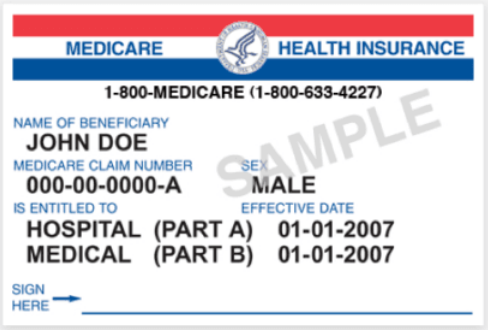
Medi-Cal Cards

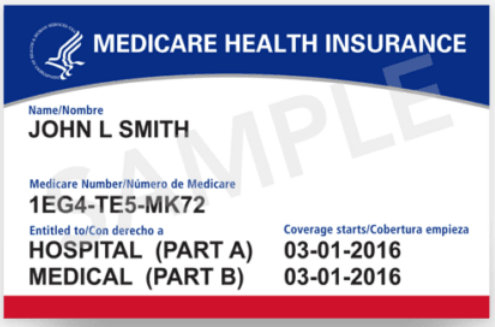


Medicare Cards

OLD
Medicare Card



NEW
Medicare Card



Example of ADAP Cards

Pharmaceutical Company Patient Assistance Programs and Cost-sharing Assistance Programs: HIV

June 19, 2018

What is a Patient Assistance Program (PAP)?

A patient assistance program is a program run through pharmaceutical companies to provide free or low-cost medications to people with low-incomes who do not qualify for any other insurance or assistance programs, such as Medicaid, Medicare, or AIDS Drug Assistance Programs (ADAPs). Each individual company has different eligibility criteria for application and enrollment in their patient assistance program.

HarborPath, a non-profit organization that helps uninsured individuals living with HIV gain access to brand-name prescription medicines at no cost, operates a special patient assistance program for individuals on ADAP waiting lists. An individual is eligible for the HarborPath ADAP waiting list program only if he or she has been deemed eligible for ADAP in his or her state and is verified to be on an ADAP waiting list in that state.

Applying for PAPs

In 2012, the Department of Health and Human Services (DHHS), along with seven pharmaceutical companies, the National Alliance of State and Territorial AIDS Directors (NASTAD), and community stakeholders developed a common patient assistance program application form that can be used by both providers and patients. Before, patients and advocates had to fill out different sets of paperwork for each company; the new application should help simplify this process; however, the form still has to be sent to each PAP to receive access to medications. This form combines common information collected on each individual company's form to allow individuals to fill out one form. Once the form is completed, case managers or individuals then submit the single form to each individual company, reducing the overall amount of paperwork necessary to apply for a patient assistance program.

In addition to serving as a special PAP for ADAP waiting list clients, HarborPath also operates as a streamlined, online portal for PAP access. HarborPath creates a single place for application and medication fulfillment. This "one stop shop" portal provides a streamlined, online process to qualify individuals and deliver the donated medications of the participating pharmaceutical companies through a mail-order pharmacy.

What is a Cost-sharing Assistance Program (CAP)?

A cost-sharing assistance program is a program operated by pharmaceutical companies to offer cost-sharing assistance (including deductibles, co-payments and co-insurance) to people with private health insurance to obtain HIV drugs at the pharmacy.

The following provides an overview of PAP contact information, drugs covered, and financial eligibility

Company	Contact Information	Drugs Covered	Financial Eligibility
AbbVie	800-222-6885 www.kaletra.com www.norvir.com	Kaletra and Norvir	500% FPL for Kaletra. No income limits for Norvir.
Boehringer Ingelheim	800-556-8317 https://www.boehringer-ingelheim.us/our-responsibility/patient-assistance-program	Aptivus and Viramune XR	500% FPL
Bristol-Myers Squibb	888-281-8981 www.bms.com	Reyataz, Evotaz, and Sustiva	500% FPL
Genentech	866-247-5084 www.fuzeon.com www.transplantaccessservices.com	Fuzeon and Invirase	Annual household income <$100,000 **OR** annual household income $100,000-$150,000 ***and*** out-of-pocket medication costs exceed 5% of income
Gilead Sciences [1]	800-226-2056 www.atripla.com, www.complera.com,	Atripla, Complera, Descovy, Emtriva,	500% FPL

[1] Effective July 1, 2015, patients who are insured and who do not meet their payer's coverage criteria will no longer be eligible for support via Gilead's patient assistance program. This includes clients whose insurer has limited access based on: step-therapy or clinical criteria (e.g., drug and alcohol testing).

	www.descovy.com, www.genvoya.com, www.odefsey.com, www.stribild.com, www.truvada.com, www.tybost.com or www.viread.com	Genvoya, Odefsey, Stribild, Truvada, Tybost, and Viread	
Janssen Therapeutics	800-652-6227 www.jjpaf.org	Edurant, Intelence, Prezcobix, and Prezista	300% FPL
Merck and Co.	800-727-5400 www.merckhelps.com	Crixivan, Isentress, and Isentress HD	400% FPL
ViiV Healthcare[2]	844-588-3288 www.ViiVconnect.com	Combivir, Epivir, Epzicom, Juluca, Lexiva, Rescriptor, Retrovir, Selzentry, Tivicay, Triumeq, Trizivir, Viracept, and Ziagen	500% FPL

[2] If seeking Epivir for the treatment of hepatitis B (not HIV), please contact GlaxoSmithKline to enroll in their PAP.

The following provides an overview of CAP contact information, drugs covered, and assistance offered.

Company	Contact Information	Drugs Covered	Assistance	Renewal
AbbVie	800-441-4987 www.kaletra.com www.norvir.com	Kaletra and Norvir	The co-payment assistance covers the first $400 per Kaletra prescription per month with a $4,800 maximum benefit per year, and up to a $100 per month/$1,200 per year for co-payments for Norvir. The cards can be used once every 30 days.	Reapply each year.
Bristol-Myers Squibb	888-281-8981 www.bms.com	Evotaz, Reyataz, and Sustiva	The program covers up to $7,500 annually for co-payments, deductibles and co-insurance in all commercially-insured plans for Evotaz, Reyataz, and Sustiva.	Automatic annual renewal for enrolled patients.
Genentech	866-247-5084 www.fuzeon.com www.transplantaccessservices.com	Fuzeon and Invirase	The program covers all out-of-pocket costs for Fuzeon prescriptions for individuals who: (1) have insurance, (2) have an annual household income of $150,000 or less, (3) spend 5% or more of their annual household income for Genetech prescriptions, and (4) have exhausted all other patient assistance options.	Must reapply each year.
Gilead Sciences	800-226-2056 www.atripla.com, www.biktarvy.com, www.complera.com, www.descovy.com, www.genvoya.com, www.odefsey.com, www.stribild.com, www.truvada.com, www.tybost.com, www.viread.com	Atripla, Biktarvy, Complera, Descovy, Emtriva, Genvoya, Odefsey, Stribild, Truvada, Tybost, and Viread	The program covers the first $7,200 per year of co-payments for Biktarvy and Genvoya; the first $6,000 per year of co-payments for Atripla, Complera, Odefsey, and Stribild; the first $4,800 per year of co-payments for Descovy and Truvada; the first $300 per month/$3,600 per year of co-payments for Emtriva and Viread; and the first $50 per month/$600 per year of co-payments for Tybost.	Automatic annual renewal for enrolled patients.

Janssen Therapeutics	877-227-3728 www.janssencarepath.com/hcp	Edurant, Intelence, Prezcobix, and Prezista	The program covers the first $7,500 per year of co-payments, deductibles, and co-insurance.	Reapply each year.
Merck and Co.	800-727-5400 www.isentress.com	Isentress and Isentress HD	The program covers out-of-pocket costs up to a maximum total program savings of $6,800. Coupon may be redeemed once every 21 days before the expiration date printed on the coupon, on each qualifying prescription up to 180 tablets each.	Must reapply after the coupon expires.
ViiV Healthcare	844-588-3288 www.ViiVconnect.com	Juluca, Lexiva, Selzentry, Tivicay, Triumeq, Trizivir, Rescriptor, Retrovir, Viracept, and Ziagen	The yearly maximum benefit is $7,500 per patient for all medications. Tivicay, Juluca, and Triumeq have a $7,500 per year/per patient maximum. Lexiva, Rescriptor, Selzentry, Retrovir, Ziagen, Trizivir, and Viracept have a $4,800 per year/per patient maximum.	Automatic annual renewal for enrolled patient.

Foundations Providing Access to Care Assistance for People Living with HIV

Needy Meds

http://www.needymeds.org/

Needy Meds offers resources that are helpful to uninsured and underinsured patients including an MRI/CAT scan discount program and medical bill mediation.

Patient Access Network (PAN) Foundation

https://panfoundation.org/index.php/en/ or 866-316-7263

The PAN Foundation offers a co-payment assistance program for individuals who have Medicare and whose annual income is less than 500% FPL. The yearly maximum benefit is $3,600. Patients may apply for a second grant during their eligibility period subject to availability of funding. Otherwise, patients must reapply each year. See website for full list of eligible HIV medications.

Patient Advocate Foundation

www.copays.org/diseases/hiv-aids-and-prevention or 800-532-5274

The Patient Advocate Foundation offers a co-payment assistance program for insured individuals whose annual income is less than 400% FPL. The yearly maximum award is $7,500 to help cover the out-of-pocket costs incurred for HIV treatment (the award is not drug-specific). Patients must have health insurance which covers the medication for which the patient seeks assistance. Patients must reapply every 12 months.

Additional Resources

The following resources may be of interest to individuals living with HIV.

Clinical Trials

www.clinicaltrials.gov

A service of the U.S. National Institutes of Health, ClinicalTrials.gov is a registry and results database of publicly and privately supported clinical studies of human participants conducted around the world.

Fair Pricing Coalition (FPC)

www.fairpricingcoalition.org

As part of their advocacy work, the Fair Pricing Coalition (FPC) negotiates with companies to ensure that Patient Assistance Programs (PAPs) are adequately generous and easy to apply for.

Health Insurance Marketplace

www.healthcare.gov

The official site of the Health Insurance Marketplace, Healthcare.gov allows individuals and families to sign-up for insurance coverage through the Affordable Care Act.

Treatment Action Group

www.treatmentactiongroup.org

Treatment Action Group collaborates with activists, community members, scientists, governments, and drug companies to make safer, more effective and less toxic treatment for viral hepatitis available.

INSURANCE BENEFIT MANAGER (IBM), MEDICAL BENEFIT MANAGER (MBM) AND PHARMACY BENEFIT MANAGER (PBM) PAYMENTS JOB AID RELEASE 8, AUGUST 29TH, 2019

Job Aid

IBM, MBM AND PBM PAYMENTS

Table of Contents

Summary of Changes

We have made the below changes since our last update on November 17th, 2018. All of the changes are reflected in orange throughout the job aid. Please note: This Job Aid is for ADAP staff and Enrollment Workers.

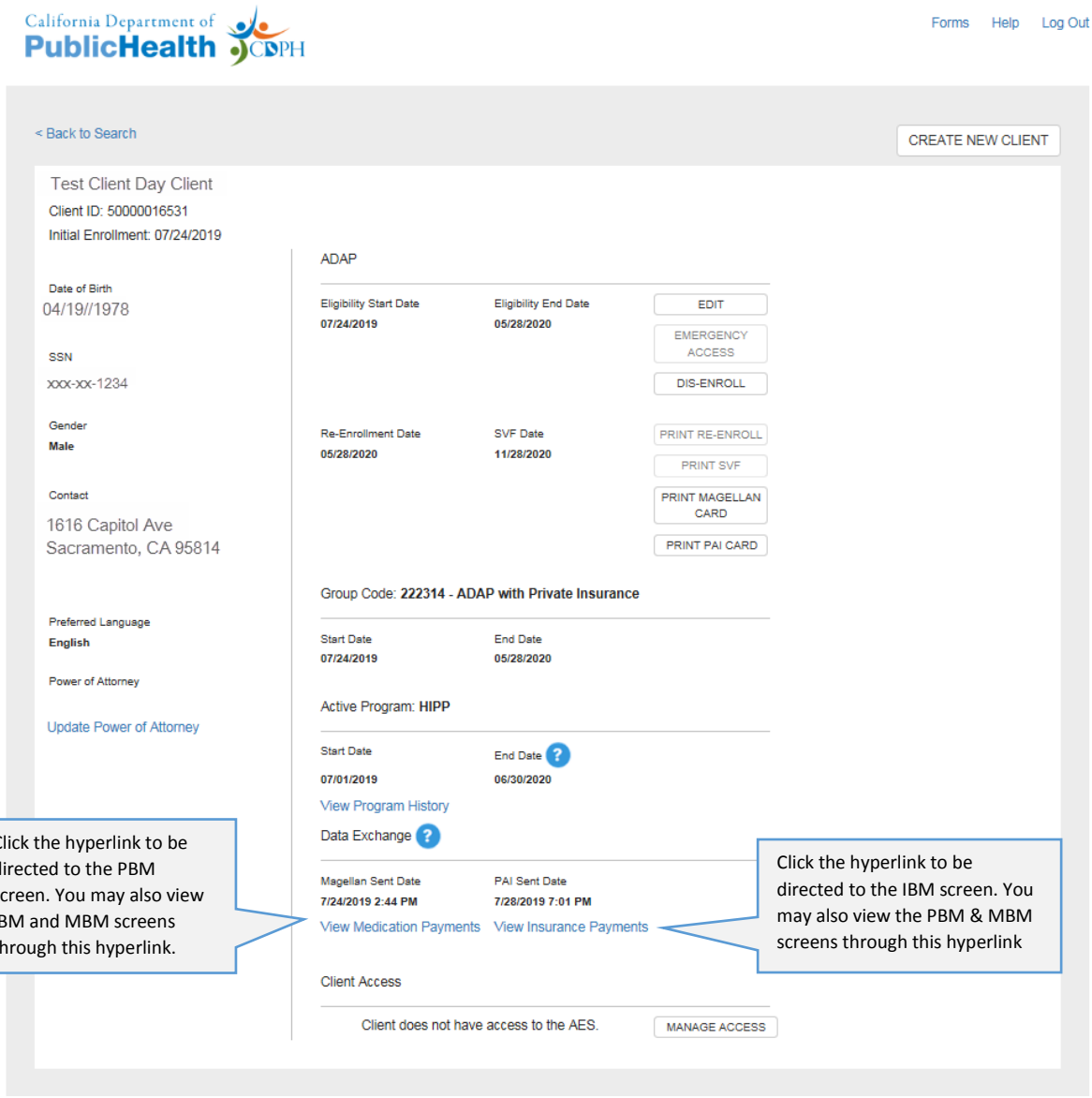
Release 8

Enrollment Workers and ADAP Staff can print Magellan and/or PAI benefit cards for clients enrolled in ADAP and/or one of ADAP's Insurance Assistance Programs.

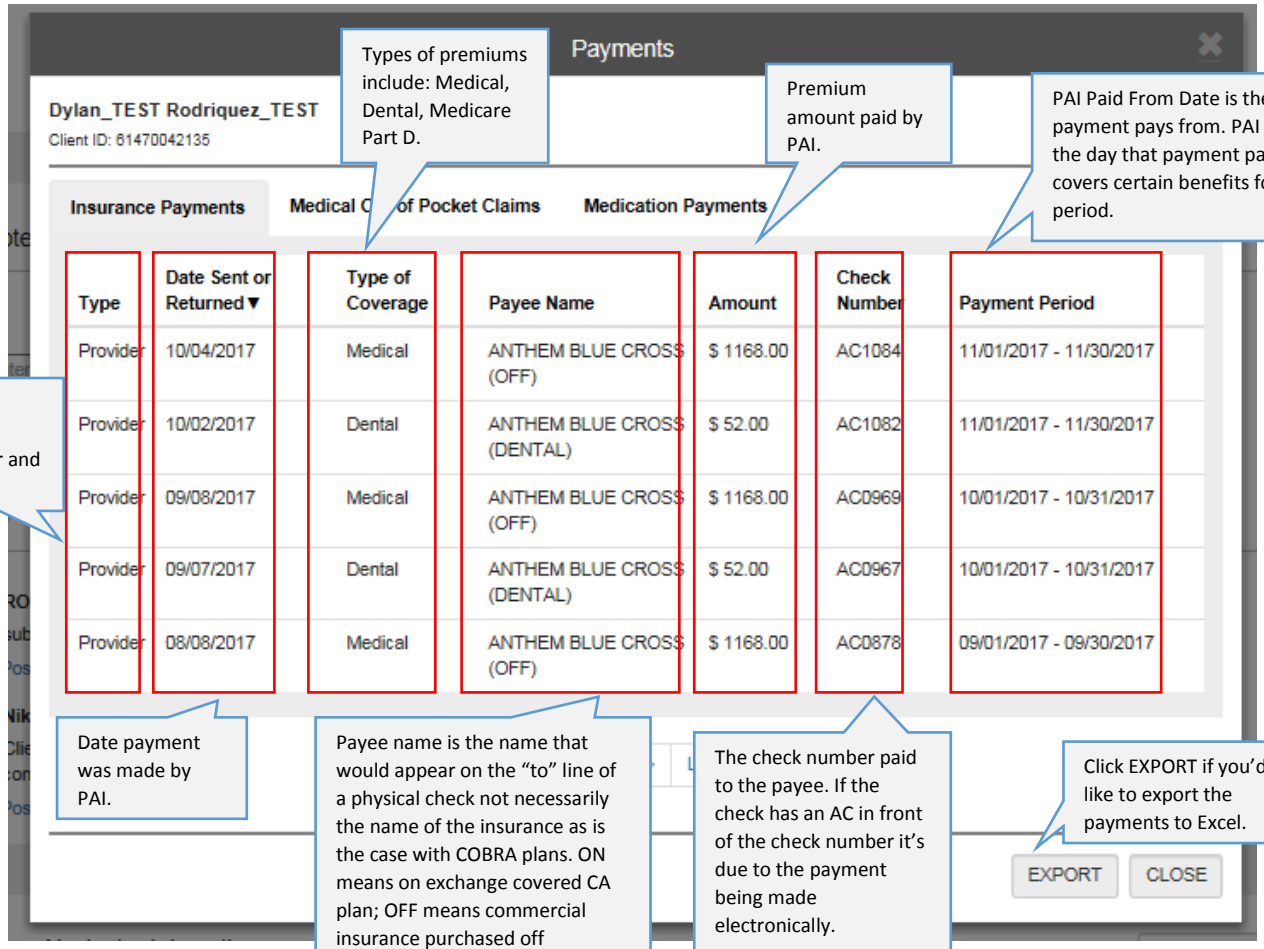
1. Enrollment Workers and ADAP Staff will have the ability to print a client's Magellan RX benefit card from the client profile screen.
2. Enrollment Workers and ADAP Staff will have the ability to print a client's PAI card from the client profile screen.

1. View IBM, MBM and PBM Payments on the Client Profile screen

Users are able to view Insurance Benefit Manager (IBM), Medication Benefit Manager (MBM) and Pharmacy Benefit Manager (PBM) Payments on the Client Profile screen by clicking the "View Insurance Payments" link or the "View Medications Payment" link.



2. View IBM Payment Information

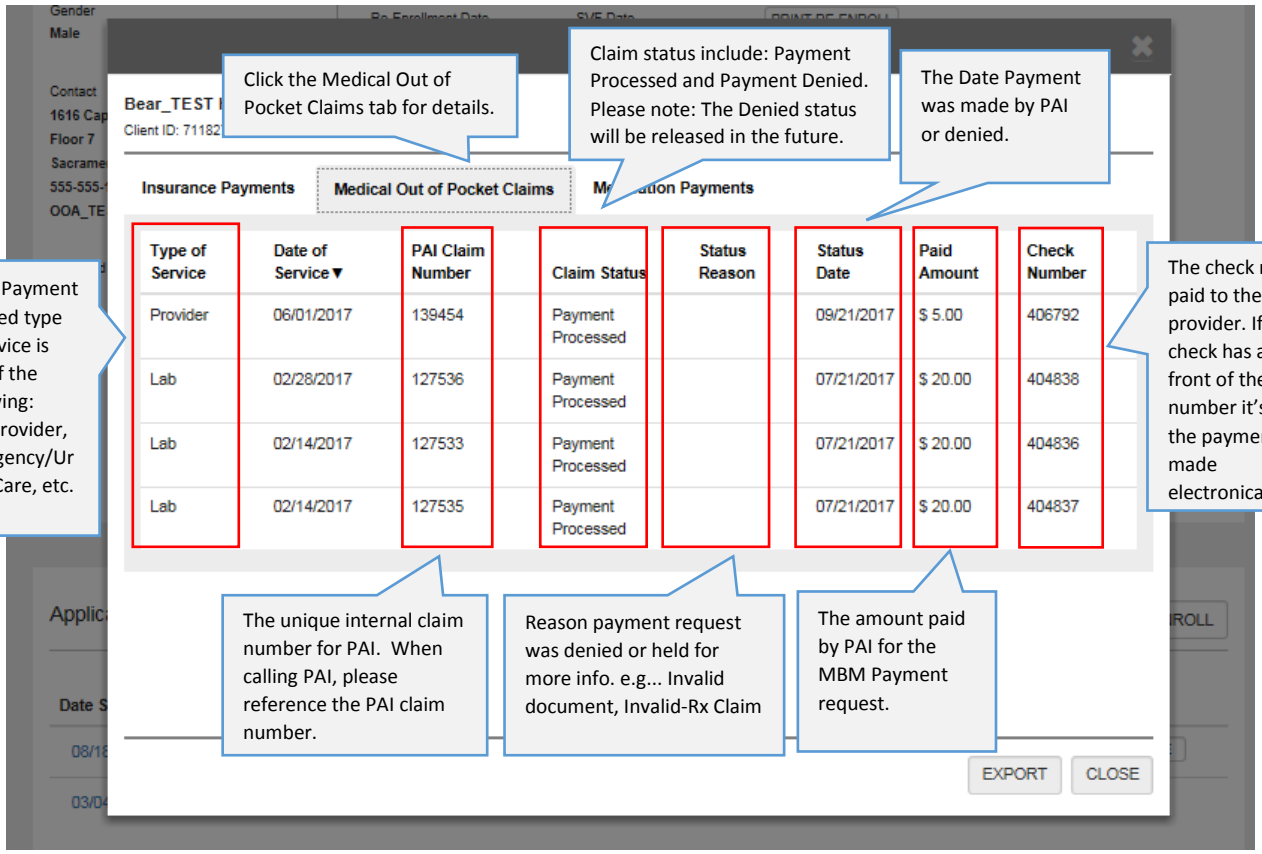


Please note:

1. Any payments prior to 7/1/2017 can NOT be viewed in the IBM tab.
2. Returned payments/refunds are NOT displayed.

3. View MBM Payment Information

Click the Medical Out of Pocket Claims tab if you'd like to view Medical Out of Pocket Claims.

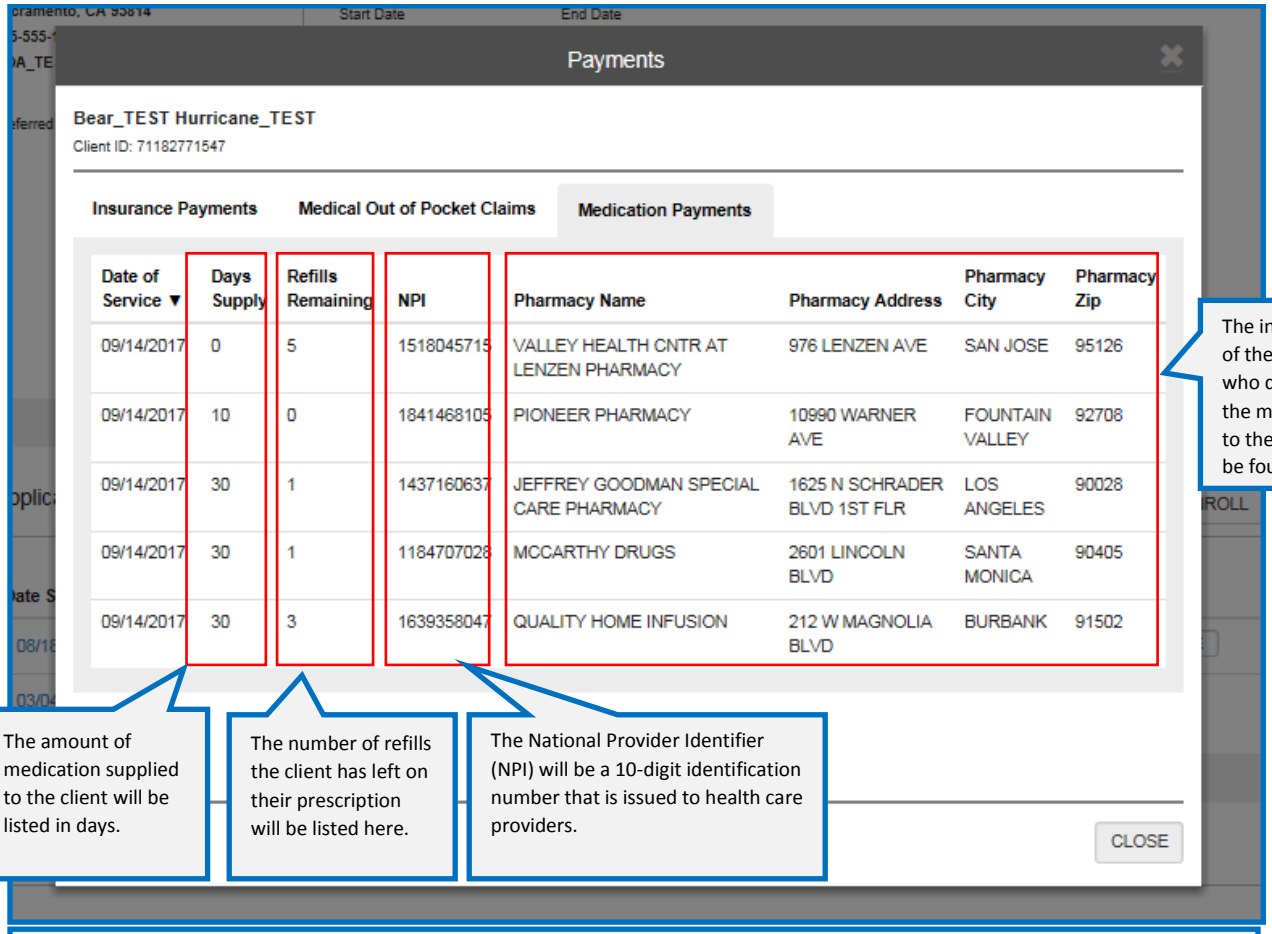


Please note:

1. Any payments prior to 7/1/2017 can NOT be viewed in the MBM tab.
2. Denied payments and payments being held for more info are NOT displayed.

4. View PBM Payment Information

Click the Medication Payments tab if you'd like to view the client's medication information.



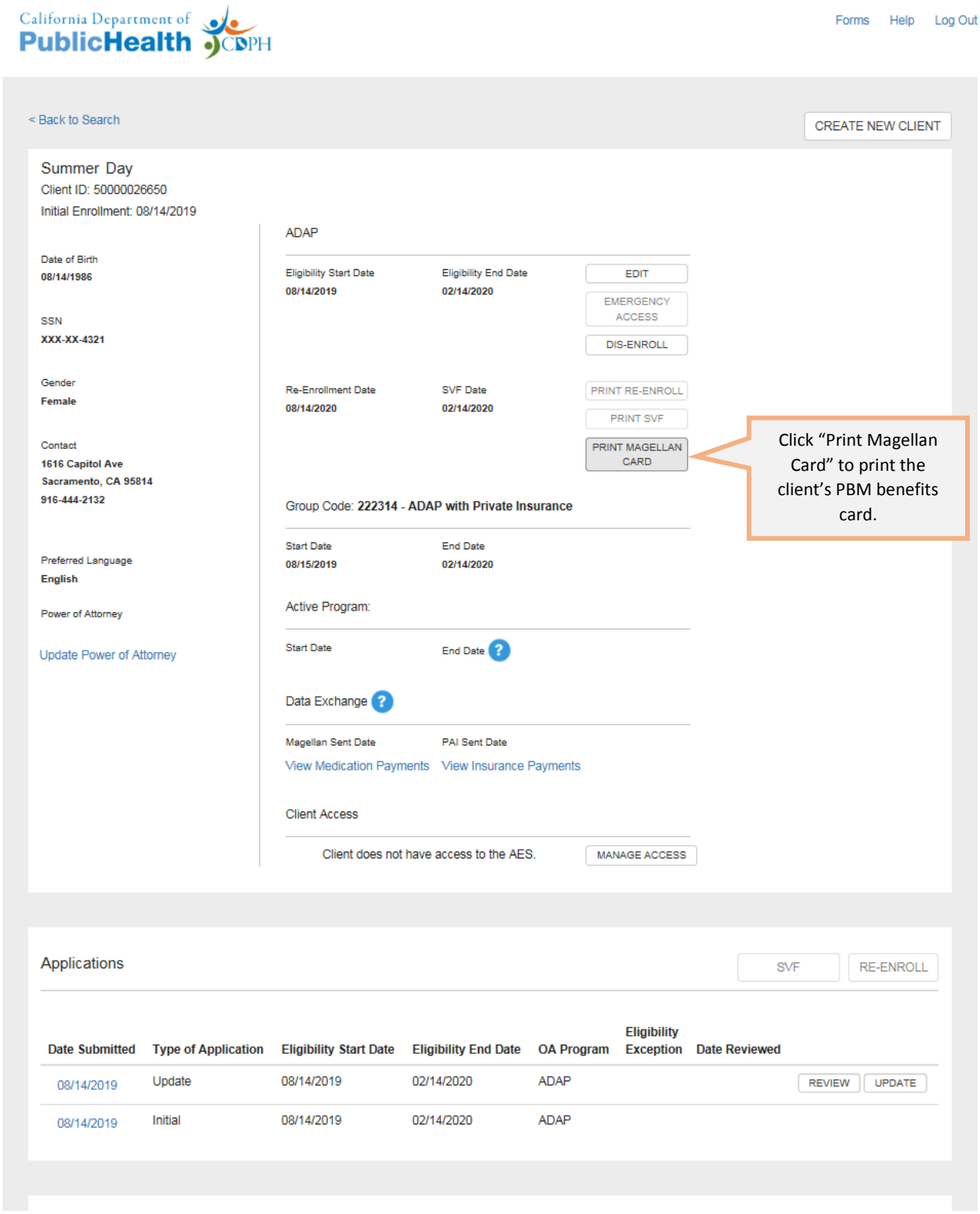
Please note:

1. Any payments prior to 7/1/2017 can NOT be viewed in the Medication tab.
2. The client's information on the Medical Tab will be updated on a weekly basis (Thursday evening). The client update will reflect all transactions that occurred from the previous Thursday-through-Wednesday.

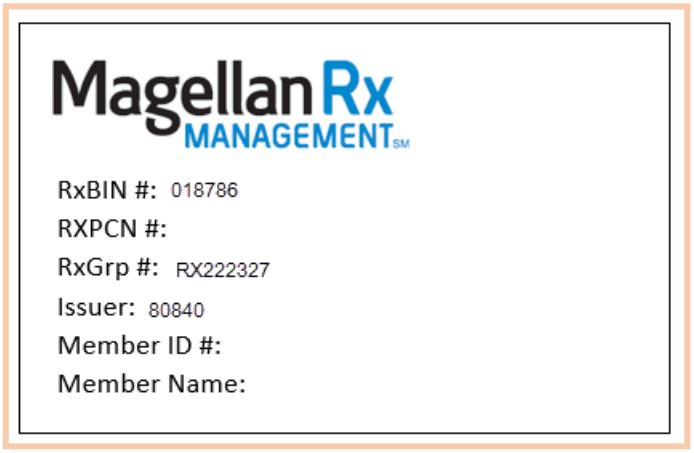
5. Print Magellan (PBM) and PAI (IBM & MBM) Benefits Cards for Clients.

Enrollment Workers and ADAP Staff can print Magellan Rx Card for clients enrolled in ADAP and can print PAI benefits cards for clients enrolled in an active Insurance Assistance Program.

Scenario 1: Navigate to the Client Profile screen to print the client's Magellan Card.



The Magellan Card will display the RXBin #, RXPCN #, RXGrp #, Issuer, Member ID number, and Mermber name. Magellen Cards will have standard Group numbers, BIN numbers, and Issuer. PCN numbers will vary according to the type of health coverage (Group Code) the client is enrolled in. The Magellan card can be printed manually and given to the client.

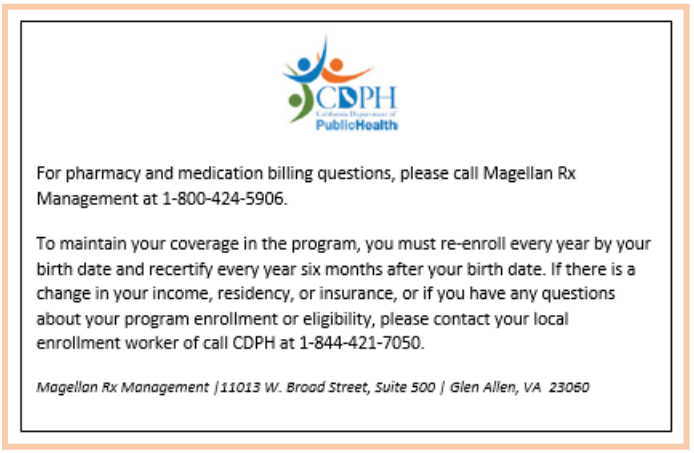


Verify the client's information is correct before printing the Magellan Card;

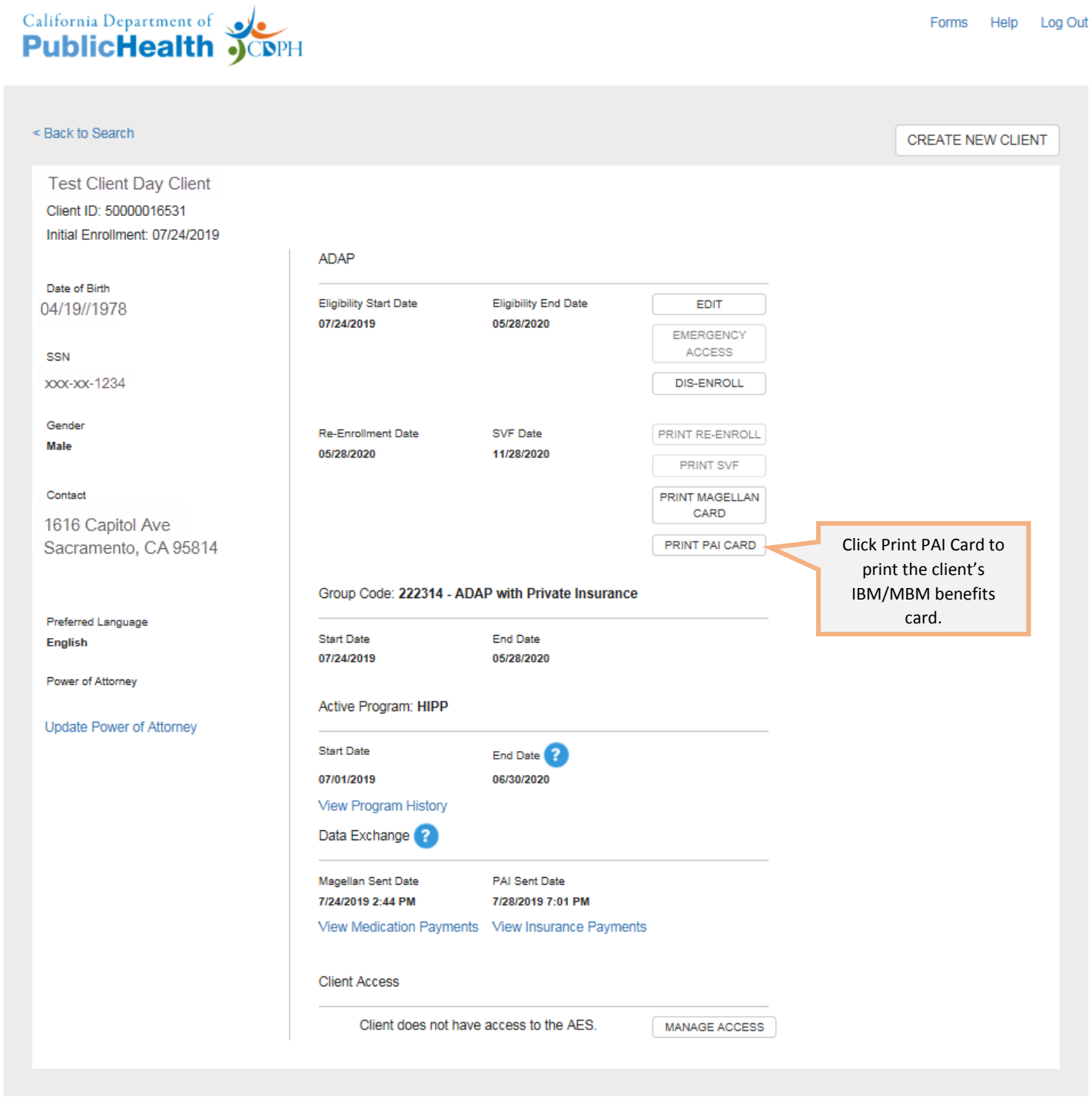
- Rx Group Number is always = RX222327
- Rx BIN Number is always = 018786
- Issuer is always = 80840

RX PCN # varies based on the following criteria:

- If Group Code is ADAP Only then PCN = RX222327
- If Group Code is ADAP with Medicare then PCN = TROOP
- If Group Code is ADAP with Medi-Cal then PCN = RX222327
- If Group Code is ADAP with Private Insurance then PCN = RX222327



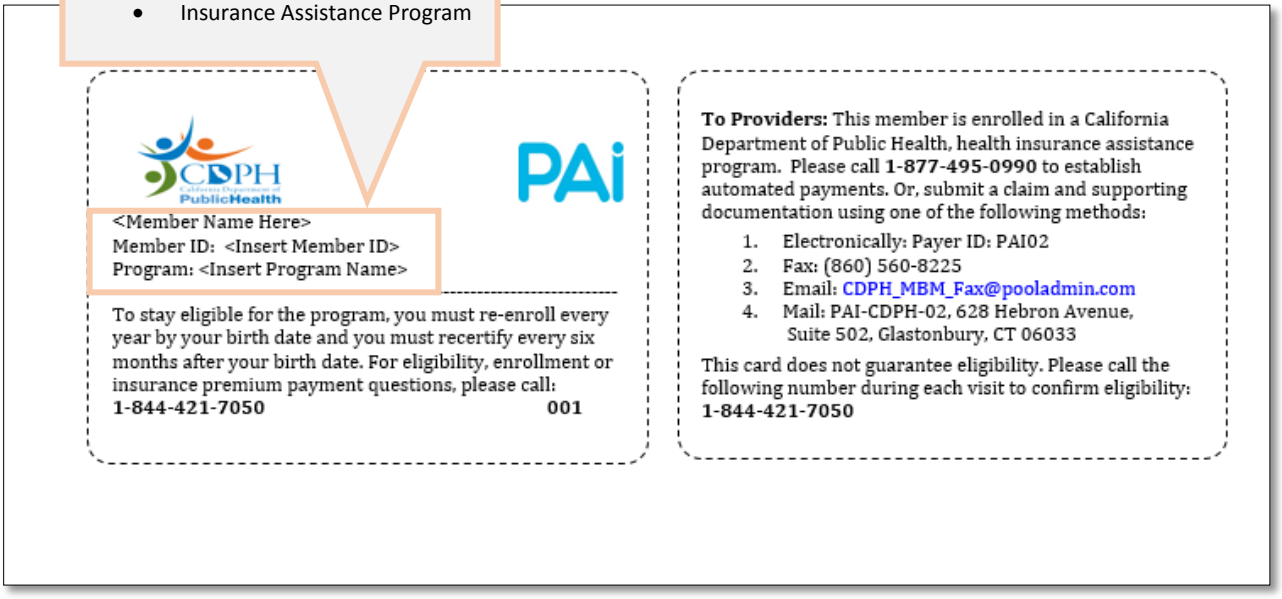
Scenario 2: Navigate to the Client Profile Screen to print the client's PAI Card.



The PAI Card will display the members name, member ID number, and the Insurance Assistance Program the client is enrolled in. The PAI card can be printed manually and given to the client.

Verify the information on the PAI card is correct before printing.

- Members Name
- Members ID number
- Insurance Assistance Program



6. Previous Changes

Release 7

1. IBM and MBM pages were deployed and accessible through the client profile page

Release 10-v3.0

1. Ability to view PBM payment information from the Client Profile page.
2. PBM page which displays client's medication payment information (i.e., date of service, day supply, refills remaining)