

Health Plan of San Joaquin



1-888-936-PLAN (7526), TTY 711
www.hpsj-mvhp.org

Community



Partnership



Wellness

**Health Plan Member Handbook-
Combined Evidence of Coverage
(EOC) and Disclosure Form 2024**

**Alpine, El Dorado, San Joaquin and
Stanislaus Counties**

DUALEOC2024E



Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. Health Plan provides written translations from qualified translators. Call Customer Service at 1-888-936-PLAN (7526) (TTY 711). The call is free. Read this Member Handbook to learn more about health care language assistance services such as interpreter and translation services.

Other formats

You can get this information in other formats such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call **Customer Service at 1-888-936-PLAN (7526) (TTY 711)**. The call is free.



Call member services at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

Interpreter services

Health Plan provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters unless it is an emergency. Interpreter, linguistic, and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this handbook in a different language, call 1-888-936-PLAN (7526) (TTY 711). The call is free.

English tagline

ATTENTION: If you need help in your language call **1-888-936-7526, TTY 711**. Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-888-936-7526, TTY 711**. These services are free.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1-888-936-7526, TTY 711**. تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1-888-936-7526, TTY 711**. هذه الخدمات مجانية.



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Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-888-936-7526, TTY 711**: Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-888-936-7526, TTY 711**: Այդ ծառայություններն անվճար են:

普通话标语 (Simplified Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 **1-888-936-7526 (TTY: 711)**。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 **1-888-936-7526 (TTY: 711)**。这些服务都是免费的

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1-888-936-7526, TTY 711**. ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ



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ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1-888-936-7526, TTY 711.**

ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-888-936-7526, TTY 711** पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-888-936-7526, TTY 711** पर कॉल करें। ये सेवाएं निः शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-888-936-7526, TTY 711**. Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-888-936-7526, TTY 711**. Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
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注意日本語での対応が必要な場合は **1-888-936-7526, TTY 711**へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。
1-888-936-7526, TTY 711へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-888-936-7526, TTY 711** 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-888-936-7526, TTY 711** 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1-888-936-7526, TTY 711**.

ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມິຕິເພີມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1-**



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ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih
qiemx longc mienh tengx faan benx meih nyei waac nor
douc waac daaih lorx taux **1-888-936-7526, TTY 711.** Liouh
lorx jauv-louc tengx aengx caux nzie gong bun taux ninh
mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-
pokc bun hluc mbiutc aengx caux aamz mborqv benx domh
sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-
888-936-7526, TTY 711.** Naaiv deix nzie weih gong-bou
jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh
oc.

(Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម
ទូរស័ព្ទទៅលេខ **1-888-936-7526, TTY 711**។ ជំនួយ និង
សេវាកម្ម សម្រាប់ ជនពិការ
ដូចជាឯកសារសរសេរជាអក្សរធំសម្រាប់ជនពិការភ្នែក
ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។
ទូរស័ព្ទមកលេខ **1- 888-936-7526, TTY 711**។



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សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-888-936-7526, TTY 711** تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-888-936-7526, TTY 711** تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-888-936-7256 (линия TTY 711)**. Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-888-936-7256 (линия TTY 711)**. Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-888-936-7526, TTY 711**. También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-888-936-7526, TTY 711**. Estos servicios son gratuitos.



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Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-888-936-7526, TTY 711**. Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-888-936-7526, TTY 711**. Libre ang mga serbisyong ito.

เท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-888-936-7526, TTY 711** นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-888-936-7526, TTY 711** ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-888-936-7526, TTY 711**. Люди з обмеженими можливостями також можуть



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скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1-888-936-7526, TTY 711**. Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-888-936-7526, TTY 711**. Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-888-936-7526, TTY 711**. Các dịch vụ này đều miễn phí.



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Welcome to Health Plan!

Thank you for joining Health Plan of San Joaquin/Mountain Valley Health Plan serving Members in San Joaquin, Stanislaus, Alpine and El Dorado counties, referred to as “Health Plan”. Health Plan is a health plan for people who have Medi-Cal. Health Plan works with the State of California to help you get the health care you need.

Member Handbook

This Member Handbook tells you about your coverage under Health Plan. Please read it carefully and completely. It will help you understand your benefits, the services available to you, and how to get the care you need. It also explains your rights and responsibilities as a member of Health Plan. If you have special health needs, be sure to read all sections that apply to you.

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. It is a summary of Health Plan’s rules and policies and is based on the contract between Health Plan and the Department of Health Care Services (DHCS). If you would like more information, call Health Plan at 1-888-936-PLAN (7526) (TTY 711).

In this Member Handbook, Health Plan is sometimes referred to as “we” or “us.” Members are sometimes called “you.” Some capitalized words have special meaning in this Member Handbook.

To ask for a copy of the contract between Health Plan and DHCS, call 1-888-936-PLAN (7526) (TTY 711). You may ask for another copy of the Member Handbook at no cost to you. You can also find the Member Handbook on the Health Plan’s website at www.hpsj-mvhp.org. You can also ask for a free copy of Health Plan’s non-proprietary clinical and administrative policies and procedures. They are also on the Health Plan’s website.

Contact us

Health Plan is here to help. If you have questions, call 1-888-936-PLAN (7526) (TTY



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Welcome to the Health Plan!

711). Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

You can also visit online at any time at www.hpsj-mvhp.org

Thank you,

Health Plan of San Joaquin/Mountain Valley Health Plan

7751 South Manthey Road

French Camp, CA 95231



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1. Getting started as a member

How to get help

Health Plan wants you to be happy with your health care. If you have questions or concerns about your care, Health Plan wants to hear from you!

Member services

Health Plan customer service is here to help you. Health Plan can:

- Answer questions about your health plan and Health Plan's covered services
- Help you choose or change a primary care provider (PCP)
- Tell you where to get the care you need.
- Help you get interpreter services if you do not speak English.
- Help you get information in other languages and formats.

If you need help, call 1-888-936-PLAN (7526) (TTY 711). Health Plan is here Monday – Friday 8:00 a.m. to 5:00 p.m. The call is free. Health Plan must make sure you wait less than 10 minutes when calling.

You can also visit Member Services online at any time at www.hpsj-mvhp.org.

Who can become a member

Every state may have a Medicaid program. In California, Medicaid is called **Medi-Cal**.

You qualify for Health Plan because you qualify for Medi-Cal and live in one of these counties: Alpine, El Dorado, San Joaquin or Stanislaus. You might also qualify for Medi-Cal through Social Security because you are getting SSI or SSP. Please contact Alpine County Health and Human Services at (530) 694-2235, El Dorado Health and Human Services Agency at (530) 621-6150, San Joaquin Human Services Agency at (209)



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468-1000, Stanislaus Community Service Agency at (209) 558-2500.

For questions about enrollment, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711). Or go to <http://www.healthcareoptions.dhcs.ca.gov/>.

For questions about Social Security, call the Social Security Administration at 1-800-772-1213. Or go to <https://www.ssa.gov/locator/>.

Transitional Medi-Cal

Transitional Medi-Cal is also called “Medi-Cal for working people.” You may be able to get Transitional Medi-Cal if you stop getting Medi-Cal because:

- You started earning more money, or
- Your family started getting more child or spousal support.

You can ask questions about qualifying for Transitional Medi-Cal at your local county health and human services office at:

<http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx>

Or call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

Identification (ID) cards

As a member of Health Plan, you will get our Health Plan ID card. You must show your Health Plan ID card **and** your Medi-Cal Benefits Identification Card (BIC) when you get health care services or prescriptions. Your BIC card is the Medi-Cal Benefits Card sent to you by the State of California. You should always carry all health cards with you. Your BIC and Health Plan Identification (ID) cards look like these:



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

1 | Getting started as a member



If you do not get your Health Plan ID card within a few weeks after your enrollment date, or if your card is damaged, lost, or stolen, call customer services right away. Health Plan will send you a new card at no cost to you. Call 1-888-936-PLAN (7526) (TTY 711).



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Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

2. About your health plan

Health plan overview

Health Plan is a health plan for people who have Medi-Cal in these counties: Alpine, El Dorado, San Joaquin, Stanislaus. Health Plan works with the State of California to help you get the health care you need.

Talk with one of Health Plan customer services representatives to learn more about the health plan and how to make it work for you. Call 1-888-936-PLAN (7526) (TTY 711).

When your coverage starts and ends

When you enroll in Health Plan, we will send your Health Plan Identification (ID) card within two weeks of your enrollment date. You must show both your Health Plan ID card and your Medi-Cal BIC when you get health care services or prescriptions.

Your Medi-Cal coverage will need renewing every year. If your local county office cannot renew your Medi-Cal coverage electronically, the county will send you a Medi-Cal renewal form. Complete this form and return it to your local county human services agency. You can return your information in person, by phone, online, by mail or by other electronic means available in your county.

You can end your Health Plan coverage and choose another health plan at any time. For help choosing a new plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711). Or go to www.healthcareoptions.dhcs.ca.gov. You can also ask to end your Medi-Cal.

Health Plan is a health plan for Medi-Cal members in Alpine, El Dorado, San Joaquin and Stanislaus counties. Find your local office at <http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx>.

Health Plan eligibility may end if any of the following is true:



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- You move out of Alpine, El Dorado, San Joaquin or Stanislaus counties.
- You no longer have Medi-Cal
- You become eligible for a waiver program that requires you to be enrolled in Fee-for-Service (FFS) Medi-Cal
- You are in jail or prison.

If you lose your Health Plan Medi-Cal coverage, you may still qualify for FFS Medi-Cal coverage. If you are not sure if you are still covered by Health Plan, call 1-888-936-PLAN (7526) (TTY 711).

Special considerations for American Indians in managed care

American Indians have a right to not enroll in a Medi-Cal managed care plan. Or, they may leave their Medi-Cal managed care plan and return to FFS Medi-Cal at any time and for any reason.

If you are an American Indian, you have the right to get health care services at an Indian Health Care Provider (IHCP). You can also stay with or disenroll (drop) from Health Plan while getting health care services from these locations. To learn more about enrollment and disenrollment, call 1-888-936-PLAN (7526) (TTY 711).

Health Plan must provide care coordination for you, including out-of-network case management. If you ask to get services from an IHCP and there is no available in-network IHCP, Health Plan must help you find an out-of-network IHCP. To learn more, read “Provider network” in Chapter 3 of this handbook.

How your plan works

Health Plan is a managed care health plan contracted with DHCS. Health Plan works with doctors, hospitals, and other health care providers in Health Plan service area to provide health care to our members. As a member of Health Plan, you may qualify for some services provided through FFS Medi-Cal. These include outpatient prescriptions, non-prescription drugs, and some medical supplies through Medi-Cal Rx.

Customer Service will tell you how Health Plan works, how to get the care you need, how to schedule provider appointments in during office hours, how to request no-cost interpreting and translation services or written information in alternative formats, and how to find out if you qualify for transportation services.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

To learn more, call 1-888-936-PLAN (7526) (TTY 711). You can also find customer service information online at www.hpsj-mvhp.org.

Changing health plans

You can leave Health Plan and join another health plan in your county of residence at any time. To choose a new plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711). You can call between 8 a.m. and 6 p.m. Monday through Friday. Or go to <https://www.healthcareoptions.dhcs.ca.gov>.

It takes up to 30 days or more to process your request to leave Health Plan and enroll in another plan in your county. To find out the status of your request, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

If you want to leave Health Plan sooner, you can call Health Care Options to ask for an expedited (fast) disenrollment.

Members who can request expedited disenrollment include, but are not limited to, children getting services under the Foster Care or Adoption Assistance programs, members with special health care needs, and members already enrolled in Medicare or another Medi-Cal or commercial managed care plan.

You can ask to leave Health Plan in person at your local county health and human services office. Find your local office at:

<http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx>.

Or call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

Students who move to a new county or out of California

You can get emergency care and urgent care anywhere in the United States, including the U.S. Territories. Routine and preventive care are covered only in your county of residence. If you are a student who moves to a new county in California to attend higher education, including college, Health Plan will cover emergency room and urgent care services in your new county. You can also get routine or preventive care in your new county, but you must notify your MCP. Read more below.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

If you are enrolled in Medi-Cal and are a student in a different county from the California county where you live, you do not need to apply for Medi-Cal in that county.

If you temporarily move away from home to be a student in another county in California, you have two choices. You can:

- Tell your eligibility worker at your local Medi-Cal office in Alpine, El Dorado, San Joaquin or Stanislaus that you are temporarily moving to attend a school for higher education and give them your address in the new county. The county will update the case records with your new address and county code. You must do this if you want to keep getting routine or preventive care while you live in a new county. If Health Plan does not serve the county where you will attend college, you might have to change health plans. For questions and to prevent delay joining the new health plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

Or

- If Health Plan does not serve the new county where you attend college, and you do not change your health plan to one that serves that county, you will only get emergency room and urgent care services for some conditions in the new county. To learn more, read Chapter 3, “How to get care.” For routine or preventive health care, you would need to use Health Plan network of providers located in the head of household’s county of residence.

If you are leaving California temporarily to be a student in another state and you want to keep your Medi-Cal coverage, contact your eligibility worker at your local Medi-Cal office in Alpine, El Dorado, San Joaquin, or Stanislaus. As long as you qualify, Medi-Cal will cover emergency services and urgent care in another state. If Health Plan approves the service and the doctor and hospital meet Medi-Cal rules, Medi-Cal will also cover emergency care that requires hospitalization in Canada and Mexico.

Routine and preventive care services, including prescription drugs, are not covered when you are outside of California. You will not qualify for Medi-Cal. Health Plan will not pay for your health care. If you want Medicaid in another state, you will need to apply in that state. Medi-Cal does not cover emergency, urgent, or any other health care services outside of the United States, except for Canada and Mexico as noted in Chapter 3.



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Continuity of care

Continuity of care for an out-of-network provider

As a member of Health Plan, you will get your health care from providers in Health Plan's network. To find out if a health care provider is in Health Plan's network, read the provider directory or use the search tool located at www.hpsj-mvhp.org. You can also request a printed provider directory by calling Customer Service at 1-888-936-PLAN (7526), (TTY 711). Providers not listed in the directory may not be in Health Plan's network.

In some cases, you might be able to get care from providers who are not in Health Plan's network. If you were required to change your health plan or to switch from FFS to managed care, or you had a provider who was in network but is now outside the network, you might be able to keep your provider even if they are not in Health Plan's network. This is called continuity of care.

If you need to get care from a provider who is outside the network, call Health Plan to ask for continuity of care. You may be able to get continuity of care for up to 12 months or more if all of these are true:

- You have an ongoing relationship with the out-of-network provider before enrollment in Health Plan
- You went to the out-of-network provider for a non-emergency visit at least once during the 12 months before your enrollment with Health Plan
- The out-of-network provider is willing to work with Health Plan and agrees to Health Plan's contract requirements and payment for services.
- The out-of-network provider meets Health Plan's professional standards.
- The out-of-network provider is enrolled and participating in the Medi-Cal program.

To learn more, call customer services at 1-888-936-PLAN (7526) (TTY 711).

If your providers do not join Health Plan network by the end of 12 months, do not agree to Health Plan's payment rates, or do not meet quality of care requirements, you will need to change to providers in Health Plan's network. To discuss your choices, call customer services at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is not required to provide continuity of care for an out-of-network provider



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for certain ancillary (supporting) services such as radiology, laboratory, dialysis centers, or transportation. You will get these services from a provider in Health Plan's network.

To learn more about continuity of care and if you qualify, call 1-888-936-PLAN (7526) (TTY 711).

Completion of covered services from an out-of-network provider

As a member of Health Plan, you will get covered services from providers in Health Plan's network. If you are being treated for certain health conditions at the time you enrolled with Health Plan or at the time your provider left Health Plan's network, you might also still be able to get Medi-Cal services from an out-of-network provider.

You might be able to continue care with an out-of-network provider for a specific time period if you need covered services for these health conditions:

Health condition	Time period
Acute conditions (a medical issue that needs fast attention)	For as long as your acute condition lasts
Serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time)	For an amount of time required to finish your course of treatment and to safely move you to a new doctor in Health Plan's network
Pregnancy and postpartum (after birth) care	During your pregnancy and up to 12 months after the end of pregnancy
Maternal mental health services	For up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later
Care of a newborn child between birth and 36 months old	For up to 12 months from the start date of the coverage or the date the provider's contract ends with Health Plan
Terminal illness (a life-threatening medical issue)	For as long as your illness lasts. You may still get services for more than 12 months from the date you enrolled with Health Plan or the time the provider stops working with Health Plan



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Performance of a surgery or other medical procedure from an out-of-network provider as long as it is covered, medically necessary, and authorized by Health Plan as part of a documented course of treatment and recommended and documented by the provider	The surgery or other medical procedure must take place within 180 days of the provider's contract termination date or 180 days from the effective date of your enrollment with Health Plan
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For other conditions that might qualify, call 1-888-936-PLAN (7526) (TTY 711).

If an out-of-network provider is not willing to keep providing services or does not agree to Health Plan's contract requirements, payment, or other terms for providing care, you will not be able to get continued care from the provider. You may be able to keep getting services from a different provider in Health Plan's network.

For help choosing a contracted provider to continue with your care or if you have questions or problems getting covered services from a provider who is no longer in Health Plan's network, call customer services at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is not required to provide continuity of care for services Medi-Cal does not cover or that are covered under Medi-Cal's contract with DHCS. To learn more about continuity of care, eligibility, and available services, call 1-888-936-PLAN (7526) (TTY 711).

Costs

Member costs

Health Plan serves people who qualify for Medi-Cal. In most cases, Health Plan members do **not** have to pay for covered services, premiums, or deductibles.

If you are an American Indian, you do not have to pay enrollment fees, premiums, deductibles, co-pays, cost sharing, or other similar charges for covered services. Health Plan must not charge any American Indian member who gets an item or service directly from an IHCP or through a referral to an IHCP or reduce payments due to an IHCP by the amount of any enrollment fee, premium, deductible, copayment, cost sharing, or similar charge.

Except for emergency care, urgent care, or sensitive care, you must get pre-approval (prior authorization) from Health Plan before you visit a provider outside Health Plan



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network. If you do not get pre-approval (prior authorization) and you go to a provider outside the network for care that is not emergency care, urgent care, or sensitive care, you might have to pay for care you got from that provider. For a list of covered services, read Chapter 4, “Benefits and services” in this handbook. You can also find the Provider Directory on the Health Plan’s website at www.hpsj-mvhp.org.

For members with long-term care and a share of cost

You might have to pay a share of cost each month for your long-term care services. The amount of your share of cost depends on your income and resources. Each month, you will pay your own health care bills, including but not limited to Long-Term Support Service (LTSS) bills, until the amount you have paid equals your share of cost. After that, Health Plan will cover your long-term care for that month. You will not be covered by Health Plan until you have paid your entire long-term care share of cost for the month.

How a provider gets paid

Health Plan pays providers in these ways:

- Capitation payments
 - Health Plan pays some providers a set amount of money every month for each Health Plan member. This is called a capitation payment. Health Plan and providers work together to decide on the payment amount.
- FFS payments
 - Some providers give care to Health Plan members and send Health Plan a bill for the services they provided. This is called an FFS payment. Health Plan and providers work together to decide how much each service costs.

To learn more about how Health Plan pays providers, call 1-888-936-PLAN (7526) (TTY 711).

If you get a bill from a health care provider

Covered services are health care services that Health Plan must pay. If you get a bill for support services fees, copayments, or registration fees for a covered service, do not pay the bill. Call customer services right away at 1-888-936-PLAN (7526) (TTY 711).

If you get a bill from a pharmacy for a prescription drug, supplies, or supplements, call Medi-Cal Rx Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week. TTY



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

users can call 711, Monday through Friday, 8 a.m. to 5 p.m. You can also go to the Medi-Cal Rx website at <https://medi-calrx.dhcs.ca.gov/home/>.

Asking Health Plan to pay you back for expenses

Covered services are health care services that Health Plan is responsible to pay for. If you get a bill for support services fees, copayments, or registration fees for a covered service, do not pay the bill. Call Customer Service right away at 1-888-936-PLAN (7526) (TTY 711).

If you paid for services that you already got, you might qualify to be reimbursed (paid back) if you meet **all** of these conditions:

- The service you got is a covered service that Health Plan is responsible for paying. Health Plan will not reimburse you for a service that Health Plan does not cover.
- You got the covered service after you became an eligible Health Plan member.
- You ask to be paid back within one year from the date you got the covered service.
- You show proof that you paid for the covered service, such as a detailed receipt from the provider.
- You got the covered service from a Medi-Cal enrolled provider in Health Plan's network. You do not need to meet this condition if you got emergency care, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval (prior authorization).
- If the covered service normally requires pre-approval (prior authorization), you need to give proof from the provider that shows a medical need for the covered service.

Health Plan will tell you if they will reimburse you in a letter called a Notice of Action (NOA). If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, Health Plan will pay you back for the full amount you paid. We must reimburse you within 45 working days of receipt of the claim.

If the provider is enrolled in Medi-Cal but is not in Health Plan network and refuses to pay you back, Health Plan will pay you back, but only up to the amount that FFS Medi-Cal would pay. Health Plan will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval (prior authorization). If



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you do not meet one of the above conditions, Health Plan will not pay you back.

Health Plan will not pay you back if:

- You asked for and got services that are not covered by Medi-Cal, such as cosmetic services.
- The service is not a covered service for Health Plan.
- You have an unmet Medi-Cal share of cost.
- You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- You have Medicare Part D co-pays for prescriptions covered by your Medicare Part D plan.



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Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

3. How to get care

Getting health care services

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

You can start getting health care services on your effective date of enrollment in Health Plan. Always carry with you your Health Plan Identification (ID) card, Medi-Cal Benefits Identification Card (BIC), and any other health insurance cards. Never let anyone else use your BIC or Health Plan ID card.

New members with only Medi-Cal coverage must choose a primary care provider (PCP) in Health Plan network. New members with both Medi-Cal and comprehensive other health coverage do not have to choose a PCP.

The Health Plan network is a group of doctors, hospitals, and other providers who work with Health Plan. You must choose a PCP within 30 days from the time you become a member of Health Plan. If you do not choose a PCP, Health Plan will choose one for you.

You can choose the same PCP or different PCPs for all family members in Health Plan, as long as the PCP is available.

If you have a doctor you want to keep, or you want to find a new PCP, go to the Provider Directory for a list of all PCPs and other providers in Health Plan network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call 1-888-936-PLAN (7526) (TTY 711). You can also find the Provider Directory on Health Plan's website at www.hpsj-mvhp.org.

If you cannot get the care you need from a participating provider in Health Plan network, your PCP or specialist in Health Plan's network must ask Health Plan for approval to send you to an out-of-network provider. This is called a referral. You do not need a referral to go to an out-of-network provider to get sensitive care services listed under the heading "Sensitive care" later in this chapter.

Read the rest of this chapter to learn more about PCPs, the Provider Directory, and the



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provider network.

The Medi-Cal Rx program administers outpatient prescription drug coverage. To learn more, read “Other Medi-Cal programs and services” in Chapter 4.

Primary care provider (PCP)

Your primary care provider (PCP) is the licensed provider you go to for most of your health care. Your PCP also helps you get other types of care you need. You must choose a PCP within 30 days of enrolling in Health Plan. Depending on your age and sex, you can choose a general practitioner, OB/GYN, family practitioner, internist, or pediatrician as your PCP.

A nurse practitioner (NP), physician assistant (PA), or certified nurse midwife can also act as your PCP. If you choose an NP, PA, or certified nurse midwife, you can be assigned a doctor to oversee your care. If you are in both Medicare and Medi-Cal, or if you also have other comprehensive health care insurance, you do not have to choose a PCP.

You can choose an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) as your PCP. Depending on the type of provider, you might be able to choose one PCP for yourself and your other family members who are members of Health Plan, as long as the PCP is available.

Note: American Indians can choose an IHCP as their PCP, even if the IHCP is not in Health Plan network.

If you do not choose a PCP within 30 days of enrollment, Health Plan will assign you to a PCP. If you are assigned to a PCP and want to change, call 1-888-936-PLAN (7526) (TTY 711). The change happens the first day of the next month.

Your PCP will:

- Get to know your health history and needs.
- Keep your health records.
- Give you the preventive and routine health care you need.
- Refer (send) you to a specialist if you need one.
- Arrange for hospital care if you need it.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

You can look in the Provider Directory to find a PCP in Health Plan network. The Provider Directory has a list of IHCPs, FQHCs, and RHCs that work with Health Plan.

You can find Health Plan Provider Directory online at www.hpsj-mvhp.org. Or you can request a Provider Directory to be mailed to you by calling 1-888-936-PLAN (7526) (TTY 711). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

You know your health care needs best, so it is best if you choose your PCP. It is best to stay with one PCP so they can get to know your health care needs. If you want to change to a new PCP, you can change anytime. You must choose a PCP who is in Health Plan provider network and is taking new patients.

Your new choice will become your PCP on the first day of the next month after you make the change.

To change your PCP, call 1-888-936-PLAN (7526) (TTY 711) or visit www.hpsj-mvhp.org to access the member portal.

Health Plan can change your PCP if the PCP is not taking new patients, has left Health Plan network, does not give care to patients your age, or if there are quality concerns with the PCP that are not resolved. Health Plan or your PCP might also ask you to change to a new PCP if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If Health Plan needs to change your PCP, Health Plan will tell you in writing.

If your PCP changes, you will get a letter in the mail. It will have the name of your new PCP. Call customer services if you have questions about getting a new ID card.

Some things to think about when picking a PCP:

- Does the PCP take care of children?
- Does the PCP work at a clinic I like to use?
- Is the PCP's office close to my home, work, or my children's school?
- Is the PCP's office near where I live and is it easy to get to the PCP's office?
- Do the doctors and staff speak my language?
- Does the PCP work with a hospital I like?
- Does the PCP provide the services I need?
- Do the PCP's office hours fit my schedule?



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- Does the PCP work with specialists I use?

Initial Health Appointment (IHA)

Health Plan recommends that, as a new member, you visit your new PCP within 120 days for an Initial Health Appointment (IHA). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP might ask you questions about your health history or may ask you to complete a questionnaire. Your PCP will also tell you about health education counseling and classes that can help you.

When you call to schedule your IHA appointment, tell the person who answers the phone that you are a member of Health Plan. Give your Health Plan ID number.

Take your BIC and Health Plan ID card to your appointment. It is a good idea to take a list of your medicine and questions with you to your visit. Be ready to talk with your PCP about your health care needs and concerns.

Be sure to call your PCP's office if you are going to be late or cannot go to your appointment.

If you have questions about IHA, call 1-888-936-PLAN (7526) (TTY 711).

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups, health education, and counseling.

Health Plan recommends that children, especially, get regular routine and preventive care. Health Plan members can get all recommended early preventive services recommended by the American Academy of Pediatrics and the Centers for Medicare and Medicaid Services. These screenings include hearing and vision screening, which can help ensure healthy development and learning. For a list of pediatrician-recommended services, read the "Bright Futures" guidelines from the American Academy of Pediatrics at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Routine care also includes care when you are sick. Health Plan covers routine care from your PCP.

Your PCP will:

- Give you most of your routine care, including regular checkups, shots, treatment, prescriptions, and medical advice.
- Keep your health records.



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Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- Refer (send) you to specialists if needed.
- Order X-rays, mammograms, or lab work if you need them.

When you need routine care, you will call your doctor for an appointment. Be sure to call your PCP before you get medical care unless it is an emergency. For an emergency, call **911** or go to the nearest emergency room.

To learn more about health care and services your plan covers, and what it does not cover, read Chapter 4, “Benefits and services” and Chapter 5, “Child and youth well care” in this handbook.

All Health Plan providers can use aids and services to communicate with people with disabilities. They can also communicate with you in another language or format. Tell your provider or Health Plan what you need.

Provider network

The Medi-Cal provider network is the group of doctors, hospitals, and other providers that work with Health Plan to provide Medi-Cal covered services to Medi-Cal members.

Health Plan is a managed care health plan. When you choose our Medi-Cal Plan, you are choosing to get your care through our medical care program. You must get most of your covered services through Health Plan from our in-network providers. You can go to an out-of-network provider without a referral or pre-approval for emergency care or for family planning services. You can also go to an out-of-network provider for out-of-area urgent care when you are in an area that we do not serve. You must have a referral or pre-approval for all other out-of-network services, or they will not be covered.

Note: American Indians can choose an IHCP as their PCP, even if the IHCP is not in Health Plan network.

If your PCP, hospital, or other provider has a moral objection to providing you with a covered service, such as family planning or abortion, call 1-888-936-PLAN (7526) (TTY 711). For more about moral objections, read “Moral objection” later in this chapter.

If your provider has a moral objection to giving you covered health care services, they can help you find another provider who will give you the services you need. Health Plan can also help you find a provider who will perform the service.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

In-network providers

You will use providers in Health Plan network for most of your health care needs. You will get preventive and routine care from in-network providers. You will also use specialists, hospitals, and other providers in Health Plan network.

To get a Provider Directory of in-network providers, call 1-888-936-PLAN (7526) (TTY 711). You can also find the Provider Directory online at www.hpsj-mvhp.org. To get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or go to the Medi-Cal Rx website at <https://medi-calrx.dhcs.ca.gov/home/>.

You must get pre-approval (prior authorization) from Health Plan before you go to a provider outside Health Plan network, including inside Health Plan's service area, except in these cases:

- If you need emergency care, call 911 or go to the nearest hospital.
- If you are outside Health Plan service area and need urgent care, go to any urgent care facility.
- If you need family planning services, go to any Medi-Cal provider without pre-approval (prior authorization).
- If you need mental health services, go to an in-network provider or a county mental health plan provider, without pre-approval (prior authorization).

If you are not in one of the cases listed above and you do not get pre-approval (prior authorization) before getting care from a provider outside the network, you might be responsible for paying for any care you got from out-of-network providers.

Out-of-network providers who are inside the service area

Out-of-network providers are health care providers that do not have an agreement to work with Health Plan. Except for emergency care, you might have to pay for any care you get from out-of-network providers. If you need medically necessary health care services that are not available in the network, you might be able to get them from an out-of-network provider at no cost to you.

Health Plan may approve a referral to an out-of-network provider if the services you need are not available in-network or are located very far from your home. If we give you a referral to an out-of-network provider, we will pay for your care.

For urgent care inside Health Plan's service area, you must go to a Health Plan in-network urgent care provider. You do not need pre-approval (prior authorization) to get urgent care from an in-network provider. You do need to get pre-approval (prior



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authorization) to get urgent care from an out-of-network provider inside Health Plan's service area.

If you get urgent care from an out-of-network provider inside Health Plan's service area, you might have to pay for that care. You can read more about emergency care, urgent care, and sensitive care services in this chapter.

Note: If you are an American Indian, you can get care at an IHCP outside of our provider network without a referral. An out-of-network IHCP can also refer American Indian members to an in-network provider without first requiring a referral from an in-network PCP.

If you need help with out-of-network services, call 1-888-936-PLAN (7526) (TTY 711).

Outside the service area

If you are outside of Health Plan's service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call 1-888-936-PLAN (7526) (TTY 711). The Health Plan's service area includes Alpine, El Dorado, San Joaquin and Stanislaus counties.

For emergency care, call **911** or go to the nearest emergency room. Health Plan covers out-of-network emergency care. If you travel to Canada or Mexico and need emergency care requiring hospitalization, Health Plan will cover your care. If you are traveling abroad outside of Canada or Mexico and need emergency care, urgent care, or any health care services Health Plan will **not** cover your care.

If you paid for emergency care requiring hospitalization in Canada or Mexico, you can ask Health Plan to pay you back. Health Plan will review your request.

If you are in another state or are in a US Territory such as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, or US Virgin Islands, you are covered for emergency care. Not all hospitals and doctors accept Medicaid. (Medi-Cal is what Medicaid is called in California only.) If you need emergency care outside of California, tell the hospital or emergency room doctor as soon as possible that you have Medi-Cal and are a member of Health Plan.

Ask the hospital to make copies of your Health Plan ID card. Tell the hospital and the doctors to bill Health Plan. If you get a bill for services you got in another state, call Health Plan right away. We will work with the hospital and/or doctor to arrange for Health Plan to pay for your care.

If you are outside of California and have an emergency need to fill outpatient



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Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

prescription drugs, have the pharmacy call Medi-Cal Rx at 1-800-977-2273.

Note: American Indians may get services at out-of-network IHCPs.

California Children's Services (CCS) Program is a state program that treats children under 21 years of age who have certain health conditions, diseases, or chronic health problems and meet the CCS program rules. If you need health care services for a CCS eligible medical condition and Health Plan does not have a CCS-paneled specialist in the network who can provide the care you need, you may be able to go to a provider outside of the provider network at no cost to you. To learn more about the CCS program, read Chapter 4, "Benefits and services" in this handbook.

If you have questions about out-of-network or out-of-service-area care, call 1-888-936-PLAN (7526) (711). If the office is closed and you want help from a representative, call 1-800-655-8294, (TTY 711).

If you need urgent care out of Health Plan's service area, go to the nearest urgent care facility. If you are traveling outside the United States and need urgent care, Health Plan will not cover your care. For more on urgent care, read "Urgent care" later in this chapter.

How managed care works

Health Plan is a managed care plan. Health Plan provides care to members who live or work in Alpine, El Dorado, San Joaquin, or Stanislaus Counties. In managed care, your PCP, specialists, clinic, hospital, and other providers work together to care for you.

Health Plan contracts with medical groups to provide care to the Health Plan's members. A medical group is made up of doctors who are PCPs and specialists. The medical group works with other providers such as laboratories and durable medical equipment suppliers. The medical group is also connected with a hospital. Check your Health Plan ID card for the names of your PCP, medical group, and hospital.

When you join Health Plan, you choose or are assigned to a PCP. Your PCP is part of a medical group. Your PCP and medical group direct the care for all of your medical needs. Your PCP may refer you to specialists or order lab tests and X-rays. If you need services that require pre-approval (prior authorization), Health Plan or your medical group will review the pre-approval (prior authorization) and decide whether to approve the service.

In most cases, you must go to specialists and other health professionals who work with the same medical group as your PCP. Except for emergencies, you must also get hospital care from the hospital connected with your medical group.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

Sometimes, you might need a service that is not available from a provider in the medical group. In that case, your PCP will refer you to a provider who is in another medical group or is outside the network. Your PCP will ask for pre-approval (prior authorization) for you to go to this provider.

In most cases, you must have prior authorization from your PCP, medical group, or Health Plan before you can go to an out-of-network provider or a provider who is not part of your medical group. You do not need pre-approval (prior authorization) for emergency services, family planning services, or in-network mental health services.

Doctors

You will choose a doctor from Health Plan's Provider Directory as your PCP. The doctor you choose must be an in-network provider. To get a copy of Health Plan's Provider Directory, call 1-888-936-PLAN (7526) (TTY 711). Or find it online at www.hpsj-mvhp.org.

If you are choosing a new PCP, you should also call the PCP you want to make sure they are taking new patients.

If you had a doctor before you were a member of Health Plan, and that doctor is not part of the Health Plan's network, you might be able to keep that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call 1-888-936-PLAN (7526) (TTY 711).

If you need a specialist, your PCP will refer you to a specialist in Health Plan's network. Some specialists do not require a referral. For more on referrals, read "Referrals" later in this chapter.

Remember, if you do not choose a PCP, Health Plan will choose one for you, unless you have other comprehensive health coverage in addition to Medi-Cal. You know your health care needs best, so it is best if you choose. If you are in both Medicare and Medi-Cal, or if you have other health care insurance, you do not have to choose a PCP from Health Plan.

If you want to change your PCP, you must choose a PCP from Health Plan's Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call 1-888-936-PLAN (7526) (TTY 711).

Hospitals

In an emergency, call **911** or go to the nearest hospital.

If it is not an emergency and you need hospital care, your PCP will decide which



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hospital you go to. You will need to go to a hospital that your PCP uses and is in Health Plan's provider network. The Provider Directory lists the hospitals in Health Plan's network.

Women's health specialists

You can go to a women's health specialist in Health Plan's network for covered care necessary to provide women's routine care services. You do not need a referral or authorization from your PCP to get these services. For help finding a women's health specialist, you can call 1-888-936-PLAN (7526) (TTY 711). You can also call the 24/7 advice nurse line at 1-800-655-8294, (TTY 711).

Provider Directory

Health Plan Provider Directory lists providers in Health Plan's network. The network is the group of providers that work with Health Plan.

Health Plan Provider Directory lists hospitals, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, FQHCs, outpatient mental health providers, managed long-term services and supports (MLTSS), Freestanding Birth Centers (FBCs), IHCPs, and RHCs.

The Provider Directory has Health Plan's in-network provider names, specialties, addresses, phone numbers, business hours, and languages spoken. It tells you if the provider is taking new patients. It also gives the physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars. To learn more about a doctor's education, training, and board certification, call 1-888-936-PLAN (7526) (TTY 711).

You can find the online Provider Directory at www.hpsj-mvhp.org.

If you need a printed Provider Directory, call 1-888-936-PLAN (7526) (TTY 711).

You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at <https://medi-calrx.dhcs.ca.gov/home/>. You can also find a pharmacy near you by calling Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711.

Timely access to care

Your in-network provider must provide timely access to care based on your health care needs. At minimum, they must offer you an appointment listed in the time frames in the table below.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

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Appointment type	You should be able to get an appointment within:
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent (routine) primary care appointments	10 business days
Non-urgent (routine) specialist care appointments	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days
Non-urgent (routine) mental health provider (non-doctor) follow-up care appointments	10 business days of last appointment
Non-urgent (routine) appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness, or other health condition	15 business days

Other wait time standards	You should be able to get connected within:
Member services telephone wait times during normal business hours	10 minutes
Telephone wait times for Nurse Advice Line	30 minutes (connected to nurse)

Sometimes waiting longer for an appointment is not a problem. Your provider might give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health. Also, if you prefer to wait for a later appointment that will better fit your schedule or go to another provider of your choice, your provider or your health plan should respect your wish.

Your doctor may recommend a specific schedule for preventive services, follow-up care for ongoing conditions or standing referrals to specialists, depending on your needs.



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Tell us if you need interpreter services when you call Health Plan or when you get covered services. Interpreter services, including sign language, are available at no cost to you. We highly discourage the use of minors or family members as interpreters. To learn more about interpreter services we offer, call 1-888-936-PLAN (7526) (TTY 711).

If you need interpreter services, including sign language, at a Medi-Cal Rx pharmacy, call Medi-Cal Rx Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week. TTY users can call 711, Monday through Friday, 8 a.m. to 5 p.m.

Travel time or distance to care

Health Plan must follow travel time or distance standards for your care. Those standards help make sure you can get care without having to travel too far from where you live. Travel time or distance standards depend on the county you live in.

If Health Plan is not able to provide care to you within these travel time or distance standards, DHCS may allow a different standard, called an alternative access standard. For Health Plan's time or distance standards for where you live, visit www.hpsj-mvhp.org. Or call 1-888-936-PLAN (7526) (TTY 711).

If you need care from a provider located far from where you live, call customer services at 1-888-936-PLAN (7526) (TTY 711). They can help you find care with a provider located closer to you. If Health Plan cannot find care for you from a closer provider, you can ask Health Plan to arrange transportation for you to go to your provider, even if that provider is located far from where you live.

If you need help with pharmacy providers, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711.

It is considered far if you cannot get to that provider within Health Plan's travel time or distance standards for your county, regardless of any alternative access standard Health Plan might use for your ZIP Code.

Appointments

When you need health care:

- Call your PCP.
- Have your Health Plan ID number ready on the call.
- Leave a message with your name and phone number if the office is closed.
- Take your BIC and Health Plan ID card to your appointment.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- Ask for transportation to your appointment, if needed
- Ask for needed language assistance or interpreting services before your appointment to have the services at the time of your visit.
- Be on time for your appointment, arrive a few minutes early to sign in, fill out forms, and answer any questions your PCP may have.
- Call right away if you cannot keep your appointment or will be late.
- Have your questions and medication information ready.

If you have an emergency, call **911** or go to the nearest emergency room. If you need help deciding how urgently you need care and your PCP is not available to speak with you, call the Nurse Advice Line at 1-800-655-8294, TTY/TDD 711.

Getting to your appointment

If you don't have a way to get to and from your appointments for covered services, Health Plan can help arrange transportation for you. Depending on your situation, you may qualify for either Medical Transportation or for Non-Medical Transportation. These transportation services are **not** for emergencies and may be available at no cost to you.

If you are having an emergency, call **911**. Transportation is available for services and appointments not related to emergency care. They may be available at no cost to you.

To learn more, read, "Transportation benefits for situations that are not emergencies" below.

Canceling and rescheduling

If you can't get to your appointment, call your provider's office right away. Most doctors require you to call 24 hours (1 business day) before your appointment if you have to cancel. If you miss repeated appointments, your doctor might stop providing care to you and you will have to find a new doctor.

Payment

You do **not** have to pay for covered services unless you have a share of cost for long-term care. To learn more, read "For members with long-term care and a share of cost" in Chapter 2. In most cases, you will not get a bill from a provider. You must show your Health Plan ID card and your Medi-Cal BIC when you get health care services or



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prescriptions, so your provider knows who to bill. You can get an Explanation of Benefits (EOB) or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call 1-888-936-PLAN (7526) (TTY 711). If you get a bill for prescriptions, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or visit the Medi-Cal Rx website at <https://medi-calrx.dhcs.ca.gov/home/>.

Tell Health Plan the amount you are being charged, the date of service, and the reason for the bill. You do not need to pay providers for any amount owed by Health Plan for any covered service. You must get pre-approval (prior authorization) from Health Plan before you visit an out-of-network provider except when:

- You need emergency services, in which case dial 911 or go to the nearest hospital.
- You need family planning services or services related to testing for sexually transmitted infections, in which case you can go to any Medi-Cal provider without pre-approval (prior authorization)
- You need mental health services; in which case you can go to an in-network provider or to a county mental health plan provider without pre-approval (prior authorization)

If you get care from an out-of-network provider and you did not get pre-approval (prior authorization) from Health Plan, you might have to pay for the care you got. If you need to get medically necessary care from an out-of-network provider because it is not available in Health Plan's network, you will not have to pay as long as the care is a Medi-Cal covered service and you got pre-approval (prior authorization) from Health Plan for it. To learn more about emergency care, urgent care, and sensitive services, go to those headings in this chapter.

If you get a bill or are asked to pay a co-pay you don't think you have to pay, call 1-888-936-PLAN (7526) (TTY 711). If you pay the bill, you can file a claim form with Health Plan. You will need to tell Health Plan in writing why you had to pay for the item or service. Health Plan will read your claim and decide if you can get money back.

For questions call 1-888-936-PLAN (7526) (TTY 711).

If you get services in the Veterans Affairs system or get non-covered or unauthorized services outside of California, you might be responsible for payment.

Health Plan will not pay you back if:

- The services are not covered by Medi-Cal such as cosmetic services.
- You have an unmet Medi-Cal share of cost.



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- You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- You asked to be paid back for co-pays for prescriptions covered by your Medicare Part D plan.

Referrals

If you need a specialist for your care, your PCP or another specialist will give you a referral to one. A specialist is a provider who focuses on one type of health care service. The doctor who refers you will work with you to choose a specialist. To help make sure you can go to a specialist in a timely way, DHCS sets time frames for members to get appointments. These time frames are listed in “Timely access to care” in this handbook. Your PCP’s office can help you set up an appointment with a specialist.

Other services that might need a referral include in-office procedures, X-rays, and lab work.

Your PCP might give you a form to take to the specialist. The specialist will fill out the form and send it back to your PCP. The specialist will treat you for as long as they think you need treatment.

If you have a health problem that needs special medical care for a long time, you might need a standing referral. This means you can go to the same specialist more than once without getting a referral each time.

If you have trouble getting a standing referral or want a copy of Health Plan referral policy, call 1-888-936-PLAN (7526) (TTY 711).

You do **not** need a referral for:

- PCP visits
- Obstetrics/Gynecology (OB/GYN) visits
- Urgent or emergency care visits
- Adult sensitive services, such as sexual assault care
- Family planning services (to learn more, call the Office of Family Planning Information and Referral Service at 1-800-942-1054)
- HIV testing and counseling (12 years or older)
- Sexually transmitted infection services (12 years or older)
- Chiropractic services (a referral may be required when provided by out-of-network FQHCs, RHCs, and IHCPs)



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

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Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- Initial mental health assessment
- Podiatry
- Eligible dental services

Minors can also get certain outpatient mental health services, sensitive services, and substance use disorder services without parent's consent. To learn more, read "Minor consent services" in this chapter and "substance use disorder treatment services" in Chapter 4 of this handbook.

California Cancer Equity Act referrals

Effective treatment of complex cancers depends on many factors. These include getting the right diagnosis and getting timely treatment from cancer experts. If you are diagnosed with a complex cancer, the new California Cancer Care Equity Act allows you to ask for a referral from your doctor to get cancer treatment from an in-network National Cancer Institute (NCI)-designated cancer center, NCI Community Oncology Research Program (NCORP)-affiliated site, or a qualifying academic cancer center.

If Health Plan does not have an in-network NCI-designated cancer center, Health Plan will allow you to ask for a referral to get cancer treatment from one of these out-of-network centers in California, if one of the out-of-network centers and Health Plan agree on payment, unless you choose a different cancer treatment provider.

If you have been diagnosed with cancer, contact Health Plan to find out if you qualify for services from one of these cancer centers.

Ready to quit smoking? To learn about services in English, call 1-800-300-8086. For Spanish, call 1-800-600-8191.

To learn more, go to www.kickitca.org.

Pre-approval (prior authorization)

For some types of care, your PCP or specialist will need to ask Health Plan for permission before you get the care. This is called asking for pre-approval or prior authorization. It means Health Plan must make sure the care is medically necessary



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(needed).

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under age 21, Medi-Cal services include care that is medically necessary to fix or help relieve a physical or mental illness or condition.

The following services always need pre-approval (prior authorization), even if you get them from a provider in Health Plan's network:

- Hospitalization, if not an emergency.
- Services out of Health Plan's service area, if not an emergency or urgent care.
- Outpatient surgery.
- Long-term care or skilled nursing services at a nursing facility.
- Specialized treatments, imaging, testing, and procedures.
- Medical transportation services when it is not an emergency.

Emergency ambulance services do not require pre-approval (prior authorization).

Under Health and Safety Code Section 1367.01(h)(1), Health Plan has 5 business days from when Health Plan gets the information reasonably needed to decide (approve or deny) pre-approval (prior authorization) requests. For requests a provider made or when Health Plan finds that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, Health Plan will make an expedited (fast) pre-approval (prior authorization) decision.

Health Plan will give you notice as quickly as your health condition requires and no later than 72 hours after getting the request for services.

Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

Health Plan does not influence the reviewers' decision to deny or approve coverage or services in any way. If Health Plan does not approve the request, Health Plan will send you a Notice of Action (NOA) letter. The NOA will tell you how to file an appeal if you do not agree with the decision.

Health Plan will contact you if Health Plan needs more information or more time to review your request.

You never need pre-approval (prior authorization) for emergency care, even if it is out of the network or out of your service area. This includes labor and delivery if you are



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pregnant. You do not need pre-approval (prior authorization) for certain sensitive care services. To learn more about sensitive care services, read “Sensitive care” later in this chapter.

For questions about pre-approval (prior authorization), call 1-888-936-PLAN (7526) (TTY 711).

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you might want a second opinion if you want to make sure your diagnosis is correct, you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan and it has not worked.

If you want to get a second opinion, we will refer you to a qualified in-network provider who can give you a second opinion. For help choosing a provider, call 1-888-936-PLAN (7526) (TTY 711).

Health Plan will pay for a second opinion if you or your in-network provider asks for it, and you get the second opinion from an in-network provider. You do not need pre-approval (prior authorization) from Health Plan to get a second opinion from an in-network provider. Your in-network provider can help you get a referral for a second opinion if you need one.

If there is no provider in Health Plan’s network who can give you a second opinion, Health Plan will pay for a second opinion from an out-of-network provider. Health Plan will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic, severe, or serious illness, or have an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, Health Plan will tell you in writing within 72 hours.

If Health Plan denies your request for a second opinion, you can file a grievance. To learn more about grievances, read “Complaints” in Chapter 6 of this handbook.

Sensitive care

Minor consent services

If you are under age 18, you can get some services without a parent’s or guardian’s



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permission. These services are called minor consent services.

You may get these services without your parent or guardian's permission:

- Sexual assault services, including outpatient mental health care.
- Pregnancy
- Family planning and birth control
- Abortion services

If you are 12 years old or older, you may also get these services without your parent's or guardian's permission:

- Outpatient mental health care for:
 - Sexual assault
 - Incest
 - Physical assault
 - Child abuse
 - When you have thoughts of hurting yourself or others
- HIV/AIDS prevention, testing, and treatment
- Sexually transmitted infections prevention, testing, and treatment
- Substance use disorder treatment.
 - To learn more, read "Substance use disorder treatment services" in Chapter 4 of this handbook.

For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be in Health Plan's network. You can choose any Medi-Cal provider and go to them for these services without a referral or pre-approval (prior authorization).

For minor consent services that are not specialty mental health services, you can go to an in-network provider without a referral and without pre-approval (prior authorization). Your PCP does not have to refer you and you do not need to get pre-approval (prior authorization) from Health Plan to get covered minor consent services.

Minor consent services that are specialty mental health services are not covered. Specialty mental health services are covered by the county mental health plan for the county where you live.

Minors can talk to a representative in private about their health concerns by calling the 24/7 advice nurse line at 1-800-655-8294, (TTY 711).

Health Plan will not send information about getting sensitive services to parents or guardians. To learn more about how to ask for confidential communications related to



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sensitive services, read “Notice of privacy practices” in Chapter 7 of this handbook.

Adult sensitive care services

As an adult 18 years or older, you may not want to go to your PCP for certain sensitive or private care. You can choose any doctor or clinic for these types of care:

- Family planning and birth control including sterilization for adults 21 and older.
- Pregnancy testing and counseling
- HIV/AIDS prevention and testing
- Sexually transmitted infections prevention, testing, and treatment
- Sexual assault care
- Outpatient abortion services

For sensitive care, the doctor or clinic does not have to be in Health Plan network. You can choose to go to any Medi-Cal provider for these services without a referral or pre-approval (prior authorization) from Health Plan. If you got care not listed here as sensitive care from an out-of-network provider, you might have to pay for it.

If you need help finding a doctor or clinic for these services, or help getting to these services (including transportation), call 1-888-936-PLAN (7526) (TTY 711). Or call the 24/7 advice nurse at 1-800-655-8294, (TTY 711).

Health Plan will not disclose medical information related to sensitive services to any other member without written authorization from you, the member receiving care. To learn more about how to ask for confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7.

Moral objection

Some providers have a moral objection to some covered services. They have a right to **not** offer some covered services if they morally disagree with the services. If your provider has a moral objection, they will help you find another provider for the needed services. Health Plan can also help you find a provider.

Some hospitals and providers do not provide one or more of these services even if they are covered by Medi-Cal:

- Family planning
- Contraceptive services, including emergency contraception.
- Sterilization, including tubal ligation at the time of labor and delivery.
- Infertility treatments
- Abortion



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To make sure you choose a provider who can give you the care you and your family needs, call the doctor, medical group, independent practice association, or clinic you want. Or call Health Plan at 1-888-936-PLAN (7526) (TTY 711). Ask if the provider can and will provide the services you need.

These services are available to you. Health Plan will make sure you and your family members can use providers (doctors, hospitals, clinics) who will give you the care you need. If you have questions or need help finding a provider, call Health Plan at 1-888-936-PLAN (7526) (TTY 711).

Urgent care

Urgent care is **not** for an emergency or life-threatening condition. It is for services you need to prevent serious damage to your health from a sudden illness, injury, or complication of a condition you already have. Most urgent care appointments do not need pre-approval (prior authorization). If you ask for an urgent care appointment, you will get an appointment within 48 hours. If the urgent care services you need require a pre-approval (prior authorization), you will get an appointment within 96 hours of your request.

For urgent care, call your PCP. If you cannot reach your PCP, call 1-888-936-PLAN (7526) (TTY 711). Or you can call the 24/7 advice nurse line 1-800-655-8294, (TTY 711), to learn the level of care that is best for you. If you need urgent care out of the area, go to the nearest urgent care facility.

Urgent care needs could be:

- Cold
- Sore throat
- Fever
- Ear pain
- Sprained muscle
- Maternity services

You must get urgent care services from an in-network provider when you are inside the Health Plan's service area. You do not need pre-approval (prior authorization) for urgent care from in-network providers inside Health Plan's service area. If you are outside Health Plan's service area, but inside the United States, you do not need pre-approval



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(prior authorization) to get urgent care.

Go to the nearest urgent care facility. Medi-Cal does not cover urgent care services outside the United States. If you are traveling outside the United States and need urgent care, we will not cover your care.

If you need mental health urgent care, call your county mental health plan or Member Services at 1-888-936-PLAN (7526) (TTY 711). Call your county mental health plan or your Health Plan Behavioral Health Organization any time, 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, go to:

<http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx>.

If you get medicines as part of your covered urgent care visit, Health Plan will cover them as part of your covered visit. If your urgent care provider gives you a prescription to take to a pharmacy, Medi-Cal Rx will decide if it is covered. To learn more about Medi-Cal Rx, read "Prescription drugs covered by Medi-Cal Rx" in "Other Medi-Cal programs and services" in Chapter 4.

Emergency care

For emergency care, call **911** or go to the nearest emergency room (ER). For emergency care, you do **not** need pre-approval (prior authorization) from Health Plan.

Inside the United States, including any United States Territory, you have the right to use any hospital or other setting for emergency care.

If you are outside the United States, only emergency care requiring hospitalization in Canada and Mexico are covered. Emergency care and other care in other countries are not covered.

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, you would place your health (or your unborn baby's health) in serious danger.

This includes risking serious harm to your bodily functions, body organs or body parts. Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain



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- Trouble breathing
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts (this may be covered by county mental health plans)

Do **not** go to the ER for routine care or care that is not needed right away. You should get routine care from your PCP, who knows you best. If you are not sure if your medical condition is an emergency, call your PCP. You can also call the 24/7 advice nurse line at 1-800-655-8294, (TTY 711).

If you need emergency care away from home, go to the nearest ER even if it is not in Health Plan's network. If you go to an ER, ask them to call Health Plan. You or the hospital that admitted you should call Health Plan within 24 hours after you get emergency care. If you are traveling outside the United States other than to Canada or Mexico and need emergency care, Health Plan will **not** cover your care.

If you need emergency transportation, call **911**. You do not need to ask your PCP or Health Plan before you go to the ER.

If you need care in an out-of-network hospital after your emergency (post-stabilization care), the hospital will call Health Plan.

Remember: Do not call **911** unless it is an emergency. Get emergency care only for an emergency, not for routine care or a minor illness like a cold or sore throat. If it is an emergency, call **911** or go to the nearest emergency room.

Health Plan Nurse Advice Line gives you free medical information and advice 24 hours a day, every day of the year. Call 1-800-655-8294, (TTY 711).

Nurse Advice Line

Health Plan Nurse Advice Line can give you free medical information and advice 24 hours a day, every day of the year. Call 1-800-655-8294 (TTY 711) to:

- Talk to a nurse who will answer medical questions, give care advice, and help



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- you decide if you should go to a provider right away
- Get help with medical conditions such as diabetes or asthma, including advice about what kind of provider may be right for your condition.

The Nurse Advice Line **cannot** help with clinic appointments or medicine refills. Call your provider's office if you need help with these.

Advance directives

An advance health directive is a legal form. You can list on the form the health care you want in case you cannot talk or make decisions later. You can also list what care you do **not** want. You can name someone, such as a spouse, to make decisions for your health care if you cannot.

You can get an advance directive form at pharmacies, hospitals, law offices, and doctors' offices. You might have to pay for the form. You can also find and download a free form online. You can ask your family, PCP, or someone you trust to help you fill out the form.

You have the right to have your advance directive placed in your medical records. You have the right to change or cancel your advance directive at any time.

You have the right to learn about changes to advance directive laws. Health Plan will tell you about changes to the state law no longer than 90 days after the change.

To learn more, you can call Health Plan at 1-888-936-PLAN (7526).

Organ and tissue donation

You can help save lives by becoming an organ or tissue donor. If you are between 15 and 18 years old, you can become a donor with the written consent of your parent or guardian. You can change your mind about being an organ donor at any time. If you want to learn more about organ or tissue donation, talk to your PCP. You can also visit the United States Department of Health and Human Services website at www.organdonor.gov.



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4. Benefits and services

What your health plan covers

This chapter explains your covered services as a member of Health Plan. Your covered services are free as long as they are medically necessary and provided by an in-network provider. You must ask us for pre-approval (prior authorization) if the care is out-of-network except for certain sensitive services and emergency care. Your health plan might cover medically necessary services from an out-of-network provider, but you must ask Health Plan for pre-approval (prior authorization) for this.

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under the age of 21, Medi-Cal services include care that is medically necessary to fix or help relieve a physical or mental illness or condition. For more on your covered services, call 1-888-936-PLAN (7526) (TTY 711).

Members under 21 years old get extra benefits and services. To learn more, read Chapter 5, “Child and youth well care.”

Some of the basic health benefits Health Plan offers are listed below. Benefits with a star (*) need pre-approval (prior authorization).



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- Acupuncture*
- Acute (short-term treatment) home health therapies and services
- Adult immunizations (shots)
- Allergy testing and injections.
- Ambulance services for an emergency
- Anesthesiologist services
- Asthma prevention
- Audiology*
- Behavioral health treatments*
- Biomarker testing
- Cardiac rehabilitation
- Chiropractic services*
- Chemotherapy & Radiation therapy
- Cognitive health assessments
- Community health worker services
- Dental services - limited (performed by medical professional/primary care provider (PCP) in a medical office.
- Dialysis/hemodialysis services
- Doula services
- Durable medical equipment (DME)*
- Dyadic services
- Emergency room visits
- Enteral and parenteral nutrition*
- Family planning office visits and counseling (you can go to a non-participating provider)
- Habilitative services and devices*
- Hearing aids
- Home health care*
- Hospice care*
- Inpatient medical and surgical care*
- Lab and radiology*
- Long-term home health therapies and services*
- Maternity and newborn care
- Major organ transplant*
- Occupational therapy*
- Orthotics/prostheses*
- Ostomy and urological supplies
- Outpatient hospital services
- Outpatient mental health services
- Outpatient surgery*
- Palliative care*
- PCP visits
- Pediatric services
- Physical therapy*
- Podiatry services*
- Pulmonary rehabilitation
- Rapid Whole Genome Sequencing
- Rehabilitation services and devices*
- Skilled nursing services
- Specialist visits
- Speech therapy*
- Surgical services
- Telemedicine/Telehealth
- Transgender services*
- Urgent care
- Vision services*
- Women's health services

Definitions and descriptions of covered services are in Chapter 8, "Important numbers and words to know."



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Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury.

Medically necessary services include those services that are necessary for age-appropriate growth and development, or to attain, maintain, or regain functional capacity.

For members under 21 years of age, a service is medically necessary if it is necessary to correct or improve defects and physical and mental illnesses or conditions under the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This includes care that is necessary to fix or help relieve a physical or mental illness or condition or maintain the member's condition to keep it from getting worse.

Medically necessary services do not include:

- **Treatments that are untested or still being tested**
- **Services or items not generally accepted as effective**
- **Services outside the normal course and length of treatment or services that don't have clinical guidelines**
- **Services for caregiver or provider convenience**

Health Plan coordinates with other programs to be sure you get all medically necessary services, even if those services are covered by another program and not Health Plan.

Medically necessary services include covered services that are reasonable and necessary to:

- **Protect life,**
- **Prevent significant illness or significant disability,**
- **Alleviate severe pain,**
- **Achieve age-appropriate growth and development, or**
- **Attain, maintain, and regain functional capacity.**



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For members younger than 21 years old, medically necessary services include all covered services listed above plus any other necessary health care, diagnostic services, treatment, and other measures to correct or improve defects and physical and mental illnesses and conditions, the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires.

EPSDT provides prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21. EPSDT covers more services than the benefit for adults. It is designed to make sure children get early detection and care to prevent or diagnose and treat health problems. The EPSDT goal is to make sure every child gets the health care they need when they need it – the right care to the right child at the right time in the right setting.

Health Plan will coordinate with other programs to make sure you get all medically necessary services, even if another program covers those services and Health Plan does not. Read “Other Medi-Cal programs and services” in this chapter.

Medi-Cal benefits covered by Health Plan

Outpatient (ambulatory) services

Adult immunizations

You can get adult immunizations (shots) from an in-network provider without pre-approval (prior authorization). Health Plan covers shots recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), including shots you need when you travel.

You can also get some adult immunization (shots) services in a pharmacy through Medi-Cal Rx. To learn more about Medi-Cal Rx, read “Other Medi-Cal programs and services” in this chapter.

Allergy care

Health Plan covers allergy testing and treatment, including allergy desensitization, hypo-sensitization, or immunotherapy.



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Anesthesiologist services

Health Plan covers anesthesia services that are medically necessary when you get outpatient care. This may include anesthesia for dental procedures when provided by an anesthesiologist who may require pre-approval (prior authorization).

Chiropractic services

Health Plan covers chiropractic services, limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to a maximum of 2 services per month, or combination of 2 services per month from the following services: acupuncture, audiology, occupational therapy, and speech therapy. Limits do not apply to children under age 21. Health Plan may pre-approve other services as medically necessary.

These members qualify for chiropractic services:

- Children under age 21.
- Pregnant people through the end of the month that includes 60-days after the end of a pregnancy.
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility.
- All members when services are provided at county hospital outpatient departments, outpatient clinics, Federally Qualified Health Center (FQHCs), or Rural Health Clinics (RHCs) in the Health Plan's network. Not all FQHCs, RHCs, or county hospitals offer outpatient chiropractic services.

Cognitive health assessments

Health Plan covers a yearly cognitive health assessment for members 65 years old or older who do not otherwise qualify for a similar assessment as part of a yearly wellness visit under the Medicare program. A cognitive health assessment looks for signs of Alzheimer's disease or dementia.

Community health worker services

Health Plan covers community health worker (CHW) services for individuals when recommended by a doctor or other licensed practitioner to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Services may include:

- Health education and training, including control and prevention of chronic or



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infectious diseases; behavioral, perinatal, and oral health conditions; and injury prevention.

- Health promotion and coaching, including goal setting and creating action plans to address disease prevention and management.

Dialysis and hemodialysis services

Health Plan covers dialysis treatments. Health Plan also covers hemodialysis (chronic dialysis) services if your doctor submits a request and Health Plan approves it.

Medi-Cal coverage does not include:

- Comfort, convenience, or luxury equipment, supplies, and features
- Non-medical items, such as generators or accessories to make home dialysis equipment portable for travel.

Doula services

Health Plan covers doula services for members who are pregnant or were pregnant in the past year when recommended by a physician or licensed practitioner. Medi-Cal does not cover all doula services. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.

Dyadic services

Health Plan covers medically necessary dyadic behavioral health (DBH) care services for members and their caregivers. A dyad is a child and their parents or caregivers. Dyadic care serves parents or caregivers and child together. It targets family well-being to support healthy child development and mental health.

Dyadic care services include DBH well-child visits, dyadic comprehensive Community Supports services, dyadic psycho-educational services, dyadic parent or caregiver services, dyadic family training, and counseling for child development, and maternal mental health services.



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Outpatient surgery

Health Plan covers outpatient surgical procedures. For some procedures, you will need to get pre-approval (prior authorization) before getting those services. Diagnostic procedures and certain outpatient medical or dental procedures are considered elective. You must get pre-approval (prior authorization).

Physician services

Health Plan covers physician services that are medically necessary.

Podiatry (foot) services

Health Plan covers podiatry services as medically necessary for diagnosis and for medical, surgical, mechanical, manipulative, and electrical treatment of the human foot. This includes treatment for the ankle and for tendons connected to the foot. It also includes nonsurgical treatment of the muscles and tendons of the leg that controls the functions of the foot.

Treatment therapies

Health Plan covers different treatment therapies, including:

- Chemotherapy
- Radiation therapy

Maternity and newborn care

Health Plan covers these maternity and newborn care services:

- Birthing center services
- Breast pumps and supplies
- Breastfeeding education and aids
- Certified Nurse Midwife (CNM)
- Delivery and postpartum care
- Diagnosis of fetal genetic disorders and counseling
- Doula Services
- Licensed Midwife (LM)
- Maternal mental health services
- Newborn care
- Prenatal care



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Telehealth services

Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider by phone, video, or other means. Or telehealth may involve sharing information with your provider without a live conversation. You can get many services through telehealth.

Telehealth may not be available for all covered services. You can contact your provider to learn which services you can get through telehealth. It is important that you and your provider agree that using telehealth for a service is appropriate for you. You have the right to in-person services. You are not required to use telehealth even if your provider agrees that it is appropriate for you.

Mental health services

Outpatient mental health services

Health Plan covers initial mental health assessments without needing pre-approval (prior authorization). You can get a mental health assessment at any time from a licensed mental health provider in Health Plan's network without a referral.

Your PCP or mental health provider might make a referral for more mental health screening to a specialist in Health Plan network to decide the level of care you need. If your mental health screening results find you are in mild or moderate distress or have impaired mental, emotional, or behavioral functioning, Health Plan can provide mental health services for you. Health Plan covers mental health services such as:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing when clinically indicated to evaluate a mental health condition.
- Development of cognitive skills to improve attention, memory, and problem solving.
- Outpatient services for the purposes of monitoring medicine therapy.
- Outpatient laboratory services.
- Outpatient medicines that are not already covered under the Medi-Cal Rx Contract Drugs List (<https://medi-calrx.dhcs.ca.gov/home/>), supplies and supplements.
- Psychiatric consultation.



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- Family therapy which involves at least 2 family members. Examples of family therapy include, but are not limited to:
 - Child-parent psychotherapy (ages 0 through 5)
 - Parent child interactive therapy (ages 2 through 12)
 - Cognitive-behavioral couple therapy (adults)

For help finding more information on mental health services provided by Health Plan, call 1-888-936-PLAN (7526) (TTY 711).

If treatment you need for a mental health disorder is not available in Health Plan network or your PCP or mental health provider cannot give the care you need in the time listed above in “Timely access to care,” Health Plan will cover and help you get out-of-network services.

If your mental health screening shows that you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider can refer you to the county mental health plan to get the care you need.

To learn more, read “Other Medi-Cal programs and services” on pages 83-84, under, “Specialty mental health services.”

Emergency care

Inpatient and outpatient services needed to treat a medical emergency

Health Plan covers all services needed to treat a medical emergency that happens in the U.S. (including territories such as Puerto Rico, U.S. Virgin Islands, etc.). Health Plan also covers emergency care that requires hospitalization in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent (reasonable) layperson (not a health care professional) could expect it to result in:

- Serious risk to your health,
- Serious harm to bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Serious risk in cases of a pregnant person in active labor, meaning labor at a time when either of the following would occur:
 - There is not enough time to safely transfer you to another hospital before delivery.
 - The transfer might pose a threat to your health or safety or to that of your



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unborn child.

If a hospital emergency room provider gives you up to a 72-hour supply of an outpatient prescription drug as part of your treatment, Health Plan will cover the prescription drug as part of your covered Emergency Services. If a hospital emergency room provider gives you a prescription that you have to take to an outpatient pharmacy to be filled, Medi-Cal Rx will cover that prescription.

If a pharmacist at an outpatient pharmacy gives you an **emergency supply** of a medication, that emergency supply will be covered by Medi-Cal Rx and not Health Plan. If the pharmacy needs help giving you an emergency medication supply, have them call Medi-Cal Rx at 1-800-977-2273.

Emergency transportation services

Health Plan covers ambulance services to help you get to the nearest place of care in an emergency. This means your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside the U.S. except emergency care that requires you to be in the hospital in Canada or Mexico. If you get emergency ambulance services in Canada or Mexico and you are not hospitalized during that care episode, Health Plan will not cover your ambulance services.

Hospice and palliative care

Health Plan covers hospice care and palliative care for children and adults, which help reduce physical, emotional, social, and spiritual discomforts. Adults ages 21 years or older may not get hospice care and palliative care services at the same time.

Hospice care

Hospice care is a benefit for terminally ill members. Hospice care requires the member to have a life expectancy of 6 months or less. It is an intervention that focuses mainly on pain and symptom management rather than on a cure to prolong life.

Hospice care includes:

- Nursing services.
- Physical, occupational, or speech services.
- Medical social services.
- Home health aide and homemaker services.



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- Medical supplies and appliances.
- Some drugs and biological services (some may be available through Medi-Cal Rx).
- Counselling services.
- Continuous nursing services on a 24-hour basis during periods of crisis and as necessary to maintain the terminally ill member at home.
- Inpatient respite care for up to five consecutive days at a time in a hospital, skilled nursing facility, or hospice facility.
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing facility, or hospice facility.

Palliative care

Palliative care is patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative care does not require the member to have a life expectancy of six months or less. Palliative care may be provided at the same time as curative care.

Palliative care includes:

- Advance care planning
- Palliative care assessment and consultation
- Plan of care including all authorized palliative and curative care
- Plan of care team including, but not limited to:
 - Doctor of medicine or osteopathy
 - Physician assistant
 - Registered nurse
 - Licensed vocational nurse or nurse practitioner
 - Social worker
 - Chaplain
- Care coordination
- Pain and symptom management
- Mental health and medical social services

Adults who are age 21 or older cannot get both palliative care and hospice care at the same time. If you are getting palliative care and qualify for hospice care, you can ask to change to hospice care at any time.



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Hospitalization

Anesthesiologist services

Health Plan covers medically necessary anesthesiologist services during covered hospital stays. An anesthesiologist is a provider who specializes in giving patients anesthesia. Anesthesia is a type of medicine used during some medical or dental procedures.

Inpatient hospital services

Health Plan covers medically necessary inpatient hospital care when you are admitted to the hospital.

Rapid Whole Genome Sequencing

Rapid Whole Genome Sequencing (RWGS) is a covered benefit for any Medi-Cal member who is one year of age or younger and is getting inpatient hospital services in an intensive care unit. It includes individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing.

RWGS is a new way to diagnose conditions in time to affect Intensive Care Unit (ICU) care of children one year of age or younger. If your child qualifies for California Children's Services (CCS), CCS may cover the hospital stay and the RWGS.

Surgical services

Health Plan covers medically necessary surgeries performed in a hospital.

The Postpartum Care Extension (PPCE) program

Health Plan covers post-partum care for up to 12 months after the end of the pregnancy regardless of income, citizenship, or immigration status. No other action is needed.

Rehabilitative and habilitative (therapy) services and devices

This benefit includes services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

Health Plan covers rehabilitative and habilitative services described in this section if all of the following requirements are met:

- The services are medically necessary.



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- The services are to address a health condition.
- The services are to help you keep, learn, or improve skills and functioning for daily living.
- You get the services at an in-network facility, unless an in-network doctor finds it medically necessary for you to get the services in another place or an in-network facility is not available to treat your health condition.

Health Plan covers these rehabilitative/habilitative services:

Acupuncture

Health Plan covers acupuncture services to prevent, change, or relieve the perception of severe, ongoing chronic pain resulting from a generally recognized medical condition.

Outpatient acupuncture services, with or without electric stimulation of needles, are limited to 2 services per month in combination with audiology, chiropractic, occupational therapy, and speech therapy services when provided by a doctor, dentist, podiatrist, or acupuncturist. Limits do not apply to children under age 21. Health Plan may pre-approve (prior authorize) more services as medically necessary.

Audiology (hearing)

Health Plan covers audiology services. Outpatient audiology is limited to 2 services per month, in combination with acupuncture, chiropractic, occupational therapy, and speech therapy services (limits do not apply to children under age 21). Health Plan may pre-approve (prior authorize) more services as medically necessary.

Behavioral health treatments

Health Plan covers behavioral health treatment (BHT) services for members under 21 years old through the EPSDT benefit. BHT includes services and treatment programs such as applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a person under 21 years old.

BHT services teach skills using behavioral observation and reinforcement or through prompting to teach each step of a targeted behavior. BHT services are based on reliable evidence. They are not experimental. Examples of BHT services include behavioral interventions, cognitive behavioral intervention packages, comprehensive behavioral treatment, and applied behavior analysis.



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BHT services must be medically necessary, prescribed by a licensed doctor or psychologist, approved by the plan, and provided in a way that follows the approved treatment plan.

Cardiac rehabilitation

Health Plan covers inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment (DME)

Health Plan covers the purchase or rental of DME supplies, equipment, and other services with a prescription from a doctor, physician assistant, nurse practitioner, or clinical nurse specialist. Prescribed DME items are covered as medically necessary to preserve bodily functions essential to activities of daily living or to prevent major physical disability.

Generally, Health Plan does not cover:

- Comfort, convenience, or luxury equipment, features, and supplies, except retail-grade breast pumps as described in this chapter under “Breast pumps and supplies” in “Maternity and newborn care”.
- Items not intended to maintain normal activities of daily living, such as exercise equipment including devices intended to provide more support for recreational or sports activities.
- Hygiene equipment, except when medically necessary for a member under age 21
- Nonmedical items such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (diabetes blood glucose monitors, continuous glucose monitors, test strips, and lancets are covered by Medi-Cal Rx)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse, except when medically necessary for a member under age 21
- Other items are not generally used mainly for health care.

In some cases, these items may be approved when your doctor submits a request for pre-approval (prior authorization).



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Enteral and parenteral nutrition

These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. Enteral nutrition formulas and parenteral nutrition products may be covered through Medi-Cal Rx, when medically necessary. Health Plan also covers enteral and parenteral pumps and tubing, when medically necessary.

Hearing aids

Health Plan covers hearing aids if you are tested for hearing loss, the hearing aids are medically necessary, and you have a prescription from your doctor. Coverage is limited to the lowest cost aid that meets your medical needs. Health Plan will cover one hearing aid unless an aid for each ear is needed for results much better than you can get with one aid.

Hearing aids for members under age 21:

In Alpine, El Dorado, San Joaquin, and Stanislaus counties, state law requires children who need hearing aid to be referred to the California Children's Services (CCS) program to decide if the child qualifies for CCS. If the child qualifies for CCS, CCS will cover the costs for medically necessary hearing aids. If the child does not qualify for CCS, we will cover medically necessary hearing aids as part of Medi-Cal coverage.

Hearing aids for members ages 21 and older.

Under Medi-Cal, we cover the following for each covered hearing aid:

- Ear molds needed for fitting.
- One standard battery package.
- Visits to make sure the aid is working right.
- Visits for cleaning and fitting your hearing aid.
- Repair of your hearing aid.

Under Medi-Cal, we will cover a replacement hearing aid if:

- Your hearing loss is such that your current hearing aid is not able to correct it.
- Your hearing aid is lost, stolen, or broken and cannot be fixed and it was not your fault. You must give us a note that tells us how this happened.

For adults ages 21 and older, Medi-Cal does **not** include:

- Replacement hearing aid batteries



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Home health services

Health Plan covers health services given in your home when found medically necessary and prescribed by your doctor or by a physician assistant, nurse practitioner, or clinical nurse specialist.

Home health services are limited to services that Medi-Cal covers, including:

- Part-time skilled nursing care
- Part-time home health aide
- Skilled physical, occupational, and speech therapy
- Medical social services
- Medical supplies

Medical supplies, equipment, and appliances

Health Plan covers medical supplies prescribed by doctors, physician assistants, nurse practitioners, and clinical nurse specialists. Some medical supplies are covered through Fee-for-Service (FFS) Medi-Cal Rx and not by Health Plan. When FFS covers supplies, the provider will bill Medi-Cal.

Medi-Cal does **not** cover:

- Common household items including, but not limited to:
 - Adhesive tape (all types)
 - Rubbing alcohol
 - Cosmetics
 - Cotton balls and swabs
 - Dusting powders
 - Tissue wipes
 - Witch hazel
- Common household remedies including, but not limited to:
 - White petrolatum
 - Dry skin oils and lotions
 - Talc and talc combination products
 - Oxidizing agents such as hydrogen peroxide
 - Carbamide peroxide and sodium perborate
- Non-prescription shampoos
- Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid, and zinc oxide paste



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- Other items not generally used primarily for health care, and that are regularly and primarily used by persons who do not have a specific medical need for them.

Occupational therapy

Health Plan covers occupational therapy services including occupational therapy evaluation, treatment planning, treatment, instruction, and consultative services.

Occupational therapy services are limited to 2 services per month in combination with acupuncture, audiology, chiropractic, and speech therapy services (limits do not apply to children under age 21). Health Plan may pre-approve (prior authorize) more services as medically necessary.

Orthotics/prostheses

Health Plan covers orthotic and prosthetic devices and services that are medically necessary and prescribed by your doctor, podiatrist, dentist, or non-physician medical provider. They include implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments, and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part.

Ostomy and urological supplies

Health Plan covers ostomy bags, urinary catheters, draining bags, irrigation supplies, and adhesives. This does not include supplies that are for comfort or convenience, or luxury equipment or features.

Physical therapy

Health Plan covers medically necessary physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and applying of topical medicines.

Pulmonary rehabilitation

Health Plan covers pulmonary rehabilitation that is medically necessary and prescribed by a doctor.

Skilled nursing facility services

Health Plan covers skilled nursing facility services as medically necessary if you are



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disabled and need a high level of care. These services include room and board in a licensed facility with 24-hour per day skilled nursing care.

Speech therapy

Health Plan covers speech therapy that is medically necessary. Speech therapy services are limited to 2 services per month, in combination with acupuncture, audiology, chiropractic, and occupational therapy services. Limits do not apply to children under age 21. Health Plan may pre-approve (prior authorize) more services as medically necessary.

Transgender services

Health Plan covers transgender services (gender-affirming services) when they are medically necessary or when the services meet the rules for reconstructive surgery.

Clinical trials

Health Plan covers routine patient care costs for patients accepted into clinical trials, including clinical trials for cancer, listed for the United States at <https://clinicaltrials.gov>. Medi-Cal Rx, a Medi-Cal FFS program, covers most outpatient prescription drugs. To learn more, read “Outpatient prescription drugs” in this chapter.

Laboratory and radiology services

Health Plan covers outpatient and inpatient laboratory and X-ray services when medically necessary. Advanced imaging procedures such as CT scans, MRIs, and PET scans, are covered based on medical necessity.

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines.
- Family planning services
- American Academy of Pediatrics Bright Futures recommendations (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Adverse childhood experiences (ACE) screening
- Asthma prevention services
- Preventive services for women recommended by the American College of



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Obstetricians and Gynecologists

- Help to quit smoking, also called smoking cessation services.
- United States Preventive Services Task Force Grade A and B recommended preventive services

Family planning services are provided to members of childbearing age to allow them to choose the number and spacing of children. These services include all methods of birth control approved by the FDA. The Health Plan's PCP and OB/GYN specialists are available for family planning services.

For family planning services, you may also choose a Medi-Cal doctor or clinic not connected with Health Plan without having to get pre-approval (prior authorization) from Health Plan. Services from an out-of-network provider not related to family planning might not be covered. To learn more, call 1-888-936-PLAN (7526) (TTY 711).

Health Plan also covers chronic disease management programs focused on the following conditions:

- Diabetes
- Cardiovascular disease
- Asthma
- Depression
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease (CKD)

For preventive care information for youth 20 years old and younger, read Chapter 5, "Child and youth well care."

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program. This 12-month program is focused on lifestyle changes. It is designed to prevent or delay the onset of Type 2 diabetes in persons diagnosed with prediabetes. Members who meet criteria might qualify for a second year. The program provides education and group support. Techniques include, but are not limited to:

- Providing a peer coach.
- Teaching self-monitoring and problem solving.



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- Providing encouragement and feedback.
- Providing informational materials to support goals.
- Tracking routine weigh-ins to help accomplish goals.

Members must meet certain rules to join DPP. To learn more about the Health Plan's DPP Program visit www.hpsj.com/dpp or email healtheducation@hpsj.com to see if you qualify.

Reconstructive services

Health Plan covers surgery to correct or repair abnormal structures of the body to improve or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by congenital defects, developmental abnormalities, trauma, infection, tumors, diseases, or treatment of disease that resulted in loss of a body structure, such as a mastectomy. Some limits and exceptions may apply.

Substance use disorder screening services

Health Plan covers:

- Alcohol and Drug Screening
- Assessment
- Brief Interventions, and
- Referral to Treatment (SABIRT)

For treatment coverage through the county, read “Substance use disorder treatment services” below in this chapter.

Vision benefits

Health Plan covers:

- Routine eye exam once every 24 months; more frequent eye exams are covered if medically necessary for members, such as those with diabetes.
- Eyeglasses (frames and lenses) once every 24 months with a valid prescription.
- Replacement eyeglasses within 24 months if your prescription changes or your eyeglasses are lost, stolen, or broken and cannot be fixed, and it was



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not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken.

- Low vision devices for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine, or surgery that interferes with a person's ability to perform everyday activities (such as age-related macular degeneration).
- Medically necessary contact lenses. Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (such as missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus.

Transportation benefits for situations that are not emergencies

You can get medical transportation if you have medical needs that do not allow you to use a car, bus, or taxi to your appointments. You can get medical transportation for covered services and Medi-Cal covered pharmacy appointments. You can request medical transportation by asking your doctor, dentist, podiatrist, or mental health or substance use disorder provider for it. Your provider will decide the correct type of transportation to meet your needs.

If they find that you need medical transportation, they will prescribe it by filling out a form and submitting it to Health Plan. Once approved, the approval is good for up to 12 months, depending on the medical need. Once approved, you can get as many rides as you need. Your doctor will need to reassess your medical need for medical transportation and re-approve it every 12 months.

Medical transportation is an ambulance, litter van, wheelchair van, or air transport. Health Plan allows the lowest cost medical transportation for your medical needs when you need a ride to your appointment. That means, for example, if you can physically or medically be transported by a wheelchair van, Health Plan will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

You will get medical transportation if:



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- It is physically or medically needed, with a written authorization by a doctor or other provider because you are not able to physically or medically able to use a bus, taxi, car, or van to get to your appointment.
- You need help from the driver to and from your home, vehicle, or place of treatment due to a physical or mental disability.

To ask for medical transportation that your doctor has prescribed for non-urgent (routine) appointments, call Health Plan at 1-888-936-PLAN (7526) (TTY 711) at least seven (7) to ten (10) business days (Monday - Friday) before your appointment. Or call as soon as you can when you have an urgent appointment. Have your member ID card ready when you call.

Limits of medical transportation

Health Plan provides the lowest cost medical transportation that meets your medical needs to the closest provider from your home where an appointment is available. You cannot get medical transportation if Medi-Cal does not cover the service you are getting, or it is not a Medi-Cal-covered pharmacy appointment. There is a list of covered services in this Member Handbook.

If Medi-Cal covers the appointment type but not through the health plan, Health Plan will not cover the medical transportation but can help you schedule your transportation with Medi-Cal. Transportation is not covered outside of the network or service area unless pre-authorized by Health Plan. To learn more or to ask for medical transportation, call Health Plan at 1-888-936-PLAN (7526) (TTY 711).

Cost to member

There is no cost when Health Plan arranges transportation.

How to get non-medical transportation

Your benefits include getting a ride to your appointments when the appointment is for a Medi-Cal covered service and you do not have any access to transportation. You can get a ride, at no cost to you, when you have tried all other ways to get transportation and are:

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



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Health Plan allows you to use a car, taxi, bus, or other public or private way of getting to your medical appointment for Medi-Cal-covered services. Health Plan will cover the lowest cost of non-medical transportation type that meets your needs. Sometimes, Health Plan can reimburse you (pay you back) for rides in a private vehicle that you arrange. Health Plan must approve this before you get the ride.

You must tell us why you cannot get a ride any other way, such as by bus. You can call, email, or tell us in person. If you have access to transportation or can drive yourself to the appointment, Health Plan will not reimburse you. This benefit is only for members who do not have access to transportation.

For mileage reimbursement, you must submit copies of the driver's:

- Driver's license,
- Vehicle registration, and
- Proof of car insurance

To request a ride for services that have been authorized, call the Health Plan at 1-888-936-PLAN (7526) (TTY 711) at least seven (7) to ten (10) business days (Monday - Friday) before your appointment. Or call as soon as you can when you have an urgent appointment. Have your member ID card ready when you call.

Note: American Indians may also contact their local Indian Health Clinic to request non-medical transportation.

Limits of non-medical transportation

Health Plan provides the lowest cost non-medical transportation that meets your needs to the closest provider from your home where an appointment is available. Members cannot drive themselves or be reimbursed directly for non-medical transportation. To learn more, call Health Plan at 1-888-936-PLAN (7526) (TTY 711).

Non-medical transportation does not apply if:

- An ambulance, litter van, wheelchair van, or other form of medical transportation is medically needed to get to a Medi-Cal covered service.
- You need help from the driver to and from the residence, vehicle, or place of treatment due to a physical or medical condition.
- You are in a wheelchair and are unable to move in and out of the vehicle without help from the driver.
- Medi-Cal does not cover the service.



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Cost to member

There is no cost when Health Plan arranges non-medical transportation.

Travel expenses

In some cases, if you have to travel for doctor's appointments that are not available near your home, Health Plan can cover travel expenses such as meals, hotel stays, and other related expenses such as parking, tolls, etc. They may also be covered for someone who is traveling with you to help you with your appointment or someone who is donating an organ to you for an organ transplant. You need to request pre-approval (prior authorization) for these services by contacting Health Plan at 1-888-936-PLAN (7526) (TTY 711).

Other Health Plan covered benefits and programs

Long-term care services and supports

Health Plan covers, for members who qualify, long-term care services and supports in the following types of long-term care facilities or homes:

- Skilled nursing facility services as approved by Health Plan
- Subacute care facility services (including adult and pediatric) as approved by Health Plan
- Intermediate care facility services Health Plan approves, including:
 - Intermediate care facility/developmentally disabled (ICF/DD),
 - Intermediate care facility/developmentally disabled-habilitative (ICF/DD-H), and
 - Intermediate care facility/developmentally disabled-nursing (ICF/DD-N)

If you qualify for long-term care services, Health Plan will make sure you are placed in a health care facility or home that gives the level of care most appropriate to your medical needs.

If you have questions about long-term care services, call 1-888-936-PLAN (7526) (TTY 711).



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Basic care management

Getting care from many different providers or in different health systems is challenging. Health Plan wants to make sure members get all medically necessary services, prescription medicines, and behavioral health services. Health Plan can help coordinate and manage your health needs, at no cost to you. This help is available even when another program covers the services.

It can be hard to figure out how to meet your health care needs after you leave the hospital or if you get care in different systems. Here are some ways Health Plan can help members:

- If you have trouble getting a follow-up appointment or medicines after you are discharged from the hospital, Health Plan can help you.
- If you need help getting to an in-person appointment, Health Plan can help you get free transportation.

If you have questions or concerns about your health or the health of your child, call 1-888-936-PLAN (7526) (TTY 711).

Complex Care Management (CCM)

Members with more complex health needs may qualify for extra services focused on care coordination. Health Plan offers Complex Care Management (CCM) services to members with ongoing chronic health, behavioral, and/or social conditions.

Members who are enrolled in CCM and Enhanced Care Management (read below) have an Assigned Care Manager at Health Plan who can help not only basic care management described above, but also an expanded set of transitional care supports that are available if you are discharged from a hospital, skilled nursing facility, psychiatric hospital, or residential treatment.

Enhanced Care Management (ECM)

Health Plan covers ECM services for members with highly complex needs. ECM has extra services to help you get the care you need to stay healthy. It coordinates your care from different doctors and other health care providers. ECM helps coordinate primary and preventive care, acute care, behavioral health, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to community resources.



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If you qualify, you may be contacted about ECM services. You can also call Health Plan to find out if and when you can get ECM. Or talk to your health care provider. They can find out if you qualify for ECM or refer you for care management services.

Covered ECM services

If you qualify for ECM, you will have your own care team with a Lead Care Manager. This person will talk to you and your doctors, specialists, pharmacists, case managers, social services providers, and others. They make sure everyone works together to get you the care you need. A Lead Care Manager can also help you find and apply for other services in your community. ECM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

To find out if ECM might be right for you, talk to your Health Plan representative or health care provider.

Cost to member

There is no cost to the member for ECM services.

Community Supports

You may get support under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members. If you qualify, these services might help you live more independently. They do not replace benefits you already get under Medi-Cal.

Health Plan offers services such as help to obtain housing, a place to recover after a hospital or facility stay when one is not available, meals/medically tailored meals, a place to sober from alcohol or other drugs, help to improve your setting when you have asthma, shower grab bars and ramps, and help for you or your caregiver.

Health Plan offers the community supports noted below to members enrolled in Alpine,



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El Dorado, San Joaquin and Stanislaus counties.

Housing Transition Navigation Services: Assistance to search, obtain, and keep housing. Eligible members experiencing homelessness must meet DHCS Community Supports criteria and services can be provided if appropriate and authorized by Health Plan.

Housing Deposits: Assistance with coordination, security deposits and start up services to establish basic housing that does not constitute room and board. Eligible members who are homeless or at risk of homeless must meet DHCS Community Supports criteria and can be provided if appropriate and authorized by Health Plan. This service is available once in a lifetime and the individual must also receive Housing Transition Navigation Services in conjunction with this service.

Housing Tenancy and Sustaining Services: Services to help persons keep safe and stable housing once housing is secured. Eligible homeless, or at risk of homeless members must meet DHCS Community Supports criteria and can be provided if appropriate and authorized by Health Plan. This service is available for a single duration in the individual's lifetime and will only be approved one additional time if medically appropriate.

Short-Term Post Hospitalization Housing: Provides those that do not have a residence, and who have a high medical or behavioral health needs, a place to recover after a hospital or facility stay. Eligible members must have medical/behavioral health needs, be homeless or at risk for homelessness and meet DHCS Community Supports criteria. Further, this service must be determined to be appropriate and authorized by Health Plan. This service is available once in an individual's lifetime and are not to exceed a duration of 6 months per episode.

Recuperative Care: Provides short term housing along with medical services and care coordination for persons who no longer require hospitalization but need to heal from an injury or illness. Eligible members include those with medical or behavioral health needs who are experiencing homelessness or at risk for homelessness and lack certain supports and who meet DHCS Community Supports criteria. Further, this service must be determined to be appropriate and authorized by Health Plan. This service is for not more than 90 days in continuous duration.



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Meals/Medically Tailored Meals: This service helps members achieve their nutrition goals at critical times to help regain and maintain health. Eligible members include persons with chronic conditions, those being discharged from hospitals or nursing facilities, and individuals with extensive care coordination needs. Eligible members must meet DHCS Community Supports, and service must be determined to be appropriate and authorized by Health Plan. Available for up to two meals per and or medically supportive food and nutrition services up to 12 weeks or longer if medically necessary. Meals must not be eligible to be reimbursed by other programs and not covered to respond solely to food insecurities.

Sobering Center: Short term place to sober for members who are found to be under the influence in public and would otherwise be transported to emergency services or jail. Eligible members must be 18 and older, intoxicated, free from medical distress, and would otherwise be transported to the emergency department or jail and are appropriate to be diverted to a sobering center. Service is covered for a duration of less than 24 hours. Sobering centers do not require prior authorization and members may go directly to sobering center providers to receive services.

Asthma Remediation: Physical changes to the home necessary to help members live in the home without asthma episodes. Eligible members include those with poorly controlled asthma, with frequent emergency or urgent care visits, and with a referral from a provider. Service must meet DHCS Community Supports criteria and be determined to be appropriate and authorized by Health Plan. This service is available up to a lifetime maximum unless additional need is supported by member's condition.

Environmental Accessibility Adaptations (Home Modifications): Physical changes to the home to allow an individual to function with greater independence and not require care in a nursing facility. Eligible members include those who are at risk for institutionalization and meet DHCS Community Supports criteria. Services must be determined to be appropriate and authorized by Health Plan. This service is available up to a lifetime maximum unless additional need is supported by member's condition.

Day Habilitation Programs: Programs designed to assist the member in obtaining and improving self-help, social skills, and adaptive skills to live successfully in natural environment. Eligible members may include those who are



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homeless or at risk for homelessness and meet DHCS Community Supports criteria. Services must be determined to be appropriate and authorized by Health Plan. This service is available to members as medically appropriate.

Personal Care and Homemaker Services: Services provided to individuals who need assistance with activities of daily life like bathing, dressing, or feeding. Eligible members may include members at risk for care in a nursing facility, members with disabilities, members who lack social support and IHSS members. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan. This service is available as medically appropriate.

Respite Services: Short-term services provided to caregivers of those who require occasional temporary supervision to give relief to the caregiver. Eligible members may include members who live in the community and are compromised in their Activities of Daily Living and depend on their caregivers to provide most of their support and require caregiver relief to avoid institutional placement. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan. The service limit is up to 336 hours per calendar year. This service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made with Health Plan authorization if caregiver experiences an episode including medical treatment and hospitalization.

Nursing Facility Transition/Diversion to Assisted Living Facilities: Services to help members live in the community and avoid nursing facility stays when possible. Eligible members are those who have resided in a nursing facility for 60+ days and are willing and able to transition and divert to an assisted living facility. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan. Members may receive services as medically appropriate. Members are directly responsible for paying for their own living expenses.

Community Transition Services/Nursing Facility Transition to a Home: Services to help members live in the community and avoid further institutionalization by providing non-recurring set up expenses for individuals transitioning from a licensed facility to a living arrangement in a private residence. Eligible members are those currently receiving medically necessary facility level of care, have lived 60+ days and are interested and able to reside



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safely back in the community. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan.

Community transition services are payable up to a total lifetime maximum amount. The only exception to the total maximum is if the member is compelled to move from a provider operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control. Members may receive services as medically appropriate.

Community support may be requested by ECM providers, Community Supports Providers, PCPs through fax request or the provider portal.

If you or your provider need help or would like to find out what Community Supports may be available for you, call 1-888-936-PLAN (7526) (TTY 711) or call your health care provider.

Major organ transplant

Transplants for children under age 21

In Alpine, El Dorado, San Joaquin, and Stanislaus counties, state law requires children who need transplants to be referred to the California Children's Services (CCS) program to decide if the child qualifies for CCS. If the child qualifies for CCS, CCS will cover the costs for the transplant and related services.

If the child does not qualify for CCS, then Health Plan will refer the child to a qualified transplant center for evaluation. If the transplant center confirms that the transplant would be needed and safe, Health Plan will cover the transplant and related services.

Transplants for adults ages 21 and older

If your doctor decides you may need a major organ transplant, Health Plan will refer you to a qualified transplant center for an evaluation. If the transplant center confirms a transplant is needed and safe for your medical condition, Health Plan will cover the transplant and other related services.

The major organ transplants Health Plan covers include, but are not limited to:

- | | |
|-------------------|---------------------|
| ▪ Bone marrow | ▪ Liver |
| ▪ Heart | ▪ Liver/small bowel |
| ▪ Heart/lung | ▪ Lung |
| ▪ Kidney | ▪ Pancreas |
| ▪ Kidney/pancreas | ▪ Small bowel |



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Street medicine programs

Members experiencing homelessness may receive covered services from Street Medicine Providers within Health Plan's provider network. A Street Medicine Provider is a licensed primary care physician or primary care non-physician in Health Plan's. Members experiencing homelessness may be able to select a Street Medicine Provider to be their Primary Care Provider (PCP), if the Street Medicine Provider meets PCP eligibility criteria and agrees to be the member's PCP. For more information on Health Plan's Street medicine program, call 888.936.7526 (TTY 711).

Other Medi-Cal programs and services

Other services you can get through Fee-for-Service (FFS) Medi-Cal or other Medi-Cal programs

Health Plan does not cover some services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. Health Plan will coordinate with other programs to make sure you get all medically necessary services, including those covered by another program and not Health Plan. This section lists some of these services. To learn more, call 1-888-936-PLAN (7526) (TTY 711).

Outpatient prescription drugs

Prescription drugs covered by Medi-Cal Rx

Prescription drugs given by a pharmacy are covered by Medi-Cal Rx, which is a Medi-Cal FFS program. Health Plan might cover some drugs a provider gives in an office or clinic. If your provider prescribes drugs given in the doctor's office, infusion center, or by a home infusion provider, these are considered physician-administered drugs.

If a non-pharmacy based medical health care professional administers a drug, it is covered under the medical benefit. Your provider can prescribe you drugs on the Medi-Cal Rx Contract Drugs List.

Sometimes, you need a drug not on the Contract Drugs List. These drugs need approval before you can fill the prescription at the pharmacy. Medi-Cal Rx will review



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and decide these requests within 24 hours.

- A pharmacist at your outpatient pharmacy may give you a 14-day emergency supply if they think you need it. Medi-Cal Rx will pay for the emergency medicine an outpatient pharmacy gives.
- Medi-Cal Rx may say no to a non-emergency request. If they do, they will send you a letter to tell you why. They will tell you what your choices are. To learn more, read “Complaints” in Chapter 6.

To find out if a drug is on the Contract Drugs List or to get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711.

Or go to the Medi-Cal Rx website at <https://medi-calrx.dhcs.ca.gov/home/>.

Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with Medi-Cal Rx. You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at:

<https://medi-calrx.dhcs.ca.gov/home/>

You can also find a pharmacy near you or a pharmacy that can mail your prescription to you by calling Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711.

Once you choose a pharmacy, take your prescription to the pharmacy. Your provider can also send it to the pharmacy for you. Give the pharmacy your prescription with your Medi-Cal Benefits Identification Card (BIC). Make sure the pharmacy knows about all medicines you are taking and any allergies you have. If you have any questions about your prescription, ask the pharmacist.

Members can also get transportation services from Health Plan to get to pharmacies. To learn more about transportation services, read “Transportation benefits for situations that are not emergencies” in Chapter 4 of this handbook.

Specialty mental health services

Some mental health services are provided by county mental health plans instead of Health Plan. These include specialty mental health services (SMHS) for Medi-Cal members who meet rules for SMHS. SMHS may include these outpatient, residential, and inpatient services:



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Outpatient services:

- Mental health services
- Medication support services
- Day treatment intensive services
- Day rehabilitation services
- Crisis intervention services
- Crisis stabilization services
- Targeted case management
- Therapeutic behavioral services covered for members under 21 years old.
- Intensive care coordination (ICC) covered for members under 21 years old.
- Intensive home-based services (IHBS) covered for members under 21 years old.
- Therapeutic foster care (TFC) covered for members under 21 years old.

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

- Psychiatric inpatient hospital services
- Psychiatric health facility services

To learn more about specialty mental health services the county mental health plan provides, you can call your county mental health plan.

To find all counties' toll-free telephone numbers online, go to dhcs.ca.gov/individuals/Pages/MHPContactList.aspx. If Health Plan finds you will need services from the county mental health plan, Health Plan will help you connect with the county mental health plan services.

Substance use disorder treatment services

Health Plan encourages members who want help with alcohol use or other substance use to get care. Services for substance use are available from general care providers such as primary care, inpatient hospitals, and emergency departments and from specialty substance use service providers. County Behavioral Health Plans often provide specialty services.

To learn more about treatment options for substance use disorders, call your primary care provider or customer services at 1-888-936-PLAN (7526) (TTY 711).

Health Plan members can have an assessment to match them to the services that best



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fit their health needs and preferences. When medically necessary, available services include outpatient treatment, residential treatment, and medicines for substance use disorders (also called Medication Assisted Treatment (MAT)) such as buprenorphine, methadone, and naltrexone.

The county provides substance use disorder services to Medi-Cal members who qualify for these services. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. For a list of all counties' telephone numbers go to

https://dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

Medi-Cal Members receive the following substance abuse disorder benefits administered by the County Behavioral Health System:

- Voluntary inpatient detoxification
- Residential treatment services
- Intensive outpatient treatment services
- Outpatient drug free services

Health Plan will provide or arrange for MAT to be given in primary care, inpatient hospitals, emergency department, and other medical settings.

Contact the service provider in your county:

Alpine County:

Alpine County Behavioral Health Services

40 Diamond Valley Road

Markleeville, CA 96120

(530) 694-1816 (TTY 711)

El Dorado County:

El Dorado County Behavioral Health West Slope Office

929 Spring Street

Placerville, Ca 95667



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

(530) 621-6290 (TTY 711)

San Joaquin County:

Substance Abuse Services Administration:

630 Aurora Street Suite #1

Stockton, CA 95202.

(209) 468-3800, TTY 711

Stanislaus County:

Stanislaus County Behavioral Health & Recovery Services

800 Scenic Drive

Modesto, CA 95350.

1-888-376-6246, TTY 711

Dental services

The Medi-Cal Dental FFS Program is the same as FFS Medi-Cal for your dental services. Before you get dental services, you must show your BIC to the dental provider. Make sure the provider takes FFS Dental and you are not part of a managed care plan that covers dental services.

Medi-Cal covers a broad range of dental services through the Medi-Cal Dental Program, including:

- Diagnostic and preventive dental services such as examinations, X-rays, and teeth cleanings
- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planning
- Complete and partial dentures
- Orthodontics for children who qualify.



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- Topical fluoride

If you have questions or want to learn more about dental services, call the Medi-Cal Dental Program at 1-800-322-6384 (TTY 1-800-735-2922 or 711). You can also go to the Medi-Cal Dental Program website at <https://www.dental.dhcs.ca.gov> or <https://smilecalifornia.org/>.

California Children's Services (CCS)

CCS is a Medi-Cal program that treats children under 21 years of age with certain health conditions, diseases, or chronic health problems and who meet the CCS program rules. If Health Plan or your PCP believes your child has a CCS-eligible condition, they will be referred to the CCS county program to check if they qualify.

County CCS program staff will decide if your child qualifies for CCS services. Health Plan does not decide CCS eligibility. If your child qualifies to get this type of care, CCS providers will treat him or her for the CCS-eligible condition. Health Plan will continue to cover the types of service that do not have to do with the CCS condition such as physicals, vaccines, and well-child checkups.

Health Plan does not cover services that the CCS program covers. For CCS to cover these services, CCS must approve the provider, services, and equipment.

CCS does not cover all health conditions. CCS covers most health conditions that physically disable or need treatment with medicines, surgery, or rehabilitation (rehab). Examples of CCS-eligible conditions include but are not limited to:

- | | |
|-----------------------------------|---|
| ▪ Congenital heart disease | ▪ Hearing loss |
| ▪ Cancers | ▪ Cataracts |
| ▪ Tumors | ▪ Cerebral palsy |
| ▪ Hemophilia | ▪ Seizures under certain circumstances |
| ▪ Sickle cell anemia | ▪ Rheumatoid arthritis |
| ▪ Thyroid problems | ▪ Muscular dystrophy |
| ▪ Diabetes | ▪ AIDS |
| ▪ Serious chronic kidney problems | ▪ Severe head, brain, or spinal cord injuries |
| ▪ Liver disease | ▪ Severe burns |
| ▪ Intestinal disease | ▪ Severely crooked teeth |
| ▪ Cleft lip/palate | |
| ▪ Spina bifida | |



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Medi-Cal pays for CCS services. If your child does not qualify for CCS program services, they will keep getting medically necessary care from Health Plan.

To learn more about CCS, go to <https://www.dhcs.ca.gov/services/ccs>. Or call 1-888-936-PLAN (7526) (TTY 711).

1915(c) waiver Home and Community-Based Services (HCBS)

California's six Medi-Cal 1915(c) waivers allow the state to provide services to persons who would otherwise need care in a nursing facility or hospital in the community-based setting of their choice. Medi-Cal has an agreement with the Federal Government that allows waiver services to be offered in a private home or in a homelike community setting. The services offered under the waivers must not cost more than the alternative institutional level of care. HCBS Waiver recipients must qualify for full-scope Medi-Cal. The six Medi-Cal 1915(c) waivers are:

- California Assisted Living Waiver (ALW)
- California Self-Determination Program (SDP) Waiver for Individuals with Developmental Disabilities
- HCBS Waiver for Californians with Developmental Disabilities (HCBS-DD)
- Home and Community-Based Alternatives (HCBA) Waiver
- Medi-Cal Waiver Program (MCWP), formerly called the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver
- Multipurpose Senior Services Program (MSSP)

To learn more about the Medi-Cal Waivers, go to <https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx>. Or call 1-888-936-PLAN (7526) (TTY 711).

In-Home Supportive Services (IHSS)

The In-Home Supportive Services (IHSS) program provides in-home personal care assistance to qualified aged, blind, and disabled persons as an alternative to out-of-home care. It enables recipients to stay safely in their own homes.



Call member services at 1-888-936-PLAN (7526) (TTY 711).
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To learn more about IHSS available in your county, go to <https://www.cdss.ca.gov/inforesources/ihss> . Or call your local county social services agency.

Services you cannot get through Health Plan or Medi-Cal

Health Plan and Medi-Cal will not cover some services. Services Health Plan or Medi-Cal do not cover include, but are not limited to:

- In vitro fertilization (IVF), including but not limited to infertility studies or procedures to diagnose or treat infertility.
- Fertility preservation
- Experimental services
- Home modifications
- Vehicle modifications
- Cosmetic surgery

Health Plan may cover a non-covered service if it is medically necessary. Your provider must submit a pre-approval (prior authorization) request to Health Plan with the reasons the non-covered benefit is medically needed.

To learn more call 1-888-936-PLAN (7526) (TTY 711).

Evaluation of new and existing technologies

DHCS may evaluate and determine medical technology assessment for inclusion in benefit packages.

- Medical Procedures
- Behavioral health procedures
- Pharmaceuticals
- Devices



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5. Child and youth well care

Child and youth members under 21 years old can get special health services as soon as they are enrolled. This makes sure they get the right preventive, dental, and mental health care, including developmental and specialty services. This chapter explains these services.

Pediatric services (Children under age 21)

Members under 21 years old are covered for needed care. The list below includes medically necessary services to treat or care for any defects and physical or mental diagnoses. Covered services include, but are not limited to:

- Well-child visits and teen check-ups (important visits children need).
- Immunizations (shots).
- Behavioral health assessment and treatment.
- Mental health evaluation and treatment, including individual, group, and family psychotherapy (specialty mental health services are covered by the county).
- Adverse childhood experiences (ACE) screening.
- Lab tests, including blood lead poisoning screening.
- Health and preventive education.
- Vision services.
- Dental services (covered under Medi-Cal Dental).
- Hearing services (covered by California Children's Services (CCS) for children who qualify. Health Plan will cover services for children who do not qualify for CCS).

These services are called Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. EPSDT services that are recommended by pediatricians' Bright Futures guidelines to help you, or your child stay healthy are covered at no cost to you.



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To read these guidelines, go to:

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Well-child health check-ups and preventive care

Preventive care includes regular health check-ups, screenings to help your doctor find problems early, and counseling services to detect illnesses, diseases, or medical conditions before they cause problems. Regular check-ups help you or your child's doctor look for any problems. Problems can include medical, dental, vision, hearing, mental health, and any substance (alcohol or drug) use disorders. Health Plan covers check-ups to screen for problems (including blood lead level assessment) any time there is a need for them, even if it is not during your or your child's regular check-up.

Preventive care also includes shots you or your child need. Health Plan must make sure all enrolled children are up to date with all the shots they need when they have their visits with their doctor. Preventive care services and screenings are available at no cost and without pre-approval (prior authorization).

Your child should get check-ups at these ages:

- | | |
|------------------------|--------------------------------------|
| ▪ 2-4 days after birth | ▪ 12 months |
| ▪ 1 month | ▪ 15 months |
| ▪ 2 months | ▪ 18 months |
| ▪ 4 months | ▪ 24 months |
| ▪ 6 months | ▪ 30 months |
| ▪ 9 months | ▪ Once a year from 3 to 20 years old |

Well-child health check-ups include:

- A complete history and head-to-toe physical exam.
- Age-appropriate shots (California follows the American Academy of Pediatrics Bright Futures schedule:
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Lab tests, including blood lead poisoning screening.
- Health education.
- Vision and hearing screening.
- Oral health screening.
- Behavioral health assessment.



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If the doctor finds a problem with your or your child's physical or mental health during a check-up or screening, you or your child might need to get medical care. Health Plan will cover that care at no cost to you, including:

- Doctor, nurse practitioner, and hospital care.
- Shots to keep you healthy.
- Physical, speech/language, and occupational therapies.
- Home health services, including medical equipment, supplies, and appliances.
- Treatment for vision problems, including eyeglasses.
- Treatment for hearing problems, including hearing aids when they are not covered by CCS.
- Behavioral Health Treatment for health conditions such as autism spectrum disorders, and other developmental disabilities.
- Case management and health education.
- Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.

Blood lead poisoning screening

All children enrolled in Health Plan should get blood lead poisoning screening at 12 and 24 months of age or between 36 and 72 months of age if they were not tested earlier. Children should also be screened whenever the doctor believes a life change has put the child at risk.

Help getting child and youth well care services

Health Plan will help members under 21 years old and their families get the services they need. A Health Plan care coordinator can:

- Tell you about available services.
- Help find in-network providers or out-of-network providers, when needed.
- Help make appointments.
- Arrange medical transportation so children can get to their appointments.



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- Help coordinate care for services available through Fee-for-Service (FFS) Medi-Cal, such as:
 - Treatment and rehabilitative services for mental health and substance use disorders.
 - Treatment for dental issues, including orthodontics.

Other services you can get through Fee-for-Service (FFS) Medi-Cal or other programs

Dental check-ups

Keep your baby's gums clean by gently wiping the gums with a washcloth every day. At about four to six months, "teething" will begin as the baby teeth start to come in. You should make an appointment for your child's first dental visit as soon as their first tooth comes in or by their first birthday, whichever comes first.

These Medi-Cal dental services are free or low-cost services for:

Babies aged 1 to 4

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Baby's first dental visit ▪ Baby's first dental exam ▪ Dental exams (every 6 months, and sometimes more) ▪ X-rays ▪ Teeth cleaning (every 6 months, and sometimes more) | <ul style="list-style-type: none"> ▪ Fluoride varnish (every 6 months, and sometimes more) ▪ Fillings ▪ Extractions (tooth removal) ▪ Emergency dental services ▪ *Sedation (if medically necessary) |
|---|---|

Kids aged 5-12

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Dental exams (every 6 months, and sometimes more) ▪ X-rays ▪ Fluoride varnish (every 6 months, and sometimes more) ▪ Teeth cleaning (every 6 months, and sometimes more) | <ul style="list-style-type: none"> ▪ Molar sealants ▪ Fillings ▪ Root canals ▪ Extractions (tooth removal) ▪ Emergency dental services ▪ *Sedation (if medically necessary) |
|---|---|

Youth aged 13-20



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- Dental exams (every 6 months, and sometimes more)
- X-rays
- Fluoride varnish (every 6 months, and sometimes more)
- Teeth cleaning (every 6 months, and sometimes more)
- Orthodontics (braces) for those who qualify.
- Fillings
- Crowns
- Root canals
- Extractions (tooth removal)
- Emergency dental services
- Sedation (if medically necessary)

*Providers should consider sedation and general anesthesia when they determine and document a reason local anesthesia is not medically appropriate, and the dental treatment is pre-approved or does not need pre-approval (prior authorization).

These are some of the reasons local anesthesia cannot be used and sedation or general anesthesia might be used instead:

- Physical, behavioral, developmental, or emotional condition that blocks the patient from responding to the provider's attempts to perform treatment.
- Major restorative or surgical procedures.
- Uncooperative child.
- Acute infection at an injection site.
- Failure of a local anesthetic to control pain.

If you have questions or want to learn more about dental services, call the Medi-Cal Dental Program at 1-800-322-6384 (TTY 1-800-735-2922 or 711). Or go to <https://smilecalifornia.org/>.

Additional preventive education referral services

If you are worried that your child is not participating and learning well at school, talk to your child's doctor, teachers, or administrators at the school. In addition to your medical benefits covered by Health Plan, there are services the school must provide to help your child learn and not fall behind. Services that can be provided to help your child learn include:

- Speech and language services
- Psychological services
- Physical therapy
- Occupational therapy
- Assistive technology



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6 | Reporting and solving problems

- Social Work services
- Counseling services
- School nurse services
- Transportation to and from school

The California Department of Education provides and pays for these services. Together with your child's doctors and teachers, you can make a custom plan that will best help your child.



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Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

6. Reporting and solving problems

There are two ways to report and solve problems:

- Use a **complaint (grievance)** when you have a problem or are unhappy with Health Plan or a provider or with the health care or treatment you got from a provider.
- Use an **appeal** when you don't agree with Health Plan's decision to change your services or to not cover them.

You have the right to file grievances and appeals with Health Plan to tell us about your problem. This does not take away any of your legal rights and remedies. We will not discriminate or retaliate against you for filing a complaint with us or reporting issues. Telling us about your problem will help us improve care for all members.

You may contact Health Plan first to let us know about your problem. Call us between 8:00 a.m. to 5:00 p.m. at 1-888-936-PLAN (7526) (TTY 711). Tell us about your problem.

If your grievance or appeal is still not resolved after 30 days, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC). Ask them to review your complaint or conduct an Independent Medical Review (IMR). If your matter is urgent, such as those involving a serious threat to your health, you may call DMHC right away without first filing a grievance or appeal with Health Plan. You can call DMHC for free at 1-888-466-2219 (TTY 1-877-688-9891 or 711). Or go to: <https://www.dmhc.ca.gov>.

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can also help. They can help if you have problems joining, changing, or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, 8 a.m. to 5 p.m. at 1-888-452-8609. The call is free.

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call 1-888-936-PLAN



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

(7526) (TTY 711).

To report incorrect information about your health insurance, call Medi-Cal Monday through Friday, 8 a.m. to 5 p.m. at 1-800-541-5555.

Complaints

A complaint (grievance) is when you have a problem or are unhappy with the services you are getting from Health Plan or a provider. There is no time limit to file a complaint. You can file a complaint with Health Plan at any time by phone, in writing, or online. Your authorized representative or provider can also file a complaint for you with your permission.

- **By phone:** Call Health Plan at 1-888-936-PLAN (7526) (TTY 711) between 8:00 a.m. to 5:00 p.m. Give your health plan ID number, your name, and the reason for your complaint.
- **By mail:** Call Health Plan at 1-888-936-PLAN (7526) (TTY 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the reason for your complaint. Tell us what happened and how we can help you.

Mail the form to:

Health Plan of San Joaquin/Mountain Valley Health Plan
 Attention: Grievance and Appeals Department
 7751 South Manthey Road
 French Camp, CA 95231

Your doctor's office will have complaint forms.

- **Online:** Go to Health Plan's website at www.hpsj-mvhp.org.

If you need help filing your complaint, we can help you. We can give you no-cost language services. Call 1-888-936-PLAN (7526) (TTY 711).

Within 5 calendar days of getting your complaint, we will send you a letter telling you we got it. Within 30 days, we will send you another letter that tells you how we resolved



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
 Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
 Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

your problem. If you call Health Plan about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and your grievance is resolved by the end of the next business day, you may not get a letter.

If you have an urgent matter involving a serious health concern, we will start an expedited (fast) review. We will give you a decision within 72 hours. To ask for an expedited review, call us at 1-888-936-PLAN (7526) (TTY 711).

Within 72 hours of getting your complaint, we will decide how we will handle your complaint and whether we will expedite it. If we find that we will not expedite your complaint, we will tell you that we will resolve your complaint within 30 days. You may contact DMHC directly for any reason, including if you believe your concern qualifies for expedited review, or Health Plan does not respond to you within the 72-hour period.

Complaints related to Medi-Cal Rx pharmacy benefits are not subject to Health Plan grievance process or eligible for Independent Medical Review. Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or go to <https://medi-calrx.dhcs.ca.gov/home/>.

Complaints related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. DMHC's toll-free telephone number is 1-888-466-2219 (TTY 1-877-688-9891). You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: <https://www.dmhc.ca.gov/>.

Appeals

An appeal is different from a complaint. An appeal is a request for us to review and change a decision we made about your services. If we sent you a Notice of Action (NOA) letter telling you that we are denying, delaying, changing, or ending a service, and you do not agree with our decision, you can ask us for an appeal. Your authorized representative or provider can also ask us for an appeal for you with your written permission.

You must ask for an appeal within 60 days from the date on the NOA you got from us. If we decided to reduce, suspend, or stop a service you are getting now, you can continue getting that service while you wait for your appeal to be decided. This is called Aid Paid Pending. To get Aid Paid Pending, you must ask us for an appeal within 10 days from



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

the date on the NOA or before the date we said your services will stop, whichever is later. When you request an appeal under these circumstances, the services will continue.

You can file an appeal by phone, in writing or online:

- **By phone:** Call Health Plan at 1-888-936-PLAN (7526) (TTY 711) between 8:00 a.m. to 5:00 p.m. Give your name, health plan ID number and the service you are appealing.
- **By mail:** Call Health Plan at 1-888-936-PLAN (7526) (TTY 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the service you are appealing.

Mail the form to:

Health Plan of San Joaquin/Mountain Valley Health Plan
Attention: Grievance and Appeals Department
7751 South Manthey Road
French Camp, CA 95231

Your doctor's office will have appeal forms available.

- **Online:** Visit Health Plan website. Go to www.hpsj-mvhp.org.

If you need help asking for an appeal or with Aid Paid Pending, we can help you. We can give you no-cost language services. Call 1-888-936-PLAN (7526) (TTY 711).

Within 5 days of getting your appeal, we will send you a letter telling you we got it. Within 30 days, we will tell you our appeal decision and send you a Notice of Appeal Resolution (NAR) letter. If we do not give you our appeal decision within 30 days, you can request a State Hearing from the California Department of Social Services (CDSS) and an Independent Medical Review (IMR) with DMHC. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR with DMHC. In this case, the State Hearing has final say.

If you or your doctor wants us to make a fast decision because the time it takes to decide your appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call 1-888-936-PLAN



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

(7526) (TTY 711). We will decide within 72 hours of receiving your appeal.

What to do if you do not agree with an appeal decision

If you requested an appeal and got a NAR letter telling you we did not change our decision, or you never got a NAR letter and it has been past 30 days, you can:

- Ask for a **State Hearing** from the California Department of Social Services (CDSS), and a judge will review your case. CDSS' toll-free telephone number is 1-800-743-8525 (TTY 1-800-952-8349). You can also ask for a State Hearing online at <https://www.cdss.ca.gov>.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have Health Plan's decision reviewed. Or ask for an **Independent Medical Review (IMR)** from DMHC. If your complaint qualifies for DMHC's Independent Medical Review (IMR) process, an outside doctor who is not part of Health Plan will review your case and make a decision that Health Plan must follow.
DMHC's toll-free telephone number is 1-888-466-2219 (TTY 1-877-688-9891). You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: www.dmhc.ca.gov/.

You will not have to pay for a State Hearing or an IMR.

You are entitled to both a State Hearing and an IMR. But if you ask for a State Hearing first and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say.

The sections below have more information on how to ask for a State Hearing and an IMR.

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by Health Plan. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711.

Complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review (IMR).

If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing. You cannot ask DMHC for an IMR for Medi-Cal Rx pharmacy benefit decisions.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

Complaints and Independent Medical Reviews (IMR) with the Department of Managed Health Care (DMHC)

An IMR is when an outside doctor who is not related to your health plan reviews your case. If you want an IMR, you must first file an appeal with Health Plan. If you do not hear from your health plan within 30 calendar days, or if you are unhappy with your health plan's decision, then you may request an IMR. You must ask for an IMR within 6 months from the date on the notice telling you of the appeal decision, but you only have 120 days to request a State Hearing so if you want an IMR and a State hearing file your complaint as soon as you can. Remember, if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say.

You may be able to get an IMR right away without first filing an appeal with Health Plan. This is in cases where your health concern is urgent, such as those involving a serious threat to your health.

If your complaint to DMHC does not qualify for an IMR, DMHC will still review your complaint to make sure Health Plan made the correct decision when you appealed its denial of services.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-936-PLAN (7526) (TTY 711)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov/ has complaint forms, IMR application forms and instructions online.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

State Hearings

A State Hearing is a meeting with Health Plan and a judge from the CDSS. The judge will help to resolve your problem or tell you that we made the correct decision. You have the right to ask for a State Hearing if you already asked for an appeal with us and you are still not happy with our decision, or if you did not get a decision on your appeal after 30 days.

You must ask for a State Hearing within 120 days from the date on our NAR letter. If we gave you Aid Paid Pending during your appeal and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 days of our NAR letter or before the date we said your services will stop, whichever is later.

If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, contact Health Plan between 8:00 a.m. to 5:00 p.m. by calling 1-888-936-PLAN (7526). If you cannot hear or speak well, call TTY 711. Your authorized representative or provider can ask for a State Hearing for you with your written permission.

Sometimes you can ask for a State Hearing without completing our appeal process.

For example, if we did not notify you correctly or on time about your services, you can request a State Hearing without having to complete our appeal process. This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- We did not make a NOA or NAR letter available to you in your preferred language.
- We made a mistake that affects any of your rights.
- We did not give you a NOA letter.
- We did not give you a NAR letter.
- We made a mistake in our NAR letter.
- We did not decide your appeal within 30 days. We decided your case was urgent but did not respond to your appeal within 72 hours.

You can ask for a State Hearing in these ways:

- **Online:** Request a hearing online at www.CDSS.CA.GOV
- **Fax:** Fill out the form that came with your appeals resolution notice and Fax it to the State Hearings Division at 1-833-281-0905
- **By phone:** Call the State Hearings Division at 1-800-743-8525 (TTY 1-800-952-8349 or 711)



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- **By mail:** Fill out the form provided with your appeals resolution notice and send it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-442
Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you no-cost language services. Call 1-888-936-PLAN (7526) (TTY 711).

At the hearing, you will give your side. We will give our side. It could take up to 90 days for the judge to decide your case. Health Plan must follow what the judge decides.

If you want CDSS to make a fast decision because the time it takes to have a State Hearing would put your life, health, or ability to function fully in danger, you, your authorized representative, or your provider can contact CDSS and ask for an expedited (fast) State Hearing. CDSS must make a decision no later than 3 business days after it gets your complete case file from Health Plan.

Fraud, waste, and abuse

If you suspect that a provider or a person who gets Medi-Cal has committed fraud, waste, or abuse, it is your responsibility to report it by calling the confidential toll-free number 1-800-822-6222 or submitting a complaint online at <https://www.dhcs.ca.gov/>.

Provider fraud, waste, and abuse includes:

- Falsifying medical records.
- Prescribing more medicine than is medically necessary.
- Giving more health care services than medically necessary.
- Billing for services that were not given.
- Billing for professional services when the professional did not perform the service.
- Offering free or discounted items and services to members to influence which provider is selected by the member.
- Changing member's primary care provider without the knowledge of the member.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

Fraud, waste, and abuse by a person who gets benefits includes, but is not limited to:

- Lending, selling, or giving a health plan ID card or Medi-Cal Benefits Identification Card (BIC) to someone else.
- Getting similar or the same treatments or medicines from more than one provider.
- Going to an emergency room when it is not an emergency.
- Using someone else's Social Security number or health plan ID number.
- Taking medical and non-medical transportation rides for non-healthcare related services, for services not covered by Medi-Cal, or when you do not have a medical appointment or prescriptions to pick up.

To report fraud, waste, and abuse, write down the name, address, and ID number of the person who committed the fraud, waste, or abuse. Give as much information as you can about the person, such as the phone number or the specialty if it is a provider. Give the dates of the events and a summary of exactly what happened.

Send your report to:

Health Plan of San Joaquin/Mountain Valley Health Plan
Attention: Compliance Department
7751 South Mantney Road
French Camp, CA 95231
Fraud, Waste and Abuse Hotline: 1-855-400-6002 (TTY 711)



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

7. Rights and responsibilities

As a member of Health Plan, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of Health Plan.

Your rights

These are your rights as a member of Health Plan:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the health plan and its services, including covered services, practitioners, and member rights and responsibilities
- To get fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about Health Plan's member rights and responsibilities policy.
- To be able to choose a primary care provider within Health Plan's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for Health Plan's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting and translation services for your language.
- To get free legal help at your local legal aid office or other groups.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Health Plan and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll (drop) from Health Plan and change to another health plan in the county upon request.
- To access minor consent services.
- To get no-cost written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by Health Plan, your providers, or the state.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside Health Plan's network pursuant to the federal law.

Your responsibilities

The Health Plan's members have these responsibilities:

- Be familiar with and ask questions about your health plan coverage. If you have questions, you should contact Customer Service at 1-888-936-PLAN (7526) (TTY 711).



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- Follow the advice and care procedures indicated by your doctors, Health Plan and the program.
- Request interpreter services at least five (5) business days before your scheduled appointment.
- Call your doctor or pharmacy at least three (3) days before you run out of medication.
- Treat your doctors and all their staff with respect. This includes being on time to appointments and calling to reschedule or cancel.
- Understand that your doctor's office may have limited seating for patients and caregivers only.
- Give accurate information to the professional staff, following instructions, and cooperating with the providers, the Health Plan, your doctor's office, and any other doctor in order to receive the best care possible.
- Understand your health problems and work with your doctor to develop mutually agreed upon treatment goals.
- Ask your doctor questions if you do not understand what they are saying.
- Care for your own health. Live a healthy lifestyle, exercise, eat a good diet, and don't smoke.
- Avoid knowingly spreading disease to others.
- Report any wrongdoing or fraud to the Health Plan.
- Understand that there are risks in receiving health care and limits to what can be done for you medically.
- Understand that it is a health care doctors duty to be efficient and fair in caring for you as well as other patients.

Notice of non-discrimination

Discrimination is against the law. Health Plan follows state and federal civil rights laws. Health Plan does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status,



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Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

gender, gender identity, or sexual orientation.

Health Plan provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages.

If you need these services, contact Health Plan between 8:00 a.m. to 5:00 p.m. by calling 1-888-936-PLAN (7526). Or, if you cannot hear or speak well, call 711 to use the California Relay Service.

How to file a grievance

If you believe that Health Plan has failed to provide these services or unlawfully discriminated in another way based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Health Plan's Health Equity Officer. You can file a grievance in writing, in person, or electronically:

- **By phone:** Contact Health Plan's Healthy Equity Officer between 8:00 a.m. to 5:00 p.m. by calling 1-888-936-PLAN (7526). Or, if you cannot hear or speak well, call 711 to use the California Relay Service.
- **In writing:** Fill out a complaint form or write a letter and send it to:

Health Plan of San Joaquin/Mountain Valley Health Plan

Attention: Health Equity Officer

7751 South Manthey Road

French Camp, CA 95231

- **In person:** Visit your doctor's office or Health Plan and say you want to file a



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

grievance.

- **Electronically:** Visit Health Plan's website at www.hpsj-mvhp.org.

Office of Civil Rights – California Department of Health Care Services

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing or electronically:

- **By phone:** Call 1-916-440-7370. If you cannot speak or hear well, call 711 (Telecommunications Relay Service).
- **In writing:** Fill out a complaint form or send a letter to:
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at

https://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- **Electronically:** Send an email to CivilRights@dhcs.ca.gov.

Office of Civil Rights – U.S. Department of Health and Human Services

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing or electronically:

- **By phone:** Call 1-800-368-1019. If you cannot speak or hear well, call TTY 1-800-537-7697 or 711 to use the California Relay Service.
- **In writing:** Fill out a complaint form or send a letter to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/cp>.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

Ways to get involved as a member

Health Plan wants to hear from you. Every other month, Health Plan has meetings to talk about what is working well and how Health Plan can improve. Members are invited to attend. Come to a meeting!

Health Plan Community Advisory Committee

Health Plan has a group called Community Advisory Committee (CAC). This group is made up of Health Plan Members. You can join this group if you would like. The group talks about how to improve Health Plan policies and is responsible for:

- Culturally appropriate services or program designs.
- Priorities for health education and outreach programs.
- Member satisfaction survey results.
- Findings of health education, cultural, and linguistic group needs assessment.
- Plan marketing materials and campaigns.
- Talk about needs for doctor network development and assessment.
- Community resources and information.

If you would like to be a part of this group, call 1-888-936-PLAN (7526), (TTY 711).

Notice of privacy practices

A statement describing Health Plan policies and procedures for preserving the confidentiality of medical records is available and will be given to you upon request.

If you are of the age and capacity to consent to sensitive services, you are not required to get any other member's authorization to get sensitive services or to submit a claim for sensitive services. You can read more about sensitive services in the "Sensitive care" section of this handbook.

You can ask Health Plan to send communications about sensitive services to another mailing address, email address, or telephone number that you choose. This is called a "request for confidential communications." If you request confidential communications, Health Plan will not give information on your sensitive care services to anyone else without your written permission. If you do not give a mailing address, email address, or telephone number, Health Plan will send communications in your name to the address or telephone number on file.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).

Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

Health Plan will honor your requests to get confidential communications in the form and format you asked for. Or we will make sure your communications are easy to put in the form and format you asked for. We will send them to the place you choose. Your request for confidential communications lasts until you cancel it or submit new request for confidential communications.

How to request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us, you would be in danger if we do not.

We will process all confidential communication changes requested by you within 7 calendar days of receiving your request through electronic/telephonic communication, and within 14 calendar days of receiving your request through first class mail. We will send you a letter acknowledging the receipt of your request. Health Plan's statement of its policies and procedures for protecting your medical information (called a "Notice of privacy Practices") is included below:

Notice of Privacy Practice

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.



Call Customer Service at 1-888-936-PLAN (7526) (TTY 711).
Health Plan is here Monday – Friday, 8:00 a.m. to 5:00 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.hpsj-mvhp.org.

- Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- We will process all confidential communication changes requested by you within 7 calendar days of receiving your request through electronic/telephonic communication, and within 14 calendar days of receiving your request through first class mail. We will send you a letter acknowledging the receipt of your request.

Ask us to limit what we share about you

- You can ask us not to use or share certain health information.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you



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- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Share your information with a family member

- If you are of the age and capacity to consent and would like to share your information with a family member, you can request this disclosure in writing.
- You may also give a start and end time for the disclosure.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

If you have questions about the notice of privacy practices please contact Privacy Officer, Health Plan of San Joaquin/Mountain Valley Health Plan, 7751 South Manthey Road, French Camp, CA 95207 or PIU@hpsj.com.

<https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf>]

Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are state and federal laws about the Medi-Cal program. Other federal and state laws may apply too.



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Notice about Medi-Cal as a payer of last resort, other health coverage, and tort recovery

The Medi-Cal program follows state and federal laws and regulations relating to the legal liability of third parties for health care services to members. Health Plan will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

Medi-Cal members may have other health coverage (OHC), also referred to as private health insurance. As a condition of Medi-Cal eligibility, you must apply for or retain any available OHC when there is no cost to you.

Federal and state laws require Medi-Cal members to report OHC and any changes to an existing OHC. You may have to repay DHCS for any benefits paid by mistake if you don't report OHC quickly. Submit your OHC online at <http://dhcs.ca.gov/OHC>.

If you do not have access to the internet, you can report OHC to your Health Plan. Or call 1-800-541-5555 (TTY 1-800-430-7077 or 711) inside California, or 1-916-636-1980 (outside California).

The California Department of Health Care Services (DHCS) has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. For example, if you are injured in a car accident or at work, auto or workers' compensation insurance may have to pay first, or reimburse Medi-Cal.

If you are injured, and another party is liable for your injury, you or your legal representative must notify DHCS within 30 days of filing a legal action or a claim. Submit your notification online:

- Personal Injury Program at <https://dhcs.ca.gov/PI>
- Workers' Compensation Recovery Program at <https://dhcs.ca.gov/WC>

To learn more, visit <https://dhcs.ca.gov/tplrd> or call 1-916-445-9891.

Notice about estate recovery

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-for-Service (FFS) and managed care premiums or capitation payments for nursing facility services, home and community-based services, and related hospital and



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prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the DHCS estate recovery website at <https://dhcs.ca.gov/er> or call 1-916-650-0590.

Notice of Action

Health Plan will send you a Notice of Action (NOA) letter any time Health Plan denies, delays, terminates, or modifies a request for health care services. If you disagree with Health Plan's decision, you can always file an appeal with Health Plan. Go to the Appeals section above for important information on filing your appeal. When Health Plan sends you a NOA it will tell you all the rights you have if you disagree with a decision we made.

Contents in notices

If Health Plan bases denials, delays, terminations, or changes in whole or in part on medical necessity, your NOA must contain the following:

- A statement of the action Health Plan intends to take.
- A clear and concise explanation of the reasons for Health Plan's decision
- How Health Plan decided, including the rules Health Plan used
- The medical reasons for the decision. Health Plan must clearly state how the member's condition does not meet the rules or guidelines.

Translations

Health Plan is required to fully translate and provide written member information in common preferred languages, including all grievance and appeals notices.

The fully translated notice must include the medical reason for Health Plan's decision to deny, delay, change, reduce, suspend, or stop a request for health care services.

If your preferred language is not available, Health Plan is required to offer verbal help in your preferred language so that you can understand the information you get.



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8. Important numbers and words to know

Important phone numbers

- Health Plan customer services 1-888-936-PLAN (7526) (TTY 711)
 - Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711
 - 24/7 Advice Nurse Line 1-888-655-8294, (TTY 711)
-

Words to know

Active labor: The time period when a woman is in the three stages of giving birth and cannot be safely transferred to another hospital before delivery or a transfer may harm the health and safety of the woman or unborn child.

Acute: A short, sudden medical condition that requires fast medical attention.

American Indian: Individual who meets the definition of “Indian” under federal law at 42 CFR section 438.14, which defines a person as an “Indian” if the person meets any of the following:

- Is a member of a federally recognized Indian tribe,
 - Lives in an urban center and meets one or more of the following:
 - Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant in the first or second degree of any such member, or
 - Is an Eskimo or Aleut or other Alaska Native, or
 - Is considered by the Secretary of the Interior to be an Indian for any purpose, or
-



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- Is determined to be an Indian under regulations issued by the Secretary of the Interior, or
- Is considered by the Secretary of the Interior to be an Indian for any purpose, or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native

Appeal: A member's request for Health Plan to review and change a decision made about coverage for a requested service.

Benefits: Health care services and drugs covered under this health plan.

California Children's Services (CCS): A Medi-Cal program that provides services for children up to age 21 with certain health conditions, diseases, or chronic health problems.

Case manager: Registered nurses or social workers who can help you understand major health problems and arrange care with your providers.

Certified Nurse Midwife (CNM): A person licensed as a registered nurse and certified as a nurse midwife by the California Board of Registered Nursing. A certified nurse midwife is allowed to attend cases of normal childbirth.

Chiropractor: A provider who treats the spine by means of manual manipulation.

Chronic condition: A disease or other medical problem that cannot be completely cured or that gets worse over time or that must be treated so you do not get worse.

Clinic: A facility that members can select as a primary care provider (PCP). It can be either a Federally Qualified Health Center (FQHC), community clinic, Rural Health Clinic (RHC), Indian Health Care Provider (IHCP), or other primary care facility.

Community-based adult services (CBAS): Outpatient, facility-based services for skilled nursing care, social services, therapies, personal care, family and caregiver training and support, nutrition services, transportation, and other services for members who qualify.

Complaint: A member's verbal or written expression of dissatisfaction about a service covered by Medi-Cal, Health Plan, a county mental health plan, or a Medi-Cal provider. A complaint is the same as a grievance.

Continuity of care: The ability of a plan member to keep getting Medi-Cal services from their existing out-of-network provider for up to 12 months if the provider and Health



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Plan agree.

Contract Drugs List (CDL): The approved drug list for Medi-Cal Rx from which your provider may order covered drugs you need.

Coordination of Benefits (COB): The process of determining which insurance coverage (Medi-Cal, Medicare, commercial insurance, or other) has primary treatment and payment responsibilities for members with more than one type of health insurance coverage.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. You are automatically enrolled in a COHS plan if you meet enrollment rules. Enrolled recipients choose their health care provider from among all COHS providers.

Copayment (co-pay): A payment you make, generally at the time of service, in addition to the insurer's payment.

Coverage (covered services): Medi-Cal services for which Health Plan is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract and as listed in this Evidence of Coverage (EOC) and any amendments.

DHCS: The California Department of Health Care Services. This is the state office that oversees the Medi-Cal program.

Disenroll: To stop using this health plan because you no longer qualify or change to a new health plan. You must sign a form that says you no longer want to use this health plan or call HCO and disenroll by phone.

DMHC: The California Department of Managed Health Care. This is the state office that oversees managed care health plans.

Durable medical equipment (DME): Equipment that is medically necessary and ordered by your doctor or other provider. Health Plan decides whether to rent or buy DME. Rental costs must not be more than the cost to buy.

Early and periodic screening, diagnostic, and treatment (EPSDT): EPSDT services are a benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early as well as any treatment to take care of or help the conditions that might be found in the check-ups.

Emergency medical condition: A medical or mental condition with such severe



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symptoms, such as active labor (go to definition above) or severe pain, that someone with a prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger.
- Cause impairment to a bodily function.
- Cause a body part or organ to not work right.

Emergency care: An exam performed by a doctor or staff under direction of a doctor, as allowed by law, to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.

Emergency medical transportation: Transportation in an ambulance or emergency vehicle to an emergency room to get emergency medical care.

Enrollee: A person who is a member of a health plan and gets services through the plan.

Established patient: A patient who has an existing relationship with a provider and has gone to that provider within a specified amount of time established by the health plan.

Excluded services: Services that are not covered by the California Medi-Cal Program.

Experimental treatment: Drugs, equipment, procedures, or services that are in a testing phase with laboratory or animal studies before testing in humans. Experimental services are not undergoing a clinical investigation.

Family planning services: Services to prevent or delay pregnancy.

Federally Qualified Health Center (FQHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an FQHC.

Fee-for-Service (FFS) Medi-Cal: Sometimes your Medi-Cal plan does not cover services, but you can still get them through Medi-Cal FFS, such as many pharmacy services through Medi-Cal Rx.

Follow-up care: Regular doctor care to check a patient's progress after a hospitalization or during a course of treatment.

Fraud: An intentional act to deceive or misrepresent by a person who knows the deception could result in some unauthorized benefit for the person or someone else.

Freestanding Birth Centers (FBCs): Health facilities where childbirth is planned to occur away from the pregnant woman's residence that are licensed or otherwise



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approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan. These facilities are not hospitals.

Grievance: A member's verbal or written expression of dissatisfaction about Health Plan, a provider, the quality of care, or the services provided. A complaint filed with Health Plan about a network provider is an example of a grievance.

Habilitation services and devices: Health care services that help you keep, learn, or improve skills and functioning for daily living.

Health Care Options (HCO): The program that can enroll or disenroll you from the health plan.

Health care providers: Doctors and specialists such as surgeons, doctors who treat cancer, or doctors who treat special parts of the body, and who work with Health Plan or are in Health Plan network. Health Plan network providers must have a license to practice in California and give you a service Health Plan covers.

You usually need a referral from your PCP to go to a specialist. Your PCP must get pre-approval from Health Plan before you get care from the specialist.

You do **not** need a referral from your PCP for some types of service, such as family planning, emergency care, OB/GYN care, or sensitive services.

Health insurance: Insurance coverage that pays for medical and surgical expenses by repaying the insured for expenses from illness or injury or paying the care provider directly.

Home health care: Skilled nursing care and other services given at home.

Home health care providers: Providers who give you skilled nursing care and other services at home.

Hospice: Care to reduce physical, emotional, social, and spiritual discomforts for a member with a terminal illness. Hospice care is available when the member has a life expectancy of 6 months or less.

Hospital: A place where you get inpatient and outpatient care from doctors and nurses.

Hospital outpatient care: Medical or surgical care performed at a hospital without admission as an inpatient.

Hospitalization: Admission to a hospital for treatment as an inpatient.

Indian Health Care Providers (IHCP): A health care program operated by the Indian



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Health Service (IHS), an Indian Tribe, Tribal Health Program, Tribal Organization or Urban Indian Organization (UIO) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. section 1603).

Inpatient care: When you have to stay the night in a hospital or other place for the medical care you need.

Intermediate care facility or home: Care provided in a long-term care facility or home that provides 24-hour residential services. Types of intermediate care facilities or homes include intermediate care facility/developmentally-disabled (ICF/DD), intermediate care facility/developmentally disabled-habilitative (ICF/DD-H), and intermediate care facility/developmentally disabled-nursing (ICF/DD-N).

Investigational treatment: A treatment drug, biological product or device that has successfully completed phase one of a clinical investigation approved by the FDA but that has not been approved for general use by the FDA and remains under investigation in an FDA approved clinical investigation.

Long-term care: Care in a facility for longer than the month of admission plus one month.

Managed care plan: A Medi-Cal plan that uses only certain doctors, specialists, clinics, pharmacies, and hospitals for Medi-Cal recipients enrolled in that plan. Health Plan is a managed care plan.

Medi-Cal Rx: An FFS Medi-Cal pharmacy benefit service known as “Medi-Cal Rx” that provides pharmacy benefits and services, including prescription drugs and some medical supplies to all Medi-Cal beneficiaries.

Medical home: A model of care that will provide better health care quality, improve self-management by members of their own care, and reduce avoidable costs over time.

Medically necessary (or medical necessity): Medically necessary services are important services that are reasonable and protect life. The care is needed to keep patients from getting seriously ill or disabled. This care reduces severe pain by treating the disease, illness, or injury. For members under the age of 21, Medi-Cal medically necessary services include care that is needed to fix or help a physical or mental illness or condition, including substance use disorders, as set forth in Section 1396d(r) of Title 42 of the United States Code.

Medical transportation: Transportation when you cannot get to a covered medical appointment or to pick up prescriptions by car, bus, train, or taxi and your provider



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prescribes it for you. Health Plan pays for the lowest cost transportation for your medical needs when you need a ride to your appointment.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

Member: Any eligible Medi-Cal member enrolled with Health Plan who is entitled to get covered services.

Mental health services provider: Licensed persons who provide mental health and behavioral health services to patients.

Midwifery services: Prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn, provided by certified nurse midwives (CNM) and licensed midwives (LM).

Network: A group of doctors, clinics, hospitals, and other providers contracted with Health Plan to provide care.

Network provider (or in-network provider): Go to “Participating provider.”

Non-covered service: A service that Health Plan does not cover.

Non-medical transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by your provider and when picking up prescriptions and medical supplies.

Non-participating provider: A provider not in Health Plan network.

Other health coverage (OHC): Other health coverage (OHC) refers to private health insurance and service payers other than Medi-Cal. Services may include medical, dental, vision, pharmacy, or Medicare supplemental plans (Part C & D).

Orthotic device: A device used as a support or brace attached outside the body to support or correct a badly injured or diseased body part that is medically necessary for the medical recovery of the member.

Out-of-area services: Services while a member is anywhere outside of the service area.

Out-of-network provider: A provider who is not part of Health Plan’s network.

Outpatient care: When you do not have to stay the night in a hospital or other place for the medical care you need.



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Outpatient mental health services: Outpatient services for members with mild to moderate mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory, supplies, and supplements

Palliative care: Care to reduce physical, emotional, social, and spiritual discomforts for a member with a serious illness. Palliative care does not require the member to have a life expectancy of 6 months or less.

Participating hospital: A licensed hospital that has a contract with Health Plan to provide services to members at the time a member gets care. The covered services that some participating hospitals might offer to members are limited by Health Plan's utilization review and quality assurance policies or Health Plan's contract with the hospital.

Participating provider (or participating doctor): A doctor, hospital, or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with Health Plan to offer covered services to members at the time a member gets care.

Physician services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while you are admitted in a hospital that are charged in the hospital bill.

Plan: Go to "Managed care plan."

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized to keep the member stabilized. Post-stabilization care services are covered and paid for. Out-of-network hospitals might need pre-approval (prior authorization).

Pre-approval (prior authorization): The process by which you or your provider must request approval from Health Plan for certain services to make sure Health Plan will cover them. A referral is not an approval. A pre-approval is the same as prior authorization.

Prescription drug coverage: Coverage for medications prescribed by a provider.



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Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed, unlike over-the-counter (“OTC”) drugs that do not require a prescription.

Primary care: Go to “Routine care.”

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need.

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- OB/GYN
- Indian Health Care Provider (IHCP)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (pre-approval): The process by which you or your provider must request approval from Health Plan for certain services to ensure Health Plan will cover them. A referral is not an approval. A prior authorization is the same as pre-approval.

Prosthetic device: An artificial device attached to the body to replace a missing body part.

Provider Directory: A list of providers in Health Plan network.

Psychiatric emergency medical condition: A mental disorder in which the symptoms are serious or severe enough to cause an immediate danger to yourself or others or you are immediately unable to provide for or use food, shelter, or clothing due to the mental disorder.

Public health services: Health services targeted at the whole population. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified provider: Doctor qualified in the area of practice appropriate to treat your condition.



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Reconstructive surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors, or disease.

Referral: When your PCP says you can get care from another provider. Some covered care services require a referral and pre-approval (prior authorization).

Rehabilitative and habilitative therapy services and devices: Services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

Routine care: Medically necessary services and preventive care, well-child visits, or care such as routine follow-up care. The goal of routine care is to prevent health problems.

Rural Health Clinic (RHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an RHC.

Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

Serious illness: A disease or condition that must be treated and could result in death.

Service area: The geographic area Health Plan serves. This includes the counties of Alpine, El Dorado, San Joaquin, and Stanislaus.

Skilled nursing care: Covered services provided by licensed nurses, technicians or therapists during a stay in a skilled nursing facility or in a member's home.

Skilled nursing facility: A place that gives 24-hour-a-day nursing care that only trained health professionals can give.

Specialist (or specialty doctor): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a referral from your PCP to go to a specialist.

Specialty mental health services: Services for members who have mental health services needs that are higher than a mild to moderate level of impairment.

Subacute care facility (adult or pediatric): A long-term care facility that provides



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comprehensive care for medically fragile persons that need special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.

Terminal illness: A medical condition that cannot be reversed and will most likely cause death within one year or less if the disease follows its natural course.

Tort recovery: When benefits are provided or will be provided to a Medi-Cal member because of an injury for which another party is liable, DHCS recovers the reasonable value of benefits provided to the member for that injury.

Triage (or screening): The evaluation of your health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of your need for care.

Urgent care (or urgent services): Services provided to treat a non-emergency illness, injury or condition that requires medical care. You can get urgent care from an out-of-network provider, if in-network providers are temporarily not available or accessible.



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Our Service Area

Alpine, El Dorado, San Joaquin, and Stanislaus Counties



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