

THIS BOOKLET BELONGS TO: _____

CENTER: _____

ADDRESS: _____

CENTER MANAGER: _____

PHYSICIAN: _____

SOCIAL WORKER: _____

FOR 24-HOUR EMERGENCY SERVICES
ON-CALL PHYSICIAN TELEPHONE NUMBER
1-714-468-1100
EMERGENCY TELEPHONE NUMBER **911**

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY



MEMBER ENROLLMENT AGREEMENT

**TERMS AND CONDITIONS
EFFECTIVE MAY 1, 2021**

CALOPTIMA PACE HEALTH PLAN ADMINISTRATION

13300 GARDEN GROVE BLVD.

GARDEN GROVE, CA 92843

1-714-468-1100

TOLL-FREE: 1-855-785-2584

TTY: 1-714-468-1063

HOURS OF OPERATION:

MONDAY–FRIDAY 8 A.M.–4:30 P.M.

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ENCLOSURES:

Notice of Non-Discrimination Insert (Material ID: PACE_IR17_4)

CHAPTER 1 — WELCOME TO CALOPTIMA PACE

CalOptima PACE is a health care services plan designed just for people age 55 and older who have ongoing health care needs. We are very pleased to welcome you as a participant. Since we enroll only individuals, dependents are not covered when you enroll.

Please keep this booklet. Your signed copy of the CalOptima PACE Enrollment Agreement form, along with these terms and conditions, are your enrollment agreement, a legally binding contract between you and CalOptima PACE.

This document should be read carefully and in full. People with special health care needs should also be sure to read those sections that apply to them. You can find a Summary of Benefits and Coverage Table showing the major provisions of CalOptima PACE at the end of this chapter. CalOptima PACE has an agreement with the Centers for Medicare & Medicaid Services and the Department of Health Care Services (DHCS) that is renewed on a periodic basis. If the agreements are not renewed, the program will end.

To learn more about the benefits of CalOptima PACE, please contact us at **1-714-468-1100**.

In this agreement, CalOptima PACE may be called “we” and you may be called the “participant” or “member.” The term “participant” is most often used at CalOptima PACE. *Some of the terms used in this document may not be familiar to you. Please refer to the “Definitions” section in the back (Chapter 13) for explanations of the terms used.*

The goal of CalOptima PACE is to help you remain as independent as you can be and living in your own community and home. We offer a complete program of health and health-related services. We focus on preventive care to maintain your well-being.

One unique feature of CalOptima PACE is our personal approach to health care and services. We make sure that you and our health care staff know each other well, so we can work as one on your behalf. We do not replace the care of your family and friends. Rather, we work with you, your family and friends to give you the care you need. Your ideas and comments are always wanted and welcomed.

CalOptima PACE operates 24 hours a day, 7 days a week and 365 days a year. To treat the many chronic health care problems our participants’ face, our health care staff assess and evaluate changes. Our health care staff then provide timely support and encourage participants to help themselves.

Based on your needs, we provide medical, nursing and nutrition services, such as:

- Rehabilitation therapy
- In-home services and training

- Medicines
- Foot care
- Hearing
- Vision
- Dental
- Mental health services
- Any other service approved by the interdisciplinary team (IDT).

On an inpatient basis, we provide acute and skilled nursing care in contracted sites. *(See Chapter 4 for a more detailed description of covered benefits.)*

Please examine this Enrollment Agreement carefully. Enrollment in CalOptima PACE is up to you. If you decide not to enroll in our program, you may return the Enrollment Agreement to us without signing. If you do sign and enroll with us, your benefits under CalOptima PACE continue until you choose to disenroll from the program or you no longer meet the conditions of enrollment. *(See Chapter 10 for information on termination of benefits.)*

Upon signing and enrolling in CalOptima PACE, you will receive these items:

- A copy of the Enrollment Agreement
- A CalOptima PACE Membership Card
- A magnet with our emergency telephone numbers to post in your home

Summary of Benefits and Coverage Table

The following table is to help you compare coverage benefits and is a summary only. There are no co-payments for PACE services.

Please read this entire booklet, which is your Enrollment Agreement with CalOptima PACE. It gives you details on the coverage benefits and limitations.

Services must be either pre-approved or obtained only from doctors, hospitals, pharmacies and other health care providers who contract with CalOptima PACE.

Prior authorization is never required for emergency, preventive or sensitive services. *Please refer to Chapter 4, Benefits and Coverage.*

CATEGORY	SERVICES AND LIMITATIONS
Deductibles	None
Lifetime Maximums	None

CHAPTER 1 — Welcome to CalOptima PACE

CATEGORY	SERVICES AND LIMITATIONS
Professional Services	<ul style="list-style-type: none"> • Physician services, including primary care providers and medical specialists, routine physicals, preventive health care, sensitive services, outpatient surgical services and outpatient mental health • Basic dental coverage (routine preventive services, including exams, X-rays and cleanings). Cosmetic dentistry is not included. • Vision care. Prescription eyeglasses and corrective lenses after cataract surgery. • Audiology services. Hearing exams and hearing aids • Routine podiatry • Medical social services/case management • Rehabilitation therapy. Includes physical, occupational and speech therapies
Outpatient Services	Coverage for surgical services, mental health, diagnostic X-ray and laboratory service.
Hospitalization Services	Coverage for semi-private room and board and all medically necessary services, including general medical and nursing services, psychiatric services, operating room fees, diagnostic or therapeutic services, laboratory services, X-ray, dressings, casts, anesthesia, blood and blood products, drugs, and biologicals. Not covered are private rooms or private duty nursing, unless medically necessary, and non-medical items.
Emergency Health Coverage	Coverage for emergency services. CalOptima PACE does not cover emergency services outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.
Ambulance Services	Coverage for Ambulance Transportation.

CATEGORY	SERVICES AND LIMITATIONS
Prescription Drug Coverage	Coverage for medications when prescribed by a physician
Durable Medical Equipment	Provision of Durable Medical Equipment as necessary
Mental Health Services	Coverage of Mental Health Services as necessary
Chemical Dependency Services	Coverage of Chemical Dependency Services as necessary
Home Health Services	Coverage of Home Health Services as necessary
Other	<ul style="list-style-type: none"> • Medicare covered skilled nursing facility. Coverage provided for semi-private rooms only. • Home care services • Day center services (including nutrition, hot meals, escort and transportation) • Necessary materials, supplies and services for management of diabetes mellitus • End-of-life care

Please note: All services and benefits are determined through the plan of care (or treatment plan) at the discretion of the IDT.

Participants must receive all needed services, other than emergency care, from CalOptima PACE providers and will be personally responsible for any unauthorized or out-of-network services.

CHAPTER 2 — SPECIAL FEATURES OF CALOPTIMA PACE

Our health care services plan has several unique features:

1. Expertise in Caring

CalOptima PACE specializes in caring for older people with health problems. Our successful approach focuses on developing customized care plans addressing specific health and health-related issues for each participant. Our dedicated, highly skilled providers both plan and provide care, so the care you receive is comprehensive and coordinated.

2. The Interdisciplinary Team

Your care is planned and provided by a team of specialists working together with you. Your team includes a physician, possibly a nurse practitioner, registered nurses, a home care nurse, social workers, physical therapist, occupational therapist, a dietitian and others who assist you, such as health workers, home health aides and drivers of our vans. Each team member's special expertise is employed to assess your health care needs. Other staff may be called upon if necessary. Together, the team develops a plan of care just for you. Immediately upon your start with the program, you will be scheduled for an initial health assessment (IHA), which will assist in the development of your personal care plan.

In some cases, a designated primary care physician (PCP) in the community can be a part of the Interdisciplinary Team, with CalOptima PACE consent.

3. Facility

You will receive many of your health care services at our centers — where your team is. Your team will be located at one or more of the following addresses in Orange County:

PACE Center

13300 Garden Grove Blvd.
Garden Grove, CA 92843

Alternative Care Settings (ACS)

11391 Acacia Parkway
Garden Grove, CA 92840

1158 N. Knollwood Circle
Anaheim, CA 92801

1101 S. Grand Ave., Suite K-M
Santa Ana, CA 92705

24260 El Toro Road
Laguna Woods, CA 92637

9451 Indianapolis Ave.
Huntington Beach, CA 92646

We provide transportation for you to come to the center. How often you come to the center will depend upon your care plan.

CalOptima PACE offers you access to medical care through our physicians and center on a 24-hour basis, 365 days of the year.

Interpreter services will also be available for after-hours services at no cost to you.

4. Choice of Physicians and Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR HEALTH CARE MAY BE OBTAINED. Because care is provided at CalOptima PACE through an IDT, the primary care physician (PCP) you choose is a member of your IDT. You will also be assigned other providers for your team. Your PCP is responsible for all of your primary health care needs and, with the help of your IDT, arranges for other medical services that you may need.

Female participants have the option to seek gynecological physician services directly from a participating gynecologist.

When necessary, services are provided in your home, a hospital or nursing home. We have contracts with physician consultants (such as cardiologists, urologists and orthopedists), pharmacies, laboratories and X-ray services, as well as with hospitals and nursing homes. Should you need such care, your team will continue working with you to monitor these services, your health and your ongoing needs.

PACE PCPs are rewarded for providing the highest quality care through an incentive program that recognizes performance above the community health standard. Additional information about this program may be requested by contacting the PACE Director.

You have the right to request a change in PCP at any time. The request can be taken by a PACE staff member and communicated to your IDT for transition. The change in PCP will take effect the first of the month. On rare occasion, a requested PCP may be unavailable (e.g. a non-PACE provider or a provider's panel is full).

If you wish to have the names, locations and hours of our contracting hospitals, nursing homes and other providers, you may request this information from the center manager at

1-714-468-1100 or toll-free 1-855-785-2584. TTY users should call 1-714-468-1063.

5. Authorization and Management of Care

You will know each member of the team very well, for they will all work closely with you to help you remain as healthy and independent as possible. Before you can receive any service from CalOptima PACE, the IDT must approve the service. However, prior authorization is never required for emergency, preventive or sensitive services.

At least every 6 months — more frequently if you are having problems — your team assesses your needs and adjusts services if necessary. You and/or your family may request an assessment. If your situation changes, the IDT adjusts your services, based on your care plan assessment and other needs.

6. Medicare/Medi-Cal Relationship

The benefits under this Enrollment Agreement are made possible through an agreement CalOptima PACE has with Medicare (the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services) and Medi-Cal (California Department of Health Care Services [DHCS]). When you sign this Enrollment Agreement, you are agreeing to accept benefits from CalOptima PACE in place of the usual Medicare and Medi-Cal benefits. CalOptima PACE will provide services based on your needs — the same benefits to which you are entitled under Medicare and Medi-Cal, plus more.

For additional information concerning Medicare-covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides health insurance counseling for California senior citizens. Call the HICAP Toll-Free telephone number, **1-800-434-0222**, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

7. No Preset Limits to Care

CalOptima PACE has no preset limit to services. There are no limits or restrictions on the number of hospital or nursing home days that are covered if your CalOptima PACE PCP determines that they are medically necessary. Home care is authorized and provided to you on a frequency and duration based on the evaluation of your needs by the team's clinical experts.

8. “Lock-in” Provision

When you enroll with CalOptima PACE, we will be your sole service provider, and you agree to receive medical services *exclusively* from our organization, and if applicable the designated PCP in the community, except in the case of an emergency or for urgently needed services. You will have access to all the care you need through our staff or through arrangements that CalOptima PACE makes with contract providers, but **you will no longer be able to obtain services from other doctors or medical providers under the traditional fee-for-service Medicare and Medi-Cal system.** Enrollment in CalOptima

PACE results in disenrollment from any other Medicare or Medi-Cal prepayment plan or optional benefit.

Electing enrollment in other Medicare or Medicaid prepayment plans or optional benefits, including the hospice benefit, after enrolling in CalOptima PACE, is considered a voluntary disenrollment. If you are a Medicaid-only or private pay participant and become eligible for Medicare after enrollment in PACE, you will be disenrolled from PACE if you elect to obtain Medicare coverage other than from the participant's PACE organization. (Please note that any services you use before your enrollment will not be paid for by CalOptima PACE unless these are specifically authorized.)

CHAPTER 3 — ELIGIBILITY

You are eligible to enroll in CalOptima PACE if you:

- Reside in CalOptima PACE’s service area, which includes the following ZIP codes:

90620	92602	92624	92649	92672	92694	92801	92832	92866
90621	92603	92625	92651	92673	92701	92802	92833	92867
90623	92604	92626	92653	92675	92703	92804	92835	92868
90630	92606	92627	92655	92676	92704	92805	92840	92869
90631	92610	92629	92656	92677	92705	92806	92841	92870
90638	92612	92630	92657	92679	92706	92807	92843	92886
90680	92614	92637	92660	92683	92707	92808	92844	92887
90720	92617	92646	92661	92688	92708	92821	92845	
90740	92618	92647	92662	92691	92780	92823	92861	
90743	92620	92648	92663	92692	92782	92831	92865	

- Are 55 years of age or older.
- Require the state’s nursing facility level of care, as assessed by our IDT.
- Are able to live in the community without jeopardizing the health and safety of yourself and others.

You must also be:

- Certified by the DHCS’ Long-Term Care Division (LTCD) as meeting these level-of- care requirements. Because CalOptima PACE serves only older individuals who meet the state’s level-of-care requirements for coverage of nursing facility services, an outside review must confirm that your health situation, in fact, qualifies you for our care.
- The DHCS’ LTCD provides this review before you sign the CalOptima PACE Enrollment Agreement based on a review of the documents prepared by the members of the IDT who have assessed your health.

CHAPTER 4 — BENEFITS AND COVERAGE

Please see Chapter 5 to learn how to receive care if you have a medical emergency or other urgent need for care.

What Do I Do if I Need Care?

All you need to do is call your center as listed on the inside cover of this booklet at any time.

Our plan provides ready access to a whole array of professionals and health care services. Upon enrollment, you will be assigned a PCP, either at the center or, if applicable, your designated PCP in the community, where you will receive services.

All benefits are covered by CalOptima PACE and will be provided according to your needs as assessed by your IDT, in accordance with professionally recognized standards. If you would like more specific information about how we authorize or deny health care services, please request this from the social worker.

Benefits include:

Services in the Center and the Community

- Primary care clinic visits (with the CalOptima PACE physician, nurse practitioner and/or nurse). If applicable, your designated PCP in the community approved by CalOptima PACE.
- Routine physicals, and preventive health evaluations and care (including pap smears, mammograms, immunizations and all generally accepted cancer screening tests). These services do not require prior authorization.
- Sensitive services, which are services related to sexually transmitted diseases and HIV testing. These services do not require prior authorization.
- Consultation with medical specialists. When medically indicated, your PCP will initiate a referral to a specialist. Referrals will be processed in a timely manner and urgent requests will be expedited.
- Kidney dialysis
- Outpatient surgical services
- Outpatient mental health/chemical dependency services
- Medical social services/case management
- Health education and counseling
- Rehabilitation therapy (physical, occupational and speech)
- Personal care

CHAPTER 4 — Benefits and Coverage

- Recreational therapy
- Social and cultural activities (intergenerational, if applicable)
- Nutritional counseling and hot meals
- Transportation, including escort (transportation provided for PACE-related services, requests are managed by PACE staff and the transport team).
- Ambulance service
- X-rays
- Laboratory procedures
- Emergency coverage anywhere in the United States and its territories.
- Durable medical equipment
- Prosthetic and orthotic appliances
- Routine podiatry
- Prescribed drugs and medicines
- Vision care (prescription eyeglasses, corrective lenses after cataract surgery).
- Hearing exams and hearing aids
- Dental care from the CalOptima PACE dentist, with the goal of restoring oral function to a condition that will help maintain optimal nutritional and health status. Dental services include preventive care (initial and yearly examinations, radiographs, prophylaxis and oral hygiene instructions); basic care (fillings and extractions); and major care (treatment determined by the condition of the mouth, for example, the amount of remaining supporting bone, the participant's ability to comply with instruction, and the participant's motivation to pursue oral health care). Major care includes temporary crowns, full or partial dentures and root canals. Cosmetic dentistry is not included.
- Diagnosis and treatment of male erectile dysfunction provided that the care is from CalOptima PACE physician or a physician specialist under contract to CalOptima PACE, and that such care is deemed medically necessary to improve and maintain overall health. The plan does not cover treatment, including medication, devices and surgery, which are deemed harmful to the participant, for cosmetic or recreational purposes, or not medically necessary.
- Mastectomy, lumpectomy, lymph node dissection, prosthetic devices and reconstructive surgery.
- Necessary materials, supplies and services for the management of diabetes mellitus.

Home Services

- Home Care
 - Personal care (e.g., grooming, dressing, assistance in using the bathroom)
 - Homemaker/chore services
 - Rehabilitation maintenance
 - Evaluation of home environment
- Home Health
 - Skilled nursing services
 - Physician visits (at discretion of physician)
 - Medical social services
 - Home health aide service

Hospital Inpatient Care

- Semi-private room and board
- General medical and nursing services
- Psychiatric services
- Meals
- Prescribed drugs, medicines and biologicals
- Diagnostic or therapeutic items and services
- Laboratory tests, X-rays and other diagnostic procedures
- Medical/surgical, intensive care, coronary care unit, as necessary
- Kidney dialysis
- Dressings, casts, supplies
- Operating room and recovery room
- Oxygen and anesthesia
- Organ and bone marrow transplants (non-experimental and non-investigative)
- Use of appliances, such as a wheelchair
- Rehabilitation services, such as physical, occupational, speech and respiratory therapy
- Radiation therapy
- Blood, blood plasma, blood factors and blood derivatives
- Medical social services and discharge planning

CalOptima PACE **does not cover** private room and private duty nursing unless medically necessary, nor any non-medical items for which there is an additional charge, such as telephone charges or television rental.

Skilled Nursing Facility

- Semi-private room and board
- Physician and nursing services
- Custodial care
- All meals
- Personal care and assistance

- Prescribed drugs and biologicals
- Necessary medical supplies and appliances, such as a wheelchair
- Physical, occupational, speech and respiratory therapy
- Medical social services

End of Life Care

CalOptima PACE's comfort care program is available to care for the terminally ill. If needed, your PCP and other clinical experts on your IDT will work with you and your family to provide these services directly or through contracts with local hospice providers. If you want to receive the Medicare hospice benefit, you will need to disenroll from our program and enroll in a Medicare-certified hospice provider.

CHAPTER 5 — EMERGENCY SERVICES AND URGENT CARE

CalOptima PACE provides emergency care 24 hours a day, 7 days a week and 365 days a year. An **Emergency Medical Condition** means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Serious jeopardy to the health of the participant.
2. Serious impairment to bodily function.
3. Serious dysfunction of any bodily organ or part.

Emergency Services include inpatient or outpatient services furnished immediately in or outside the service area because of an Emergency Medical Condition.

Call “911” if you reasonably believe that you have an Emergency Medical Condition that requires an emergency response and/or ambulance transport services. Shock, unconsciousness, difficulty breathing, symptoms of a heart attack, severe pain or a serious fall are all examples of Emergency Medical Conditions that require an emergency response.

After you have used the “911” emergency response system, you or your family must notify CalOptima PACE as soon as reasonably possible in order to maximize the continuity of your medical care. CalOptima PACE physicians who are familiar with your medical history will work with the emergency service providers in following up with your care and transferring your care to a CalOptima PACE contracted provider when your medical condition is stabilized.

Preparing to Go Out of the CalOptima PACE Service Area

Before you leave the CalOptima PACE service area to go out of town, please notify your IDT through your CalOptima PACE social worker. Your social worker will explain what to do if you become ill while you are away from your CalOptima PACE physician. Make sure that you keep your CalOptima PACE membership card with you at all times, especially when traveling out of the service area. Your card identifies you as a CalOptima PACE participant and provides information to care providers (emergency rooms and hospitals) about your health care coverage and how to reach us, if necessary.

Emergencies and Urgent Care When You Are Out of the Service Area

CalOptima PACE covers both emergency services and urgent care when you are temporarily out of our service area but still in the United States or its territories. Urgent care includes inpatient or outpatient services that are necessary to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area.

CHAPTER 5 — Emergency Services and Urgent Care

If you use emergency services or urgent care when out of the service area (for example, ambulance or inpatient services), you must notify CalOptima PACE within 48 hours or as soon as reasonably possible. If you are hospitalized, we have the right to arrange a transfer when your medical condition is stabilized to a CalOptima PACE contracted hospital or another hospital designated by us. We may also transfer your care to a CalOptima PACE physician.

CalOptima PACE will pay for all medically necessary health care services provided to you that are necessary to maintain your stabilized condition up to the time that CalOptima PACE arranges your transfer or you are discharged.

CalOptima PACE must approve any routine medical services (i.e., medical services that do **not** constitute a medical emergency or other urgent need for care) when you are out of the service area. For authorization of any non-emergency, out-of-the-area services, you must call CalOptima PACE at **1-714-468-1100** or toll-free **1-855-785-2584** and speak with your nurse, social worker or PCP.

Reimbursement Provisions

If you have paid for emergency services or urgent care you received when you were outside our service area but still in the United States, CalOptima PACE will reimburse you. Request a receipt from the facility or physician involved at the time you pay. This receipt must show: the physician's name, your health problem, date of treatment and release, as well as charges. Please send a copy of this receipt to your CalOptima PACE social worker within 30 business days.

Please note that if you receive any medical care or covered services as described in this document outside of the United States, CalOptima PACE will not be responsible for the charges.

CHAPTER 6 — EXCLUSIONS AND LIMITATIONS ON BENEFITS

Please see Chapter 5 to learn how to receive care if you have a medical emergency or other urgent need for care. Except for emergency services and urgent care received outside our service area, and preventive and sensitive services, all care requires authorization in advance by the appropriate member of the IDT.

The following general and specific exclusions are in addition to any exclusions or limitations described in Chapter 4 for particular benefits.

Covered Benefits Do Not Include:

- Any service not authorized by the physician or other qualified decision maker on the IDT, even if it is listed as a covered benefit, except emergency, urgent, preventive, and sensitive services. If a CalOptima PACE provider requests prior approval to provide health care services and the IDT decision maker, director or medical director denies, defers or modifies the request, you will be notified in writing of the reason for this denial and given information on how to appeal this decision, in accordance with California and federal law.
- Prescription drugs and over-the-counter drugs not prescribed by a CalOptima PACE physician except when prescribed as part of emergency services or urgent care provided to you.
- Cosmetic surgery, unless the physician on your IDT determines that it is medically necessary for improved functioning of or to correct a malformed part of the body resulting from an accidental injury, trauma, infection, tumor or disease, or to restore and achieve symmetry after a mastectomy.
- Experimental or investigational medical, surgical or other health procedures not generally available.
- In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the IDT as part of your Plan of Care.
- Any services rendered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.
- The cost of labor and materials to modify your home environment, unless authorized by the occupational therapist and physician on your IDT.

CHAPTER 7 — YOUR RIGHTS AND RESPONSIBILITIES

At CalOptima PACE, we are dedicated to providing you with quality health care services so you may remain as independent as possible. Our staff is committed to treating each and every participant with dignity and respect and ensuring that all participants are involved in planning for their care and treatment.

As a CalOptima PACE participant, you have the following rights:

YOU HAVE THE RIGHT TO BE TREATED WITH RESPECT.

You have the right to be treated with dignity and respect at all times, have all of your care kept private, and receive compassionate, considerate care. You have the right to

- Receive your health care in an accessible manner and in a safe, clean environment.
- Be free from harm. Harm includes physical or mental abuse, neglect, excessive medications, physical punishment or being placed by yourself against your will, as well as any physical or chemical restraint used on you for discipline or convenience of staff that you do not need to treat your medical symptoms or prevent injury.
- Be free from hazardous procedures.
- Receive treatment and rehabilitation services designed to promote your functional ability to the optimal level and to encourage your independence.
- Receive care from professionally trained staff that has the education and experience to carry out the services for which they are responsible.
- Participate in a program of services and activities that promote positive attitudes on usefulness and capabilities and are designed to encourage learning, growth and awareness of constructive ways to develop your interests and talents.
- Self-determination within the day care setting, including the opportunity to:
 1. Participate in developing a plan for services
 2. Decide whether or not to participate in any given activity
 3. Be involved to the extent possible in program planning and operation.
- To be cared about in an atmosphere of sincere interest and concern in which needed support and services are provided.
- Be ensured of auditory and visual privacy during all health care examinations and treatment visits.
- Be encouraged and assisted to exercise your rights in CalOptima PACE.

- Receive assistance, if you need it, to use the Medicare and Medi-Cal complaint and appeal processes, and your civil and other legal rights.
- Be encouraged and helped in talking to CalOptima PACE staff about voicing your complaints and recommending changes in policies and services to CalOptima PACE staff and to outside representatives of your choice. There will be no restraint, interference, coercion, discrimination or reprisal by our staff if you do so.
- Use a telephone while at the CalOptima PACE Center, make and receive confidential calls and/or have such calls made, if necessary.
- Not have to do work or services for CalOptima PACE.

YOU HAVE A RIGHT TO PROTECTION AGAINST DISCRIMINATION.

Discrimination is against the law. Every company or agency that works with Medicare and Medi-Cal must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnic origin
- National origin
- Religion
- Age
- Sex
- Sexual orientation
- Mental or physical disability
- Source of payment for your health care (for example, Medicare or Medi-Cal)

As a participant of CalOptima PACE, you have the right to receive competent, considerate, respectful care from staff and contractors without regard to race, national/ethnic origin, religion, age, sex, sexual orientation, mental or physical disability, or source of payment for your health care.

If you think you have been discriminated against for any of these reasons, contact a staff member at CalOptima PACE to help you resolve your concerns.

If you have any questions, you can call the Office for Civil Rights toll-free at 1-800-368-1019. TTY users should call 1-800-537-7697.

YOU HAVE A RIGHT TO INFORMATION AND ASSISTANCE.

You have the right to receive accurate, easy to understand information and to have someone help you make informed health care decisions. You have the right to

- Have someone help you if you have a language or communication barrier in order that you can understand all information provided you.
- Have someone interpret all information given to you into your preferred language in a culturally competent manner, if your first language is not English and you cannot speak English well enough to understand the information being given to you.
- Have the Enrollment Agreement discussed fully and explained to you in a manner you understand.
- Receive marketing materials and CalOptima PACE Rights in English and any other frequently used language in your community. You can also receive these materials in braille or in an audio format, if necessary.
- Receive a written copy of your rights from CalOptima PACE. CalOptima PACE will post these rights in a public place in the CalOptima PACE Center where it is easy to read them.
- Be fully informed, in writing, of the services offered by CalOptima PACE. This includes telling you which services are provided by contractors instead of the CalOptima PACE staff. You will be given this information before you join CalOptima PACE, at the time you join and when there is a change in services.
- Review, with assistance if needed, the results of the most recent review of CalOptima PACE. Federal and State agencies review all PACE programs. You also have a right to review how CalOptima PACE plans to correct any problems that are found at inspection.
- You can request a copy of CalOptima PACE's non-proprietary clinical and administrative policies and procedures from the PACE Director. Requests are to be submitted in writing.

YOU HAVE A RIGHT TO A CHOICE OF PROVIDERS.

- You have the right to choose a health care provider within the CalOptima PACE network and to receive quality health care.
- Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.
- You have the right to have reasonable and timely access to specialists as indicated by your health condition and consistent with current clinical practice guidelines.

YOU HAVE A RIGHT TO ACCESS EMERGENCY SERVICES.

You have the right to receive emergency services when and where you need them without CalOptima PACE approval. A medical emergency is when you think your health is in serious danger — when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States.

YOU HAVE A RIGHT TO PARTICIPATE IN TREATMENT DECISIONS.

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right to:

- Have all treatment options explained to you in a language you understand, be fully informed of your health and functional status and how well you are doing and make health care decisions.
- Be informed of all treatment prescribed by the interdisciplinary team prior to being treated, when and how services will be provided, and the names and functions of people providing your care.
- Refuse treatment or medications. If you choose not to receive treatment, you must be told how this will affect your health.
- Be assured that decisions regarding your care will be made in an ethical manner.
- Be assured that you and your family will be educated about an illness affecting you so that you can help yourself, and your family can understand your illness and help you.
- Receive information on advance directives and have CalOptima PACE help you create an advance directive. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself.
- Participate in making and carrying out your plan of care, which will be designed to promote your functional ability to the highest level and encourage your independence. You can ask for your plan of care to be reviewed at any time. You also can request a reassessment by the interdisciplinary team at any time.
- Appeal any treatment decision made by CalOptima PACE or our contractors through our appeals process and request a State Hearing.
- Receive necessary care across all care settings, up to and including placement in a long-term care facility when PACE can no longer maintain you safely in the community through the support of PACE services.

CHAPTER 7 — Your Rights and Responsibilities

- Be given advance notice, in writing, of any plan to move you to another treatment setting, and the reason you are being moved.

YOU HAVE A RIGHT TO HAVE YOUR HEALTH INFORMATION KEPT PRIVATE.

You have the right to:

- Talk with health care providers in private and have your personal health care information kept private as protected under state and federal laws.
- Review and receive copies of your medical records and request amendments to those records.
- Be assured that all information contained in your health record will be held in confidence, including information contained in any automated data bank. CalOptima PACE will require your written consent for the release of information to persons not otherwise authorized under law to receive it. You may provide written consent, which limits the degree of information and the persons to whom information may be given.
- Be assured of confidentiality when accessing Sensitive Services such as Sexually Transmitted Disease (STD) and HIV testing.
- There is a new participant privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule, you may call the Office for Civil Rights toll-free at **1-800-368-1019**. TTY users should call **1-800-537-7697**.

YOU HAVE A RIGHT TO FILE A COMPLAINT.

You have a right to complain about the services you receive, or that you need and do not receive, about the quality of care, or any other concerns or problems you have with CalOptima PACE. You have the right to a fair and timely process for resolving concerns with CalOptima PACE. You have the right to:

- A full explanation of the complaint and appeals process.
- Assistance to exercise civil, legal and participant rights, including the CalOptima PACE grievance process, the Medi-Cal State Hearing process and the Medicare and Medi-Cal appeals processes.
- Contact 1-800-MEDICARE for information or to make a complaint.

- Be encouraged and helped to freely explain your complaints to CalOptima PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened or discriminated against.
- Appeal any treatment decision by CalOptima PACE, staff or contractors.

YOU HAVE A RIGHT TO LEAVE THE PROGRAM.

If for any reason you do not feel that CalOptima PACE is what you want, you have the right to leave the program at any time.

If you feel any of your rights have been violated, please report them immediately to your social worker or call our office during regular business hours at:

1-714-468-1100 or toll-free 1-855-785-2584

If you want to talk with someone outside of CalOptima PACE about your concerns, you may call:

1-800-MEDICARE (1-800-633-4227), or 1-888-452-8609 (Department of Health Care Services Office of the Ombudsman)

CHAPTER 8 — PARTICIPANT GRIEVANCE AND APPEALS PROCESS

All of us at CalOptima PACE share responsibility for your care and your satisfaction with the services you receive. Our grievance procedures are designed to enable you or your representative to express any concerns or dissatisfaction you have so that we can address them in a timely and efficient manner. You also have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services, or to pay for services that you believe we are required to pay.

The information in this chapter describes our grievance and appeals processes. You will receive written information about the grievance and appeals processes when you enroll and annually after that. If at any time you wish to file a grievance or an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because a grievance or appeal has been filed. CalOptima PACE will continue to provide you with all the required services during the grievance or appeals process. We will maintain the confidentiality of your grievance or appeal throughout the process, and information pertaining to your grievance or appeal will only be released to authorized individuals.

Grievance Procedure

Definition: A grievance is a complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of care. A grievance may include, but is not limited to:

- The quality of services a PACE participant receives in the home, at the PACE Center or during an inpatient stay (hospital, rehabilitation facility, skilled nursing facility, intermediate care facility or residential care facility);
- Waiting times on the telephone, in the waiting room or exam room;
- Behavior of any of the care providers or program staff;
- Adequacy of center facilities;
- Quality of the food provided;
- Transportation services; and
- A violation of a participant's rights.

Filing of Grievances

The information below describes the grievance process for you or your representative to follow should you or your representative wish to file a grievance.

1. You can verbally discuss your grievance either in person or by telephone with PACE

program staff of the center you attend. The staff person will make sure that you are provided with written information on the grievance process and that your grievance is documented on the Grievance Report form. You will need to provide complete information about your grievance so the appropriate staff person can help to resolve your grievance in a timely and efficient manner. If you wish to submit your grievance in writing, please send your written grievance to:

Quality Improvement Coordinator
CalOptima PACE
13300 Garden Grove Blvd.
Garden Grove, CA 92843

You may also contact our Quality Improvement Coordinator at **1-714-468-1100** or **toll-free at 1-855-785-2584** to request a Grievance Report form and receive assistance in filing a grievance. TTY users can call **1-714-468-1063**. Our Quality Improvement Coordinator will provide you with written information on the grievance process. You may also access our website at **www.caloptima.org** to receive information about the grievance process.

2. The staff member who receives your grievance will help you document your grievance (if your grievance is not already documented) and coordinate investigation and action. All information related to your grievance will be held in strict confidence .
3. You will be sent a written acknowledgement of receipt of your grievance within 5 calendar days. Investigation of your grievance will begin immediately to find solutions and take appropriate action.
4. The CalOptima PACE staff will make every attempt to resolve your grievance within 30 calendar days of receipt of your grievance, and you will receive a written letter with the resolution. If you are not satisfied with that resolution, you and/or your representative have the right to pursue further action.
5. In the event resolution is not reached within 30 calendar days, you or your representative will be notified in writing of the status and estimated completion date of the grievance solution.

Expedited Review of Grievances

If you feel your grievance involves a serious or imminent threat to your health, including, but not limited to, potential loss of life, limb or major bodily function; severe pain; or violation of your participant rights, we will expedite the review process to a decision within 72 hours of receiving your written grievance and request for expedition. In this case, you will be immediately informed by phone of: (a) the receipt of your request for expedited review, and (b) your right to notify the Department of Social Services of your grievance through the State Hearing process.

Resolution of Grievances

Upon CalOptima PACE completion of the investigation and reaching a final resolution of your grievance, you will receive written notification that will provide you with a written report describing the reason for your grievance, a summary of actions taken to resolve your grievance, and options to pursue if you are not satisfied with the resolution of your grievance.

Grievance Review Options

If after completing the grievance process or after participating in the process for at least 30 calendar days, you or your representative are still dissatisfied, you or representative may pursue the options described below. **Note:** If you feel that waiting 30 calendar days represents a serious health threat, you and/or your representative need not complete the entire grievance process nor wait 30 calendar days to pursue the options described below.

If you are covered by **Medi-Cal only or by Medi-Cal and Medicare**, you are entitled to pursue your grievance with the Department of Health Care Services by contacting or writing to:

Ombudsman Unit
Medi-Cal Managed Care Division
Department of Health Care Services
P.O. Box 997413, Mail Station
4412 Sacramento, CA 95899-7413
Telephone: 1-888-452-8609
TTY: 1-800-735-2922

State Hearing Process: At any time during the grievance process, per California State law, you may also request a State Hearing from the California Department of Social Services by contacting or writing to:

California Department of Social Services
State Hearing Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: 1-916-229-4410
TTY: 1-800-952-8349

If you want a State Hearing, you must ask for it within 90 days from the date of receiving the letter for resolved grievance. You or your representative may speak at the State Hearing or have someone else speak on your behalf, including a relative, friend or an attorney. You may also be able to get free legal help. You or your representative will be provided a list of Legal Services offices in Orange County at the time you file a grievance

Appeals Process

Definition: An appeal is a participant’s action taken with respect to CalOptima PACE’s decision not to cover or pay for a service, including denials, reductions or termination of services.

When CalOptima PACE decides not to cover or pay for a service you want, you may take action to change our decision. The action you take — whether verbally or in writing — is called an appeal. You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services, or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process when you enroll and annually after that. You will also receive this information and necessary appeals forms whenever CalOptima PACE denies, defers or modifies a request for a service or request for payment.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both are described below.

If you request a **standard appeal**, your appeal must be filed within 180 calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date that appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than 30 calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If you ask for one, we will automatically make a decision on your appeal as promptly as your health requires, but no later than 72 hours after we receive your request for an appeal. We may extend this time frame up to 14 days if you ask for the extension or if we justify to DHCS the need for more information and how the delay benefits you.

***Note:** CalOptima PACE will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and CalOptima PACE denies, defers or modifies the request, you may appeal the decision. A written “**Notice of Action of Service or Payment Request**” (NOA) will be provided to you and/or your representative, which will explain the reason for the denial, deferral or modification of your service request or request for payment.

2. You can make your appeal either verbally, in person, by telephone or in writing with PACE staff at the center you attend. The staff person will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information about your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing to us at the address listed below. If more information is needed, you will be contacted by the center manager or the Quality Improvement Department who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our center manager or Quality Improvement Department at **1-714-468-1100** from 8 a.m. to 4:30 p.m., Monday through Friday to request an appeal form and/or to receive assistance in filing an appeal. TTY users can call **1-714-468-1063**.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

Quality Improvement Department
CalOptima PACE
13300 Garden Grove Blvd.
Garden Grove, CA 92843

You will be sent a written acknowledgement of receipt of your appeal within 5 working days for a **standard appeal**. For an **expedited appeal**, we will notify you or your representative within 1 business day by telephone or in person that the request for an expedited appeal has been received.

5. The reconsideration of a CalOptima PACE decision will be made by a person(s) not involved in the initial decision-making process in consultation with the IDT. We will ensure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.
6. Upon CalOptima PACE's completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, CalOptima PACE will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on Your Appeal:

If we decide fully in your favor on a **standard appeal** for a request for **service**, we are required to provide or arrange for services as quickly as your health condition requires, but no later than 30 calendar days from when we received your request for an appeal. **If we decide**

fully in your favor on a request for **payment**, we are required to make the requested payment within 60 calendar days after receiving your request for an appeal.

*If we **DO NOT decide fully in your favor** on a **standard appeal**, or if we fail to provide you with a decision within 30 calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights below**). We also are required to notify you as soon as we make a decision and also to notify the Centers for Medicare & Medicaid Services and the Long-Term Care Division of DHCS. We will inform you in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.*

*If we **decide fully in your favor** on an **expedited appeal**, we are required to obtain the service or provide you the service as quickly as your health condition requires, but no later than 72 hours after we received your request for an **expedited appeal**.*

*If we **DO NOT decide fully in your favor** on an **expedited appeal**, or fail to notify you within 72 hours, you have the right to pursue an external appeal process under either Medicare or Medi-Cal (see **Additional Appeal Rights**). We are required to notify you as soon as we make a decision that is not fully in your favor and also to notify the Centers for Medicare & Medicaid Services and the Long-Term Care Division of DHCS. We will inform you in writing of your **external appeal** rights through the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.*

Additional Appeal Rights Under Medicare and Medi-Cal

If we do not decide in your favor on your appeal or fail to provide you a decision within the required time frame, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

Medicare contracts with an “**Independent Review Organization**” to provide external review on appeals involving PACE programs. This review organization is completely independent of CalOptima PACE.

Medi-Cal conducts its next level of appeal through the State Hearing process. If you are enrolled in Medi-Cal, you can appeal if CalOptima PACE wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, we will help you choose which appeals process you should follow. We also will send your appeal to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal processes are described below.

Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State Hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: 1-916-229-4410
TTY: 1-800-952-8349

If you choose to request a State Hearing, you must ask for it within 90 days from the date of receiving the Notice of Action (NOA) for service or Payment Request from CalOptima PACE.

You may speak at the State Hearing or have someone else speak on your behalf, such as someone you know, including a relative, friend or attorney. You may also be able to get free legal help. We will provide you with a list of Legal Services offices in Orange County at the time that we deny, modify or defer a service or payment of a service.

If the Administrative Law Judge (ALJ) rules in favor of your appeal, CalOptima PACE will follow the judge's instruction as to the time frame for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is not in your favor of your appeal, for either a standard or expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are **enrolled in both Medicare and Medi-Cal OR Medicare only**, and choose to appeal our decision using Medicare's external appeals process, we will send your appeal to the current contracted Medicare appeals entity to impartially review your appeal. The current contracted Medicare appeals entity will contact us with the results of their review. The current contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor.

The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14524-1302
Phone: 1-855-348-3300
Facsimile: 1-585-425-5292

Expedited and Standard Appeals Process

You can request an **expedited external appeal** if you believe your health would be jeopardized by not receiving a specific service. In an expedited external review, we will send your appeal to the current contracted Medicare appeals entity as quickly as your health requires. The current contracted Medicare appeals entity must give us a decision within 72 hours after they receive the appeal from us. The current contracted Medicare appeals entity may ask for more time to review the appeal, but they must give us their decision within 14 calendar days.

You can request a **standard external appeal** if we deny your request for non-urgent services or do not pay for a service. For a standard external appeal, you will receive a decision on your appeal no later than 30 calendar days after you request the appeal.

If the current contracted Medicare appeals entity's decision is **in your favor** for a standard appeal, and if you have requested a service that you have not received, we will provide you with the service you asked for as quickly as your health condition requires.

OR

If you have requested payment for a service that you have already received, we will pay for the service within 60 calendar days for either a standard or expedited appeal.

If the current contracted Medicare appeals entity's decision is **not in your favor** for either a standard or expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

For more information regarding the appeals process or to request forms, please call **1-714-468-1100**, 8 a.m. to 4:30 p.m., Monday through Friday or contact CalOptima PACE Quality Assurance Department at 13300 Garden Grove Blvd., Garden Grove, CA 92843. TTY users can call **1-714-468-1063**.

CHAPTER 9 — MONTHLY FEES

CalOptima PACE sets fees on an annual basis and has the right to change fees with a 30-day written notice.

Prepayment Fees

Your payment responsibility will depend upon your eligibility for Medicare, Medi-Cal and Medi-Cal's Medically Needy Only (MNO) programs:

1. If you are eligible for Medi-Cal or a combination of Medi-Cal and Medicare, you will pay nothing to CalOptima PACE for the benefits and services described in Chapter 4, including prescription drugs.
2. If you qualify for Medicare and Medi-Cal's Medically Needy Only (MNO) program, you are not liable for any premiums but will be responsible for paying your MNO share of cost.
3. If you are eligible only for Medicare, you will be charged a monthly premium. Because this premium does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage. This monthly premium may be reduced if you qualify for a low-income subsidy.
4. If you are not eligible for Medi-Cal or Medicare, you will be charged the full monthly premium. This premium will include the cost of prescription drugs.

Please refer to your signed Enrollment Agreement for the amount you will be charged. If you have a monthly responsibility for payment of a premium or prescription drug coverage, the enrollment representative will explain this to you. We will also discuss your payment with you at the enrollment conference and write the amount on your Enrollment Agreement before you are asked to sign it. If you are charged both premiums, you may pay them together or you may contact your social worker for additional payment options. We will notify you in writing of any change in your monthly premium at least 30 days before the change takes effect.

Your usual monthly Medicare Part B premium will continue to be deducted from your Social Security check.

Prescription Drug Coverage Late Enrollment Penalty

Please be aware that if you are eligible for Medicare prescription drug coverage and are enrolling in CalOptima PACE after going without Medicare prescription coverage or coverage that was as least as good as Medicare drug coverage for 63 or more consecutive days, you may have to pay a higher monthly amount for Medicare prescription drug coverage. Contact your CalOptima PACE social worker for more information about whether this applies to you.

If you are required to pay a monthly premium or a premium for prescription drug coverage, you will receive an invoice. You must pay this amount by the first day of the month after you sign the Enrollment Agreement and on the first day of each subsequent month. Payment may be made by check or money order to:

CalOptima
Attention: Accounting Department
505 City Parkway West
Orange, CA 92868

Late Charges

Monthly payments are due on the first day of each month. If you have not paid this premium by the 10th day of the month, you may be assessed a late fee of \$20, in accordance with applicable law. Late charges do not apply to participants with Medi-Cal coverage.

Termination for Non-Payment

If you pay a monthly premium, your monthly invoice will remind you that you are required to pay your monthly fee by the first day of each month. If you have not paid your monthly premium by the 10th day of the month, CalOptima PACE may terminate your coverage. If this occurs, CalOptima PACE will mail you a written Cancellation Notice on the 10th day of the month, informing you that your Enrollment Agreement will be terminated if you still have not paid the premium due (the monthly premium and late charge) by the cancellation date given in the Cancellation Notice. The cancellation date will be at least 20 days after CalOptima PACE mails you the Cancellation Notice. The Cancellation Notice will also inform you that, if you pay the required amount within a 30-day grace period after CalOptima PACE gives you the Cancellation Notice, you will be reinstated with no break in coverage. You are obligated to pay the premium for any month in which you use CalOptima PACE services. If your benefits are terminated and you wish to re-enroll, please refer to Chapters 10 and 11 regarding CalOptima PACE termination policy and renewal provisions.

Other Charges: None. There are no co-payments or deductibles for authorized services.

CHAPTER 10 — COVERAGE AND TERMINATION OF BENEFITS

Your enrollment in CalOptima PACE is effective the first day of the calendar month following the date you sign the Enrollment Agreement. For example, if you sign the Enrollment Agreement on March 14, your enrollment will be effective on April 1. Please note that you may not enroll in CalOptima PACE at a Social Security office.

- CalOptima PACE will complete the initial assessments and plan of care for you. The DHCS' LTCD will make the final determination of clinical eligibility. If you are determined eligible by DHCS' LTCD, CalOptima PACE will then initiate the enrollment process.
- If you are eligible for Medi-Cal, your official enrollment with DHCS as a CalOptima PACE participant is subject to a 15- to 45-day enrollment processing period after the date you sign the CalOptima PACE Enrollment Agreement.
- If you do not meet the financial eligibility requirements for Medi-Cal, you may pay privately for your care (see Chapter 9).

After signing the Enrollment Agreement, your benefits under CalOptima PACE continue indefinitely unless you choose to disenroll from the program (voluntary disenrollment) or you no longer meet the conditions of enrollment (involuntary disenrollment). The effective date of termination is the first day of the month that begins 30 days after the day the notice of disenrollment is received or sent by CalOptima PACE (except termination for failure to pay a required fee (see Chapter 9).

CalOptima PACE will work to transition you back into traditional Medi-Cal and/or Medicare services as quickly as possible. Medical records will be forwarded as requested and authorized by you or your representative and referrals to other resources in the community will be made to ensure continuity of care.

You are required to continue to use CalOptima PACE's services and to pay the monthly fee, if applicable, until termination becomes effective. If you should require care before your reinstatement occurs, CalOptima PACE will pay for the service to which you are entitled by Medicare or Medi-Cal.

Voluntary Disenrollment

If you wish to cancel your benefits by disenrolling, you should discuss this with your social worker. You may disenroll from CalOptima PACE without cause at any time. You will need to sign a Disenrollment Form. This form will indicate that you will no longer be entitled to services through CalOptima PACE effective the first day of the month following the date the PACE organization receives the participant's notice of voluntary disenrollment. Please note

that a participant may not enroll in CalOptima PACE, nor disenroll from CalOptima PACE at a Social Security office.

Involuntary Disenrollment

We may terminate your enrollment with CalOptima PACE if:

- You move out of the CalOptima PACE service area (see list of ZIP codes below) or are out of the service area for more than 30 days without prior approval (see Chapter 6).

90620	92602	92624	92649	92672	92694	92801	92832	92866
90621	92603	92625	92651	92673	92701	92802	92833	92867
90623	92604	92626	92653	92675	92703	92804	92835	92868
90630	92606	92627	92655	92676	92704	92805	92840	92869
90631	92610	92629	92656	92677	92705	92806	92841	92870
90638	92612	92630	92657	92679	92706	92807	92843	92886
90680	92614	92637	92660	92683	92707	92808	92844	92887
90720	92617	92646	92661	92688	92708	92821	92845	
90740	92618	92647	92662	92691	92780	92823	92861	
90743	92620	92648	92663	92692	92782	92831	92865	

- You or your caregiver engage in disruptive or threatening behavior, i.e., your behavior jeopardizes the health or safety of yourself or others, your caregiver’s behavior jeopardizes your health and safety, his or her safety, or the safety of others, or you consistently refuse to comply with the terms of your Plan of Care or Enrollment Agreement, when you have decision-making capacity. Disenrollment under these circumstances is subject to prior approval by DHCS and will be sought in the event that you display disruptive interference with care planning or threatening behavior that interferes with the quality of PACE services provided to you and other PACE participants.
- You are determined to no longer meet the Medi-Cal nursing home level of care criteria and are not deemed eligible.
- You fail to pay or fail to make satisfactory arrangements to pay any premium due to CalOptima PACE within the 30-day period specified in any Cancellation Notice.
- The agreement between CalOptima PACE, the Centers for Medicare & Medicaid Services and the DHCS is not renewed or is terminated.
- CalOptima PACE is unable to offer health care services due to the loss of our state licenses or contracts with outside providers.

All rights to benefits will stop effective first day of the next month that begins 30 days after the voluntary disenrollment notice is received by CalOptima PACE or the involuntary disenrollment notice is sent by CalOptima PACE, except in the case of termination due to failure to pay fees owed. (See Chapter 9). We will coordinate the disenrollment date between Medicare and Medi-Cal, if you are eligible for both programs.

CHAPTER 10 — Coverage and Termination of Benefits

You are required to use CalOptima PACE services (except for emergency services and urgent care provided outside our service area) until termination becomes effective.

During transition of health plans, our eligibility specialist will support and ensure appropriate transition of care. DHCS will be notified of such action.

If you are hospitalized or undergoing a course of treatment at the time your disenrollment becomes effective, CalOptima PACE has the responsibility for service provision until you are reinstated with Medicare and Medi-Cal benefits (according to your entitlement and eligibility).

CHAPTER 11 — RENEWAL PROVISIONS

Your coverage by CalOptima PACE is continuous indefinitely (with no need for renewal).

However, your coverage will be terminated if:

1. You fail to pay or fail to make satisfactory arrangements to pay any amount due CalOptima PACE after the 30-day grace period (see Chapter 9)
2. You voluntarily disenroll (see Chapter 10), or
3. You are involuntarily disenrolled due to one of the other conditions specified in Chapter 10.

If you choose to leave CalOptima PACE (disenroll voluntarily), you may be re-enrolled. To be re-enrolled, you must reapply, meet the eligibility requirements and complete our assessment process.

If you are disenrolled due to failure to pay the monthly fee (see Chapter 9), you can re-enroll simply by paying the monthly fee provided you make this payment before the end of the 30-day grace period (see Chapter 9). In this case, you will be reinstated with no break in coverage.

CHAPTER 12 — GENERAL PROVISIONS

Authorization to Obtain Medical Records

By accepting coverage under this Enrollment Agreement, you authorize CalOptima PACE to obtain and use your medical records and information from any and all health care facilities and providers who have treated you in the past. This will include information and records concerning treatment and care you received before the effective date of this Enrollment Agreement.

Access to your own medical record is permitted in accordance with California law. This information will be stored in a secure manner to protect your privacy and will be kept for the time period required by law.

Authorization to Take and Use Photographs

By accepting coverage under this Enrollment Agreement, you authorize CalOptima PACE to make and use photographs, video tapes, digital or other images for the purpose of medical care, identification, payment for services or internal operation of CalOptima PACE. Images will only be released or used outside CalOptima PACE upon your authorization.

Changes to Enrollment Agreement

Changes to this Enrollment Agreement may be made if they are approved by the Centers for Medicare & Medicaid Services and DHCS. We will give you at least a 30-day advance written notice of any such change, and you will be deemed to have contractually agreed to such change.

Confidentiality of Medical Records Policy

The personal and medical information collected by CalOptima PACE adheres to a confidentiality policy to prevent disclosure of your personal and medical information other than as needed for your care. You may request a copy of our confidentiality policy by calling your social worker at 1-714-468-1100.

Continuation of Services on Termination

If this Enrollment Agreement terminates for any reason, you will be reinstated back into the traditional Medicare and Medi-Cal programs, according to your eligibility. CalOptima PACE will work to transition you back into the traditional Medicare and/or Medi-Cal programs so your care is not jeopardized.

Cooperation in Assessments

So we can determine the best services for you, your full cooperation is required in providing medical and financial information to us.

Non-discrimination

CalOptima PACE shall not unlawfully discriminate against participants in the rendering of service on the basis of race, age, religion, color, national origin, ancestry, sex, marital status, sexual orientation or disability. CalOptima PACE shall not discriminate against participants in the provision of service on the basis of having or not having an Advance Health Care Directive.

Notices

Any notice that we give you under this Enrollment Agreement will be mailed to you at your address as it appears on our records. It is your responsibility to notify us promptly of any change to your address. When you give us any notice, please mail it to:

CalOptima PACE
Attn: Medical Records
13300 Garden Grove Blvd.
Garden Grove, CA 92843

Notice of Certain Events

If you may be materially and adversely affected, we shall give you reasonable notice of any termination, breach of Enrollment Agreement or inability to perform by hospitals, physicians or any other person with whom we have a contract to provide services. We will give you a 30-day written notice if we plan to terminate a contract with a medical group or individual practice association from whom you are receiving treatment. In addition, we will arrange for the provision of any interrupted service by another provider.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allow recipients of transplants to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your CalOptima PACE PCP. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization helps coordinate the donation.

Our Relationship to CalOptima PACE Providers

CalOptima PACE providers, other than CalOptima PACE staff, are independent organizations and are related to us by contract only. These providers are not our employees or agents. CalOptima PACE providers maintain a relationship with you and are solely responsible for any of their acts or omissions, including malpractice or negligence. Nothing in this Enrollment Agreement changes the obligation you have to any provider who renders care to you to abide by the rules, regulations and other policies established by the provider.

Participation in Public Policy of Plan

The Board of Directors of CalOptima PACE has a standing committee, known as the PACE Participant Advisory Committee (PPAC), which reports to the Board every quarter and advises the Board on issues related to the actions of CalOptima PACE and our staff to ensure participant comfort, dignity and convenience. The committee has 9 members, at least 5 of whom are participants enrolled in CalOptima PACE. In addition, at least 1 committee member is a CalOptima PACE Board member and at least 1 committee member is a provider. All members of the committee are appointed by the Board, but are nominated by the committee itself. The committee elects its own co-chairs, at least 1 of whom must be a participant. In addition to the PPAC, any material changes in our health care services plan are communicated to participants at least annually.

Payment for Services Under This Enrollment Agreement

Payment for services provided under this Enrollment Agreement will be made by CalOptima PACE to the provider. You cannot be required to pay anything that is owed by CalOptima PACE to the selected providers.

Payment for Unauthorized Services

You will be responsible to pay for unauthorized services, except for emergency services and urgent care. (See “Reimbursement Provisions” in Chapter 5.)

Recovery From Third Party Liability

If you are injured or suffer an ailment or disease due to an act or omission of a third-party giving rise to a claim of legal liability against the third party, CalOptima PACE must report such instances to DHCS. If you are a Medi-Cal beneficiary, any proceeds that you collect, pursuant to the injury, ailment or disease are assigned to DHCS.

Reduction of Benefits

We may not decrease in any manner the benefits stated in this Enrollment Agreement, except after a period of at least a 30-day written notice. The 30-day period will begin on the date postmarked on the envelope.

Reimbursement From Insurance

If you are covered by private or other insurance, including but not limited to motor vehicle, liability, health care or long-term care insurance, CalOptima PACE is authorized to seek reimbursement from that insurance if it covers your injury, illness or condition. (Instances of tort liability of a third party are excluded.) We will directly bill these insurers for the services and benefits we provide (and upon receipt of reimbursement, reduce any payment responsibility you may have to CalOptima PACE). You must cooperate and assist us by giving us information about your insurance and completing and signing all claim forms and other documents we need to bill the insurers. If you fail to do so, you, yourself, will have to make your full monthly payment. (See Chapter 9 for payment responsibility.)

Safety

To provide a safe environment, CalOptima PACE’s Safety Policy includes mandatory use of quick-release wheelchair seat belts for all participants while in transit, either in a vehicle or from one program area to another.

Second Opinion Policy

You may request a second medical opinion, as may others on your behalf, including your family, your PCP and the IDT. If you desire a second opinion, you should notify your PCP or nurse practitioner. CalOptima PACE will issue a decision on second opinions within 72 hours. The timeline is available upon request by calling **1-714-468-1100** or contacting:

CalOptima PACE
13300 Garden Grove Blvd.
Garden Grove, CA 92843

Tuberculosis Testing

A tuberculosis (TB) skin test(s) or chest X-ray is required upon enrollment. CalOptima PACE will provide treatment if the TB test is positive.

CHAPTER 13 — DEFINITIONS

Benefits and coverage are the health and health-related services we provide through this Enrollment Agreement. These services take the place of the benefits you would otherwise receive through Medicare and/or Medi-Cal. Their provision is made possible through an agreement between CalOptima PACE, Medicare (Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services) and Medi-Cal (Department of Health Care Services). This Enrollment Agreement gives you the same benefits you would receive under Medicare and Medi-Cal, plus many additional benefits. To receive any benefits under this Enrollment Agreement, you must meet the conditions described in this Enrollment Agreement.

Enrollment Agreement means the agreement between you and CalOptima PACE that establishes the terms and conditions and describes the benefits available to you. This Enrollment Agreement remains in effect until disenrollment and/or termination takes place.

Contracted provider means a health facility, health care professional or agency that has contracted with CalOptima PACE to provide health and health-related services to you.

Coverage decision means the approval or denial of health services by CalOptima PACE substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of our Enrollment Agreement with you.

Credentialed refers to the requirement that all practitioners (physicians, psychologists, dentists and podiatrists) who serve CalOptima PACE participants must undergo a formal process to confirm competence that includes thorough background checks to verify their education, training and experience.

Department of Health Care Services (DHCS) is the California department responsible for administration of the federal Medicaid program (referred to as Medi-Cal in California), California Children’s Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health-related programs.

Disputed health care service means any health care service eligible for payment under your Enrollment Agreement with CalOptima PACE that has been denied, modified or delayed by a decision of CalOptima PACE in whole or in part due to the finding that a service is not medically necessary. A decision regarding a “disputed health care service” relates to the practice of medicine and is not a coverage decision.

Eligible for nursing home care means that your health status, as evaluated by the CalOptima PACE Interdisciplinary Team, meets the State of California’s criteria for placement in either an

intermediate care facility (ICF) or a skilled nursing facility (SNF). CalOptima PACE’s goal, however, is to help you stay in the community as long as possible, even if you are eligible for nursing home care.

Emergency medical condition and emergency services are defined in Chapter 5.

Exclusion means any service or benefit that is not included in this Enrollment Agreement. For example, non-emergency services received without authorization from the CalOptima PACE’s Interdisciplinary Team of qualified clinical professionals are excluded from coverage. You would have to pay for any unauthorized services.

Experimental and investigational service means a service that is not seen as safe and effective treatment by generally accepted medical standards (even if it has been authorized by law for use in testing or other studies in humans); or has not been approved by the government to treat a condition.

Family means your spouse, significant other, children and relatives; the definition of “family” may also be expanded to include close friends or any other person you choose to involve in your care.

Health services include medical care, diagnostic tests, medical equipment, appliances, drugs, prosthetic and orthopedic devices, nutrition counseling, nursing, social services, therapies, dentistry, optometry, podiatry and audiology. Health services may be provided in a CalOptima PACE center or clinic, in your home, or in professional offices of contracted specialists or other providers, hospitals, or nursing homes under contract with CalOptima PACE.

Health-related services are those services that help CalOptima PACE provide health services and enable you to maintain your independence. Such services include personal care, homemaker/chore service, attendant care, recreational therapy, escorts, translation services, transportation, home-delivered meals and assistance with housing problems.

Home health care refers to two categories of services — supportive and skilled services. Based on individualized plans of care, supportive services are provided to participants in their homes and may include household services and related chores such as laundering, meal assistance, cleaning and shopping, as well as assistance with bathing and dressing as needed. Skilled services may be provided by the program’s social workers, nurses, occupational therapists and on-call medical staff.

Hospital services are those services generally and customarily provided by acute general hospitals.

Interdisciplinary Team (IDT) means CalOptima PACE’s team of service providers, facilitated by a program manager, and consisting of a primary care physician (PCP), registered

nurse(s), master's level social worker, personal care attendant, home care coordinator, driver, physical, recreational and occupational therapists, and a dietitian. Members of the IDT will assess your medical, functional and psychosocial status and develop a plan of care that identifies the services needed. Many of the services are provided and monitored by this team. All services you receive must be authorized by your physician or other qualified clinical professionals on the IDT. Periodic reassessment of your needs will be done by the team and changes in your treatment plan may occur.

Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease or condition is interrupted.

Medically necessary means medical or surgical treatments provided to a participant by a participating provider of the plan that are: (a) appropriate for the symptoms and diagnosis or treatment of a condition, illness or injury; (b) in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment; and (c) not for the convenience of a participant or a participating provider.

Monthly fee means the amount you must pay each month in advance to CalOptima PACE to receive benefits under this Enrollment Agreement.

Nursing home means a health facility licensed as either an intermediate care facility or a skilled nursing facility by DHCS.

Out-of-area is any area beyond CalOptima PACE's service area. (See below for definition of service area.)

PACE is the acronym for the **Program of All-Inclusive Care for the Elderly**. PACE is the comprehensive service plan that integrates acute and long-term care for older people with serious health problems. Payments for services are on a monthly capitation basis, combining both state and federal dollars through Medicare and Medi-Cal. Individuals not eligible for these programs pay privately. PACE arranges for participants to come to CalOptima PACE to receive individualized care from doctors, nurses and other health and social service providers. The goal is to help participants stay independent in the community for as long as safely possible.

CalOptima PACE physician is a doctor who is either employed by CalOptima PACE or has a contract with CalOptima PACE to provide medical services to participants.

Representative means a person who is acting on behalf of or assisting a PACE participant, and may include, but is not limited to a family member, a friend, a PACE employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, conservator, guardian, etc.

Sensitive services are those services related to sexually transmitted diseases (STDs) and HIV testing.

Service area means the geographical location that CalOptima PACE serves. This area includes ZIP codes:

90620	92602	92624	92649	92672	92694	92801	92832	92866
90621	92603	92625	92651	92673	92701	92802	92833	92867
90623	92604	92626	92653	92675	92703	92804	92835	92868
90630	92606	92627	92655	92676	92704	92805	92840	92869
90631	92610	92629	92656	92677	92705	92806	92841	92870
90638	92612	92630	92657	92679	92706	92807	92843	92886
90680	92614	92637	92660	92683	92707	92808	92844	92887
90720	92617	92646	92661	92688	92708	92821	92845	
90740	92618	92647	92662	92691	92780	92823	92861	
90743	92620	92648	92663	92692	92782	92831	92865	

Urgent care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (for example, sore throats, fever, minor lacerations and some broken bones). Urgent care includes inpatient or outpatient services from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area.

APPENDIX

This Appendix explains your rights to make health care decisions and how you can plan what should be done in the event that you cannot speak for yourself. A federal law requires us to give you this information. We hope this information will help increase your control over the medical treatment you receive.

Who Decides About My Treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You may say “Yes” to treatments you want. You may say “No” to treatments you don’t want. You are entitled to say “No” to a treatment you don’t want even if that treatment might keep you alive longer. If you have a conservator, you still may make your own health care decisions. This only changes if and when a judge decides that your conservator will also make your health care decisions on your behalf.

How Do I Know What I Want?

Your doctor must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects. Your doctor must offer you information about serious problems that medical treatment may cause.

Often, more than one treatment might help you — and people have different ideas about which is best. Your doctor can tell you which treatments are available to you and which treatments may be most effective for you. Your doctor can also discuss whether the benefits of treatment are likely to outweigh potential drawbacks. However, your doctor can’t choose for you. That choice depends on what is important to you.

What If I Am Too Sick To Decide?

If you are unable to make treatment decisions, your doctor will ask your closest available relative, friend or the person you have personally identified to the doctor as the one you want to speak for you to help decide what is best for you. That works most of the time. But sometimes everyone doesn’t agree about what you want to happen if you cannot speak for yourself. There are several ways you can prepare in advance for someone you choose to speak for you. Under California Law, these are called Advance Health Care Directives.

An Advance Health Care Directive lets you write down the name of the person you want to make health care decisions for you when you are unable to do so. This part of an Advance Health Care Directive is called a Durable Power of Attorney for Health Care. The person you choose is called the agent. There are Advance Health Care Directive forms you can use, or you can write down your own version as long as you follow a few basic guidelines.

Who Can Write An Advance Health Care Directive?

If you are 18 or older and of sound mind, you can. You do not need a lawyer to make or fill out an Advance Health Care Directive.

Who Can I Name To Make Medical Treatment Decisions When I'm Unable To Do So?

When you make your Advance Health Care Directive, you can choose an adult relative or friend you trust. That person will then be able to speak for you in the event that you're too sick to make your own decisions.

How Does This Person Know What I Would Want?

Talk to the family member or friend you are considering to be your agent about what you would want. Make sure they feel comfortable with your wishes and are able to carry them out on your behalf. You may write down your treatment wishes in the Advance Health Care Directive. You may include when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent. Take a copy with you when you go into a hospital or other treatment facility.

Sometimes treatment decisions are hard to make, and it truly helps your family and doctors if they know what you want. The Advance Health Care Directive also gives your health care team legal protection when they follow your decisions.

What If I Do Not Have Anybody To Make Decisions For Me?

If you do not want to choose someone, or do not have anybody to name as your agent, you may just write down your wishes about treatment. This is still an Advance Health Care Directive. There is a place on the standard form to write your wishes or you may write them on your own piece of paper. If you use the form, simply leave the Power of Attorney for Health Care section blank.

Writing down your wishes this way tells your doctor what to do in the event that you can no longer speak for yourself. You may write that you do not want any treatment that would only prolong your dying, or you may write that you do want life-prolonging care. You may provide more detail about the type and timing of the treatment you would want. (Whatever you write, you would still receive care to keep you comfortable.)

The doctor must follow your wishes about your treatment unless you have requested something illegal or against accepted medical standards. If your doctor does not want to follow your wishes for another reason, your doctor must turn your care over to another doctor who will follow your wishes. Your doctors are also legally protected when they follow your wishes.

May I Just Tell My Doctor Who I Want Making Decisions For Me?

Yes, as long as you personally tell your doctor the name of the person you want making these health care decisions. Your doctor will write what you said in your medical chart. The person you named will be called your “surrogate.” Your surrogate will be able to make decisions based on your treatment wishes, but only for 60 days or until your specific treatment is done.

What If I Change My Mind?

You may change your mind or revoke your Advance Health Care Directive at any time as long as you communicate your wishes.

Do I Have To Fill Out One Of These Forms?

No, you do not have to fill out forms if you do not want to. You may just talk to your doctors and ask them to write down in your medical chart what you have said, and you may talk with your family. But people will be clearer about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

Will I Still Be Treated If I Do Not Fill Out These Forms Or Do Not Talk To My Doctor About What I Want?

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make medical decisions, someone else will have to make them for you.

Remember that:

- A Durable Power of Attorney for Health Care lets you name someone to make treatment decisions for you. That person can make most medical decisions — not just those about life-sustaining treatment — when you can’t speak for yourself.
- If you do not have someone you want to name to make decisions when you cannot, you may also use an Advance Health Care Directive to just say when you would and would not want particular types of treatment.
- If you already have a “Living Will” or Durable Power of Attorney for Health Care, it is still legal and you do not need to make a new Advance Health Care Directive unless you wish to do so.