Health Plan of San Joaquin

Health Plan of San Joaquin | Mountain Valley Health Plan

2026

Health Plan Medi-Cal Combined Evidence of Coverage (EOC) and Disclosure Form

Member Handbook

Alpine, El Dorado, San Joaquin and Stanislaus Counties

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

DUALEOC2026E

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages for free. Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") provides written translations from qualified translators. Call **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 format, and accessible electronic formats (data CD) at no cost to you. Call Customer Service at 1-888-936-PLAN (7526), TTY 711. The call is free.

Interpreter services

Health Plan provides oral interpretation services, as well

as sign language, 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 for free. Help is available 24 hours a day, 7 days a week. For help in your language, or to get this handbook in a different language, call Customer Service 1-888-936-PLAN (7526), TTY 711. The call is free.

English

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 of charge.

العربية (Arabic)

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

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-888-936-7526, TTY 711**: Կան նաև օժանդակ միջոցներու ծառայություններ

հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-888-936-7526, TTY 711**: Այս ծառայություններն անվճար են:

中文 (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。**另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1-888-936-7526, TTY 711**。这些服务都是免费的。

हिंदी (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 निःशुल्क हैं।

Hmoob (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 (Japanese)

注意：日本語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を用意しています。**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 (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.

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານ ໃຫ້ໂທຫາເບີ **1-888-936-7526, TTY 711**.
ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການ ເຊັ່ນ: ເອກະສານທີ່ເປັນອັກສອນນູນ ແລະ ມີໂຕພິມໃຫຍ່, ໃຫ້ໂທຫາເບີ **1-888-936-7526, TTY 711**.
ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍໆ

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 hluo 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.

ខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក
សូមទូរសព្ទទៅលេខ **1-888-936-7526, TTY 711**។ ជំនួយ
ឯសេវាកម្មសម្រាប់ជនពិការ
ដូចជាឯកសារសរសេរជាអក្សរផុសសម្រាប់ជនពិការ
និងជាពុម្ពអក្សរធំក៏អាចរកបានផងដែរ។ ទូរសព្ទទៅលេខ
1-888-936-7526, TTY 711។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ ។

فارسی (Farsi)

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

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ
1-888-936-7526, TTY 711 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ
ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ
ਉਪਲਬਧ ਹਨ। **1-888-936-7526, TTY 711** 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ

ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-888-936-7526, TTY 711**. Предоставляются также средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-888-936-7526, TTY 711**. Такие услуги предоставляются бесплатно

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.

Tagalog (Filipino)

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.

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-888-936-7526, TTY 711**. นอกจากนี้ ยังพร้อมให้ค วามช่วยเหลือและบริการต่าง ๆ ส าหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วย ตัวอักษรขนาดใหญ่. กรุณาโทรศัพท์ไปที่หมายเลข **1-888-936-7526, TTY 711**. ไม่มีค่าใช้จ่ายส าหรับบริการเหล่านี้.

Українська (Ukrainian)

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

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 bản in khổ chữ lớn. Vui lòng gọi số **1-888-936-7526, TTY 711**. Các dịch vụ này đều miễn phí.

Welcome to Health Plan!

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

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. **This EOC and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.** To learn more, 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 the California Department of Health Care Services (DHCS), call 1-888-936-PLAN (7526), TTY 711. You may ask for another copy of the Member Handbook for free. You can also find the Member Handbook on the Health Plan 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 website www.hpsj-mvhp.org.

Contact us

Health Plan is here to help. If you have questions, 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.

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

Table of contents

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!

Customer Service

Health Plan Customer Service is here to help you. Health Plan can:

- Answer questions about your health plan and Health Plan 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 speak limited 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 Customer Service 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. Please contact Alpine County Health and Human Services at 1-530-694-2235, El Dorado Health and Human Services Agency at 1-530-621-6150, San Joaquin Human Services Agency at 1-209-468-1000, or Stanislaus Community Services Agency at 1-209-558-2500. You might also qualify for Medi-Cal through Social Security because you are getting SSI or SSP.

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.

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

You may be able to get Transitional Medi-Cal if you started earning more money and you no longer qualify for Medi-Cal.

You can ask questions about qualifying for Transitional Medi-Cal at your local county 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 Identification (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 Medi-Cal BIC card is the benefits identification card sent to you by the State of California. You should always carry all health cards with you. Your Medi-Cal BIC and Health Plan 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.

If you do not get your Health Plan ID card within a few weeks after your enrollment date, or if your Health Plan ID card is damaged, lost, or stolen, call Customer Service right away. Health Plan will send you a new card for free. Call 1-888-936-PLAN (7526), TTY 711. If you do not have a Medi-Cal BIC card or if your card is damaged, lost, or stolen, call the local county office. To find your local county office, go to http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

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, and Stanislaus. Health Plan works with the State of California to help you get the health care you need.

Talk with one of the Health Plan's 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 Benefits Identification Card (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 pre-populated Medi-Cal renewal form. Complete this form and return it to your local county office. You can return your information in person, by phone, by mail, online, 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.

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

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 Medi-Cal coverage may end if any of the following is true:

- 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 in- and out-of-network case management. If you ask to get services from an IHCP, Health Plan must help you find an in- or out-of-network IHCP of your choice. 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 providers in the 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 during office hours, how to request free 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 if another health plan is available. 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 by contacting your local county office. Find your local county 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 United States 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 Health Plan. Read more below.

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.

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 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 County 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 in joining a 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” in this handbook. For routine or preventive health care, you would need to use the Health Plan’s network of providers located in, Alpine, El Dorado, San Joaquin, or Stanislaus counties.

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 care and urgent care in another state. Medi-Cal will also cover emergency care that requires hospitalization in Canada and Mexico.

Routine and preventive care services are not covered when you are outside of California. You will not qualify for Medi-Cal medical benefit coverage for those out-of-state services. 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 emergency care requiring hospitalization in Canada and Mexico as noted in Chapter 3.

Out-of-state pharmacy benefits are limited to up to a 14-day emergency supply when delays would prevent a medically necessary service. For more help, call Medi-Cal Rx at 1-800-977-2273 or visit them online at https://medi-calrx.dhcs.ca.gov/home.

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 the Health Plan's network, read Section 3: Provider Network or visit www.hpsj-mvhp.org. Providers not listed in the directory may not be in the Health Plan's network.

In some cases, you might be able to get care from providers who are not in the Health Plan network. If you were required to change your health plan or to switch from FFS Medi-Cal 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 the 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 Service at 1-888-936-PLAN (7526), TTY 711.

If your providers do not join the 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 the Health Plan network. To discuss your choices, call Customer Service at 1-888-936-PLAN (7526), TTY 711.

Health Plan is not required to provide continuity of care for an out-of-network provider for certain ancillary (supporting) services such as radiology, laboratory, dialysis centers, or transportation. You will get these services with 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 up to 12 months from the coverage start or the date the provider's contract ends with Health Plan.
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.
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.

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 Service 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 not covered under Health Plan'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. 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.

If you are enrolled in the County Children's Health Initiative Program (CCHIP) in Santa Clara, San Francisco, or San Mateo counties or are enrolled in Medi-Cal for Families, you might have a monthly premium and co-pays.

Except for emergency care, urgent care that is outside the Health Plan service area, or sensitive care, you must get pre-approval (prior authorization) from Health Plan before you visit a provider outside the Health Plan 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, out-of-area 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 website at www.hpsj-mvhp.org.

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.

For members with long-term care and a Monthly Resident Cost

You might have to pay a Monthly Resident Cost (share of cost) each month for your long-term care services. The amount of your Monthly Resident Cost depends on your income. Each month, you will pay your own health care bills, including but not limited to, long-term care bills, until the amount you have paid equals your Monthly Resident 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 Monthly Resident 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 any Medi-Cal covered services, do not pay the bill. Call Customer Service right away at 1-888-936-PLAN (7526), TTY 711. Health Plan will help you figure out if the bill is correct.

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 users can use option 7 or call 711. 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

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 while you were 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, or someone on your behalf, 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.

If the provider is enrolled in Medi-Cal but is not in the Health Plan's 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 care, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval (prior authorization). If 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 Monthly Resident 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.

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 card or Health Plan ID card.

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

The Health Plan's Medi-Cal network is a group of doctors, hospitals, and other providers who work with Health Plan. If you have only Medi-Cal coverage, 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 the Health Plan's 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 the Health Plan's website at www.hpsj-mvhp.org.

If you cannot get the care you need from a participating provider in the Health Plan's 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

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 of this handbook.

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 the Health Plan's 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 you to a specialist if you need one
- Arrange for hospital care if you need it

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

You can find the 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. However, if you want to change to a new PCP, you can change anytime. You must choose a PCP who is in the 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.

Health Plan can change your PCP if the PCP is not taking new patients, has left the 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 and new Health Plan member ID card in the mail. It will have the name of your new PCP. Call Customer Service 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?
- 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 your first health appointment, called an Initial Health Appointment (IHA). The purpose of the first health appointment 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 first health appointment, tell the person who answers the phone that you are a member of Health Plan. Give your Health Plan ID number.

Take your Medi-Cal BIC card, Health Plan ID card and any other health insurance cards 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 your first health appointment, 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 check-ups, screenings, immunizations, 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 check-ups, immunizations

(shots), treatment, prescriptions, required screenings, and medical advice.
- Keep your health records.
- Refer 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 PCP for an appointment. Be sure to call your PCP before you get medical care unless it is an emergency. For emergency care, call **911** or go to the nearest emergency room or hospital.

To learn more about health care and services Health 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 in-network 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. 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 the Health Plan’s 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.

In-network providers

You will use providers in the Health Plan's 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 the Health Plan's 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 visit an out-of-network provider except when:

- If you need emergency care, call **911** or go to the nearest emergency room or hospital.
- If you are outside the 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 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 providers that do not have an agreement to work with Health Plan. Except for emergency care, and care pre-approved by Health Plan, you might have to pay for any care you get from out-of-network providers in your service area.

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 for free. 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. For Health Plan's time or distance standards for where you live, go to www.hpsj-mvhp.org. If we give you a referral to an out-of-network provider, we will pay for your care.

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

If you get urgent care from an out-of-network provider inside Health Plan 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 the Health Plan 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. 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 or hospital. 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. To learn more about being paid back, read Chapter 2, "About your health plan" in this handbook.

If you are in another state or are in a United States Territory such as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, or the United States 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 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.

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

If you need urgent care out of the 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 health plan. Health Plan provides care to members who live 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 Health Plan 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. If you have a medical emergency, you can get care right away at any emergency room, hospital or urgent care facility, even if it is not connected to your medical group. To learn more, read "Urgent care" and "Emergency care" in Chapter 3 of this handbook.

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 care, family planning services, or in-network mental health services.

Members who have both Medicare and Medi-Cal

Members who have both Medicare and Medi-Cal and are enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO) will have access to providers who are part of their Medicare coverage as well as providers who are included in the Medi-Cal plan coverage. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP members should refer to the Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP Member Handbook and Provider Directory for information about benefits, services, and providers offered by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. For more information, please call Customer Service at 1-888-361-7526 (TTY: 711) or visit www.hpsj-mvhp.org.

Doctors

You will choose a doctor or other provider from the Health Plan Provider Directory as your PCP. The PCP you choose must be an in-network provider. To get a copy of the Health Plan 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 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 Chapter 2, “About your health plan” 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 the Health Plan 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 the Health Plan 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 emergency room or hospital.

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital that your PCP uses and is in the Health Plan provider network. The Provider Directory lists the hospitals in the Health Plan 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 preventative and 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.

For family planning services, your provider does not have to be in the Health Plan provider network. You can choose any Medi-Cal provider and go to them without a referral or pre-approval (prior authorization). For help finding a Medi-Cal provider outside the Health Plan provider network, call 1-888-936-PLAN (7526), TTY 711.

Provider Directory

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

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

The Provider Directory has Health Plan's in-network provider names, specialties, addresses, phone numbers, business hours, languages spoken, and whether the

provider is taking new patients. The Provider Directory also shows whether a provider has informed Health Plan that they offer gender affirming services. 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, professional qualifications, residency completion, 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 shown in the table below. Health Plan must authorize a referral for care to an out-of-network provider if the services you need are not available in-network within these timely access standards.

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 including psychiatrist	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days

Appointment type	You should be able to get an appointment within:
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:
Customer Service 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. You can choose to wait for a later appointment or call Health Plan to go to another provider of your choice. Your provider and Health Plan will 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.

Tell us if you need interpreter services, including sign language, when you call Health Plan or when you get covered services. Interpreter services are available for free. 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, 8:00 a.m. to 5:00 p.m.

Travel time or distance to care

Heath 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, go to www.hpsj-mvhp.org. Or call 1-888-936-PLAN (7526), TTY 711.

It is considered far if you cannot get to that provider within the 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.

If you need care from a provider located far from where you live, call Customer Service 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.

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 Medi-Cal BIC card and Health Plan ID card to your appointment.
- 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 or hospital. If you need help deciding how urgently you need care and your PCP is not available to speak with you, call the Health Plan's Nurse Advice Line at 1-800-655-8294, TTY 711.

Getting to your appointment

If you do not 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 Non-Medical Transportation. These transportation services are not for emergencies and are available for free.

If you are having an emergency, call **911**. Transportation is available for services and appointments not related to emergency care.

To learn more, read “Transportation benefits for situations that are not emergencies” in Chapter 4 of this handbook.

Canceling and rescheduling

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

Payment

You do **not** have to pay for covered services unless you have a Monthly Resident Cost for long-term care. To learn more, read “For members with long-term care and a Monthly Resident Cost” in Chapter 2. of this handbook. 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 card when you get health care services or 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 go to 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. Health Plan will help you figure out if the bill was for a covered service or not. You do not need to pay providers for any amount owed by Health Plan for any covered service. 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.

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 must get pre-approval (prior authorization) from Health Plan before you visit an out-of-network provider except when:

- You need emergency care, in which case call **911** or go to the nearest emergency room or 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 need to get medically necessary care from an out-of-network provider because it is not available in the Health Plan 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 do not 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 about the item or service you paid for. 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 Monthly Resident 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 ask to be paid back for Medicare Part D 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” earlier in this chapter. 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. Having a standing referral 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 the 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)
- Initial mental health assessment
- Minor consent services (under 18 years old)
- Immunizations provided by the county Local Health Department
- Podiatry visits

Minors can also get certain outpatient mental health treatment or counseling and substance use disorder (SUD) treatment and services without a parent or guardian’s consent. To learn more, read “Minor consent services” later in this chapter and “Substance use disorder (SUD) 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 the out-of-network center 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 (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 the Health Plan network:

- Hospitalization, if not an emergency

- Services out of the Health Plan service area, if not an emergency or urgent care
- Outpatient surgery
- Long-term care or skilled nursing services at a nursing facility (including adult and pediatric Subacute Care Facilities contracted with the Department of Health Care Services Subacute Care Unit) or intermediate care facilities (including Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N))
- 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).

Health Plan has five business days from when Health Plan gets the information reasonably needed to decide (approve or deny) pre-approval (prior authorization) requests. When a pre-approval (prior authorization) request is made by a provider and 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 a pre-approval (prior authorization) decision in no longer than 72 hours. This means that after getting the request for pre-approval (prior authorization), Health Plan will give you notice as quickly as your health condition requires and no later than 72 hours or five days after 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 Health Plan network or out of your service area. This includes labor and delivery if you are 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. 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. If you want to get a second opinion, we will refer you to a qualified in-network provider who can give you one.

To ask for a second opinion and get help choosing a provider, call 1-888-936-PLAN (7526), TTY 711. Your in-network provider can also help you get a referral for a second opinion if you want one.

If there is no provider in the Health Plan 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 five 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 do not need parent or guardian permission to get some health care services and you can receive them confidentially, which means your parent or guardian will not be notified or contacted if you get these services without your written permission. These services are called minor consent services.

You can get the following services at any age without your parent or guardian’s permission:

- Sexual assaults services
- Pregnancy and pregnancy related services, including abortion services

- Family planning services, such as contraception services (e.g., birth control)

If you are at **age 12 or older** in addition to the services above, you can also get the following services without your parent or guardian's permission:

- Outpatient mental health treatment or counseling. This will depend on your maturity and ability to take part in your health care, as determined by a professional person.
- Infections, contagious, or communicable disease diagnosis and treatment, including for HIV/AIDS
- Sexually transmitted infection (STI) prevention, testing, diagnosis, and treatment for STIs like syphilis, gonorrhea, chlamydia, and herpes simplex
- Intimate partner violence services
- Substance use disorder (SUD) treatment for drug and alcohol abuse including screening, assessment, intervention, and referral services

You can get minor consent services from any Medi-Cal provider or clinic. Providers do not have to be in the Health Plan network. You do not need a referral from your PCP or pre-approval (prior authorization).

If you use an out-of-network provider for services **not** related to sensitive care, then they may not be covered.

To find a Medi-Cal provider outside the Health Plan Medi-Cal network for minor consent services, or to ask for transportation help to get to a provider, call Health Plan Customer Services at 1-888-936-PLAN (7526), TTY 711.

For more on contraceptive services, read "Preventive and wellness services and chronic disease management" in Chapter 4 of this handbook.

Health Plan does not cover minor consent services that are specialty mental health services (SMHS) or most SUD services. The county where you live covers these services. To learn more, including how to access these services, read the "Specialty Mental Health Services (SMHS)" and "Substance Use Disorder (SUD) Treatment Services" in Chapter 4 of this handbook. To learn more, call 1-888-936-PLAN (7526), TTY 711.

For a list of all counties' toll-free telephone numbers for SMHS, go to: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

For a list of all counties' toll-free telephone numbers for SUD treatment services, go to: https://www.dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

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.

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

You can also ask to get private information about your medical services in a certain form or format, if available. You can have it sent to you at another location. To learn more about how to ask for confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7 of this handbook.

Adult sensitive care services

If you are an adult who is 18 years or older, you do not have 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. For adults 21 years and older, these services include sterilization.
- Pregnancy testing and counseling and other pregnancy-related services
- 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 the 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 nurse line at 1-800-655-8294, TTY 711.

Health Plan will not give information on your sensitive care services to your Health Plan policyholder or primary subscriber, or to any Health Plan enrollees, without your written permission. You can get private information about your medical services in a certain form or format, if available, and have it sent to you at another location. To learn more about how to request confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7 of this handbook.

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. These

services are still available to you from another provider. 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

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. Ask if the provider can and will provide the services you need. Or call Health Plan at 1-888-936-PLAN (7526), TTY 711.

These services are available to you. Health Plan will make sure you and your family members can use providers (doctors, hospitals, and 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 nurse advise line 24/7 at 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

When you are inside Health Plan's service area and need urgent care, you must get the urgent care services from an in-network provider. You do not need pre-approval (prior authorization) for urgent care from in-network providers inside Health Plan's service area. If you need help finding an in-network urgent care provider, call Customer Service at 1-888-936-PLAN (7526), TTY 711 or go to www.hpsj-mvhp.org.

If you are outside the Health Plan service area, but inside the United States, you do not need pre-approval (prior authorization) to get urgent care outside the service area. 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 urgent mental health care or substance use disorder services, call your county mental health or substance use disorder program, or Customer Service at 1-888-936-PLAN (7526), TTY 711. Call your county mental health or substance use disorder program or your Health Plan Behavioral Health Plan 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 while you are there, Health Plan will cover them as part of your covered visit. If your urgent care provider gives you a prescription that you need 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 Chapter 4 of this handbook.

Emergency care

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

Inside the United States (including territories such as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, or the United States Virgin Islands), 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 do not 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
- Trouble breathing
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts

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. You do not need to ask your PCP or Health Plan before you go to the ER. However, if you are not sure if your medical condition is an emergency, call your PCP. You can also call the nurse advise line 24/7 at 1-800-655-8294, TTY 711.

If you need emergency care outside the Health Plan service area, go to the nearest ER even if it is not in the Health Plan 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**.

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

If you or someone you know is in crisis, please contact the **988** Suicide and Crisis Lifeline. **Call or text 988** or **chat online at 988lifeline.org/chat**. The **988** Suicide and Crisis Lifeline offers free and confidential support for anyone in crisis. That includes

people who are in emotional distress and those who need support for a suicidal, mental health, and/or substance use crisis.

Remember: Do not call **911** unless you reasonably believe you have a medical 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 or hospital.

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 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 health care directives

An advance health care directive, or advance 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 health 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), TTY 711.

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 go to the United States Department of Health and Human Services website at www.organdonor.gov.

4. Benefits and services

What benefits and services your health plan covers

This chapter explains benefits and services covered by Health Plan. Your covered services are free as long as they are medically necessary and provided by a Health Plan in-network provider. You must ask Health Plan for pre-approval (prior authorization) if the care is out-of-network except for certain sensitive services, emergency care, and urgent care outside of Health Plan service area. 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” in this handbook.

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

- Acupuncture*
- Acute (short-term treatment) home health therapies and services
- Allergy testing and injections
- Ambulance services for an emergency
- Anesthesiologist services
- Asthma prevention
- Audiology*
- Basic care management services
- Behavioral health treatment*
- Biomarker testing*
- Cardiac rehabilitation
- Chiropractic services*
- Chemotherapy & Radiation therapy
- Cognitive health assessments
- Community Health Worker (CHW) services
- Community Supports
- Complex Care Management (CCM) 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
- Enhanced Care Management (ECM) services
- Enteral and parenteral nutrition*
- Family planning services (you can go to an out-of-network provider)
- Gender-affirming care
- Habilitative services and devices*
- Hearing aids
- Home health care*
- Hospice care*
- Immunizations (shots)
- Inpatient medical and surgical care*
- Intermediate care facility for developmentally disabled services
- Lab and radiology*
- Long-term home health therapies and services*
- Long-term services and supports
- Maternity and newborn care
- Mental health treatment
- Occupational therapy*
- Organ and bone marrow transplant*
- 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, including subacute services
- Specialist visits
- Speech therapy*
- Street medicine services
- Substance use treatment
- Surgical services

- Telemedicine/Telehealth
- Transgender services*
- Transitional care 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" in this handbook.

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 age 21, a service is medically necessary if it is necessary to correct or improve defects and physical and mental illnesses or conditions under the Medi-Cal for Kids and Teens (also known as 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 do not 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

For members younger than 21 years old, medically necessary services include all covered services listed above plus any other necessary health care, screening, immunizations, diagnostic services, treatment, and other measures to correct or improve defects and physical and mental illnesses and conditions, the Medi-Cal for Kids and Teens benefit requires. This benefit is known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit under federal law.

Medi-Cal for Kids and Teens provides prevention, diagnostic, and treatment services for enrolled infants, children, and adolescents under 21 years old. Medi-Cal for Kids and Teens covers more services than services offered to adults. It is designed to make sure children get early detection and care to prevent or diagnose and treat health problems as soon as possible. The goal of Medi-Cal for Kids and Teens 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” later in this chapter.

Medi-Cal benefits covered by Health Plan

Outpatient (ambulatory) services

Adult immunizations (shots)

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

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

Allergy care

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

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 two services per month, or combination of two 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 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 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 (CHW) services

Health Plan covers 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. CHW services have no service location limits and members can receive services in

settings, such as the emergency room. Services may include:

- Health education and individual support or advocacy, including control and prevention of chronic or infectious diseases; behavioral, perinatal, and oral health conditions; and violence or injury prevention
- Health promotion and coaching, including goal setting and creating action plans to address disease prevention and management
- Health navigation, including providing information, training, and support to help get health care and community resources
- Screening and assessment services that do not require a license, and help connect a member to services to improve their health

CHW violence prevention services are available to members who meet any of the following circumstances as determined by a licensed practitioner:

- The member has been violently injured as a result of community violence.
- The member is at significant risk of experiencing violent injury as a result of community violence.
- The member has experienced chronic exposure to community violence.

CHW violence prevention services are specific to community violence (e.g., gang violence). CHW services can be provided to members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

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 provided by in-network doula providers during a member's pregnancy; during labor and delivery, including stillbirth, miscarriage, and abortion; and within one year of the end of a member's pregnancy. Medi-Cal does not cover all doula services. Doula services do not include determination of medical conditions, providing medical advice, or any type of clinical assessment, exam, or procedure. The following Medi-Cal services are not part of the doula benefit:

- Behavioral health services

- Belly binding after cesarean section by a clinician
- Clinical case coordination
- Childbirth education group classes
- Comprehensive health education, including orientation, assessment, and planning (Comprehensive Perinatal Services program services)
- Health care services related to pregnancy, birth, and the postpartum period
- Hypnotherapy (non-specialty mental health service (NSMHS))
- Lactation consulting, group classes, and supplies
- Medically Necessary Community Supports services
- Nutrition services (assessment, counseling, and care plan development)
- Transportation

If a member needs or wants doula or pregnancy-related services that are **not** covered, the member or doula can request care. Call the member's PCP or Health Plan Customer Service.

Doula providers 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, stillbirth, miscarriage, and abortion.

Any pregnant or postpartum member may receive the following services from an in-network doula provider:

- One initial visit
- Up to eight additional visits that can be a mix of prenatal and postpartum visits
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage
- Up to two extended three-hour postpartum visits after the end of a pregnancy

Members may receive up to nine additional postpartum visits with an additional written recommendation from a physician or other licensed practitioner.

Any pregnant or postpartum member who wants doula services may find a doula by calling Customer Service at 1-888-936-PLAN (7526), TTY 711. Health Plan must coordinate for out-of-network access to doula services for members if an in-network doula provider is not available.

Dyadic services

Health Plan covers medically necessary Dyadic Behavioral Health (DBH) care services for members and their caregivers. A dyad is a child age 0 to 20 and their parents or

caregivers. Dyadic care serves parents or caregivers and the 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

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:

- Delivery in a birthing center, home, or hospital based on what the member prefers and what is medically best for them.

- Breast pumps and supplies
- Breast-feeding education and aids
- Care coordination
- Counseling
- Diagnosis of fetal genetic disorders and counseling
- Doula Services
- Maternal mental health services
- Newborn care
- Nutrition education
- Pregnancy-related health education
- Prenatal, delivery, and postpartum care from a certified nurse midwife (CNM), licensed midwife (LM) or physician, based on member prefers and what is medically best for them
- Social and mental health assessments and referrals
- Vitamin and mineral supplements

Every pregnant and postpartum member may receive all of the above services. Members may contact Health Plan for help getting services.

Extended postpartum coverage

Health Plan covers full-scope coverage for up to 12 months after the end of the pregnancy, regardless of changes in income, or how the pregnancy ends.

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 the Health Plan network without a referral.

Your PCP or mental health provider might make a referral for more mental health screening to a specialist in the Health Plan network to decide the level of care you need. If your screening results find you are mildly or moderately impaired due to a mental health condition, 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
- Family therapy which involves at least two 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 the 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. Health

Plan will help you coordinate your first appointment with a county mental health plan provider to choose the right care for you. To learn more, read “Other Medi-Cal programs and services” in Chapter 4 of this handbook.

If you or someone you know is in crisis, contact the **988** Suicide and Crisis Lifeline. **Call or text 988** or **chat online at 988lifeline.org/chat**. The **988** Suicide and Crisis Lifeline offers free and private help. Anyone can get help, including those in emotional distress and those who need support for a suicidal, mental health, and/or substance use crisis.

Emergency care services

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 United States (including territories such as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, or the United States Virgin Islands. 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 any of the following:

- Serious risk to your health
- Serious harm to bodily functions
- Serious dysfunction of any bodily organ or part
- 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 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 care. 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 you need an emergency supply of a medication from an outpatient pharmacy while traveling, Medi-Cal Rx will be responsible for covering the medication, 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 United States 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 age 21 years or older may not get hospice care and curative (healing) 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 six 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
- 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

Health Plan may require that you get hospice care from an in-network provider unless

medically necessary services are not available in-network.

Palliative care

Palliative care is patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative care is available to children and adults with a serious or life-threatening illness. It 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
- Palliative 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 curative 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.

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 the California Children's Services (CCS) program, CCS may cover the hospital stay and the RWGS.

Surgical services

Health Plan covers medically necessary surgeries performed in a hospital.

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
- 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 two 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 two 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 Medi-Cal for Kids and Teens 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 member 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 behavioral analysis.

BHT services must be medically necessary, prescribed by a licensed doctor or psychologist, approved by Health 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.
- Medi-Cal Rx covers disposable outpatient devices commonly available from a pharmacy for testing blood glucose or urine, such as diabetes blood glucose monitors, continuous glucose monitors, test strips, and lancets.

Generally, Health Plan does not cover:

- Comfort, convenience, or luxury equipment, features, and supplies, except retail-grade breast pumps as described earlier 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 (unless available and offered through Community Supports) or car
- 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 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) and the items are medically necessary and meet the definition of DME.

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 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 hearing aid that meets your medical needs. Health Plan will cover one hearing aid unless a hearing aid for each ear is needed for better results than what you can get with one hearing aid.

Hearing aids for members under age 21:

In Alpine, El Dorado, San Joaquin, and Stanislaus counties, state law requires children under 21 years old who need hearing aids 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, Health Plan will cover medically necessary hearing aids as part of Medi-Cal coverage.

Hearing aids for members age 21 and older:

Under Medi-Cal, Health Plan will cover the following for each covered hearing aid:

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

Under Medi-Cal, Health Plan 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 age 21 and older, Medi-Cal does **not** cover:

- Replacement hearing aid batteries

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 Medi-Cal Rx, part of Fee-for-Service (FFS) Medi-Cal, and not by Health Plan. When Medi-Cal Rx 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
- 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 two 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 when prescribed by a doctor, dentist, or podiatrist. Services include physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and applying of topical medicines. Prescriptions are limited to six months and may be renewed for medical necessity.

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 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 and prescribed by a doctor or dentist. Prescriptions are limited to six months and may be renewed for medical necessity. Speech therapy services are limited to two 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 than two services per month 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, part of FFS Medi-Cal, covers most outpatient prescription drugs. To learn more, read “Outpatient prescription drugs” later 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

Health Plan covers includes, but is not limited to:

- Advisory Committee for Immunization Practices (ACIP) 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 preventive services
- Preventive services for women recommended by the American College of 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

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 Food and Drug Administration (FDA). Health Plan’s PCP and OB/GYN specialists are available for family planning services.

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

Chronic disease management

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

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

For preventive care information for members under age 21, read Chapter 5, “Child and youth well care” in this handbook.

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
- 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 Health Plan’s DPP Program visit www.hpsj-mvhp/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 (SUD) 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 (SUD)

treatment services" later in this chapter.

Vision benefits

Health Plan provides vision benefits through Vision Service Plan (VSP). Contact VSP for help with vision services and finding an optometrist at **1-888-321-7526.** VSP covers:

- A 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 not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken.
- Low vision devices if you have vision impairment that impacts your ability to perform everyday activities (such as age-related macular degeneration) and standard glasses, contact lenses, medicine, or surgery cannot correct your visual impairment.
- 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.
- Artificial eye services and materials for members who have lost an eye or eyes to disease or injury.

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, train, taxi, or other form of public or private transportation to get to your appointments for medical care. You can get medical transportation for covered services and Medi-Cal covered pharmacy appointments. You can request medical transportation by asking for it from your provider. This includes your doctor, dentist, podiatrist, physical therapist, speech therapist, occupational therapist, mental health or substance use disorder (SUD) provider, physician assistant, nurse practitioner, or certified nurse midwife. 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 for your covered medical and pharmacy appointments. Your provider will need to re-assess your medical need for medical transportation and, if appropriate, re-

approve your prescription for medical transportation when it expires, if you still qualify. Your doctor may re-approve the medical transportation for up to 12 months or less.

Medical transportation is transportation in 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:

- It is physically or medically needed, with a written authorization by your provider because you are not able to physically or medically able to use a car, bus, train, or other form of public or private transportation 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. For urgent appointments, call as soon as possible. Have your Health Plan 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. The list of covered services is in the “Benefits and services” section in Chapter 4 of this 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 Health Plan network or service area unless pre-approved (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, for free, 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

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 for an approved private vehicle ride, you must submit copies of the driver's:

- Valid driver's license,
- Valid vehicle registration, and
- Valid vehicle insurance.

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

Note: American Indians may also contact their Indian Health Care Provider 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 get 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.

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. These travel expenses 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

Health Plan covers, for members who qualify, long-term care services 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 as approved by Health Plan, including:
  - Intermediate care facility/developmentally disabled (ICF/DD)
  - Intermediate care facility/developmentally disabled-habilitative (ICF/DD-H)
  - 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. Health Plan will work with your local Regional Center to determine if you qualify for ICF/DD, ICF/DD-H, or ICF/DD-N services.

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

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 (mental health and/or substance use disorder services). Health Plan can help coordinate care and manage your health needs for free. This help is available even when another program covers the services.

If you have questions or concerns about your health or the health of your child, call Customer Service at 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 CCM services to members with ongoing chronic health, behavioral, and/or social conditions.

If you are enrolled in CCM or Enhanced Care Management (ECM), (read below), Health Plan will make sure you have an assigned care manager who can help with basic care management described above and with other transitional care supports 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 doctors and other providers. ECM helps coordinate primary and preventive care, acute care, behavioral health (mental health and/or substance use disorder services), developmental, oral health, community-based long-term services and supports (LTSS), and referrals to community resources.

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. They 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. Your 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.

Transitional care services

Health Plan can help you manage your health care needs during transitions (changes). For example, going home after a hospital stay is a transition when a member may have new health needs for medicines and appointments. Members can get support to have a safe transition. Health Plan can help you with these transitional care services:

- Scheduling a follow-up appointment
- Getting medicines
- Getting free transportation to an in-person appointment.

Health Plan has a dedicated phone number that is only helping members during care transitions. Health Plan also has a care manager that is only for higher risk members, including those who are pregnant or post-partum, or those admitted to or discharged from a nursing home. This care manager who members contact for help coordinating services that may affect their health including housing and food services.

To request transitional care services, contact your Health Plan representative. They will help you with programs, providers or other support in your language.

Community Supports

You may qualify to get certain Community Supports services, if applicable. 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 for and agree to receive these services, they might help you live more independently. They do not replace benefits you already get under Medi-Cal.

- **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.
- **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 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 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.

Health Plan offers Transitional Rent in limited circumstances and is designed to support housing stability for eligible members. If you need help or want to find out what

Community Supports might be available for you, call Customer Service at 1-888-936-PLAN (7526), TTY 711. Or call your health care provider.

Organ and bone marrow transplant

Transplants for children under age 21

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, the CCS program will cover the costs for the transplant and related services.

If the child does not qualify for CCS, Health Plan will refer the child to a qualified transplant center for an evaluation. If the transplant center confirms that a transplant is safe and needed for the child's medical condition, Health Plan will cover the transplant and other related services.

Transplants for adults age 21 and older

If your doctor decides you may need an organ and/or bone marrow 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 organ and bone marrow transplants Health Plan covers include, but are not limited to:

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

Street medicine services

Members experiencing homelessness may receive covered services from street medicine providers within Health Plan's provider network. Members experiencing homelessness may be able to select a Health Plan street medicine provider to be their primary care provider (PCP), if the street medicine provider meets PCP eligibility rules and agrees to be the member's PCP. To learn more about Health Plan's street medicine services, call Customer Service at 1-888-936-PLAN (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 Customer Service at 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 part of FFS Medi-Cal. 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 or infusion center, these may be 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 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 of this handbook.

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 pressing 7 or 711.

Once you choose a pharmacy, your provider can send a prescription to your pharmacy electronically. Your provider may also give you a written prescription to take to your pharmacy. 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 (SMHS)

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

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)
- Intensive home-based services (IHBS) covered for members under 21 years old
- Therapeutic foster care (TFC) covered for members under 21 years old
- Mobile crisis services
- Peer Support Services (PSS) (optional)

Residential services:

- Adult residential treatment services

- Crisis residential treatment services

Inpatient services:

- Psychiatric inpatient hospital services
- Psychiatric health facility services

To learn more about SMHS 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: https://www.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 (SUD) 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 providers such as primary care, inpatient hospitals, emergency rooms, and substance use service providers. SUD services are provided through counties. Depending on where you live, some counties offer more treatment options and recovery services.

To learn more about treatment options for SUD, call Customer Service at 1-888-936-PLAN (7526), TTY 711.

Health Plan members can have an assessment to match them to the services that best fit their health needs and preferences. A member may request behavioral health services, including SUD assessments, by contacting Health Plan. Members may also visit their PCP who can refer them to an SUD provider for assessment. When medically necessary, available services include outpatient treatment, and medicines for SUD (also called Medications for Addiction Treatment or MAT) such as buprenorphine, methadone, and naltrexone.

Members who are identified for SUD treatment services are referred to their county substance use disorder program for treatment. Members may be referred by their PCP or self-refer by contacting an SUD provider directly. If a member self-refers, the provider will conduct an initial screening and assessment to decide if they qualify and the level of care they need. For a list of all counties' telephone numbers go to:

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

Health Plan will provide or arrange for MAT to be given in primary care, inpatient hospital, emergency room, 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
1-530-694-1816, TTY 711

El Dorado County

El Dorado County Behavioral Health West Slope Office
929 Spring Street
Placerville, CA 95667
(530) 621-6290, TTY 711

San Joaquin County

Substance Abuse Services Administration
620 Aurora Street Suite #1
Stockton, CA 95202
1-209-468-3800, TTY 711

Stanislaus County

Stanislaus County Behavioral Health & Recovery Services
800 Scenic Drive
Modesto, CA 95350
1-888-376-6246, TTY 711

Dental services

FFS Medi-Cal Dental is the same as FFS Medi-Cal for your dental services. Before you get dental services, you must show your Medi-Cal BIC card 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 Medi-Cal Dental, including:

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

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

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 county CCS program to check if they qualify.

County CCS staff will decide if you or your child qualifies for CCS services. Health Plan does not decide CCS eligibility. If your child qualifies to get this type of care, CCS paneled providers will treat them 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 check-ups.

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 covers most health conditions. Examples of CCS eligible conditions include, but are not limited to:

- Congenital heart disease
- Cancers
- Tumors
- Hemophilia
- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts
- Cerebral palsy
- Seizures under certain circumstances
- Rheumatoid arthritis

- Muscular dystrophy
- HIV/AIDS
- Severe head, brain, or spinal cord injuries
- Severe burns
- Severely crooked teeth

Medi-Cal pays for CCS services in counties participating in the Whole Child Model (WCM) program. 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 Customer Service at 1-888-936-PLAN (7526), TTY 711.

Transportation and travel expenses for CCS

You may be able to get transportation, meals, lodging, and other costs such as parking, tolls, etc. if you or your family needs help to get to a medical appointment related to a CCS-eligible condition and there is no other available resource. Call Health Plan and request pre-approval (prior authorization) before you pay out of pocket for transportation, meals, and lodging. Health Plan does provide non-medical and non-emergency medical transportation as noted in Chapter 4, “Benefits and services” of this handbook.

If your transportation or travel expenses that you paid for yourself are found necessary and Health Plan verifies that you tried to get transportation through Health Plan, Health Plan will pay you back.

Home and community-based services (HCBS) outside of CCS services

If you qualify to enroll in a 1915(c) waiver (special government program), you may be able to get home and community-based services that are not related to a CCS-eligible condition but are necessary for you to stay in a community setting instead of an institution. For example, if you require home modifications to meet your needs in a community-based setting, Health Plan cannot pay those costs as a CCS-related condition. But if you are enrolled in a 1915(c) waiver, home modifications may be covered if they are medically necessary to prevent institutionalization.

When you turn 21 years old, you transition (change) from the CCS program to adult health care. At that time, you may need to enroll in a 1915(c) waiver to keep getting services you have through CCS, such as private duty nursing.

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

California’s six Medi-Cal 1915(c) waivers (special government programs) allow the state to provide long-term services and supports (LTSS) to persons in a community-based

setting of their choice, instead of getting care in a nursing facility or hospital. 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 provided under the waivers must not cost more than getting the same care in an institutional setting. HCBS Waiver recipients must qualify for full-scope Medi-Cal. Some 1915(c) waivers have limited availability across the State of California and/or may have a waitlist. The six Medi-Cal 1915(c) waivers are:

- Assisted Living Waiver (ALW)
- 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 Medi-Cal waivers, go to: https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx. Or call Customer Service at 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 as an alternative to out-of-home care to qualified Medi-Cal-eligible persons, including those who are aged, blind, and/or disabled. IHSS allows recipients to stay safely in their own homes. Your health care provider must agree that you need in-home personal care assistance and that you would be at risk of placement in out-of-home care if you did not get IHSS services. The IHSS program will also perform a needs assessment.

To learn more about IHSS available in your county, go to https://www.cdss.ca.gov/in-home-supportive-services. 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:

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 vitro fertilization (IVF) including, but not limited to infertility studies or procedures to diagnose or treat infertility
- Fertility preservation
- Vehicle modifications
- Experimental services
- 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 Customer Service at 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

5. Child and youth well care

Child and youth members under 21 years old can get needed health care 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.

Medi-Cal for Kids and Teens

Needed health care services are covered and free for members under 21 years old. The list below includes common 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 (mental health and/or substance use disorder) assessment and treatment
- Mental health evaluation and treatment, including individual, group, and family psychotherapy (specialty mental health services (SMHS) are covered by the county)
- Adverse childhood experiences (ACE) screening
- Enhanced Care Management (ECM) for Children and Youth Populations of Focus (POFs) (a Medi-Cal managed care plan (MCP) benefit)
- 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)
- Home Health Services, such as private duty nursing (PDN), occupational therapy,

physical therapy, and medical equipment and supplies

These services are called Medi-Cal for Kids and Teens (also known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)) services. Additional information for members regarding Medi-Cal for Kids and Teens can be found at https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Member-Information.aspx. Medi-Cal for Kids and Teens services that are recommended by pediatricians' Bright Futures guidelines to help you, or your child, stay healthy are covered for free. To read the Bright Futures guidelines, go to: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Enhanced Care Management (ECM) is a Medi-Cal managed care plan (MCP) benefit available in all California counties to support comprehensive care management for MCP members with complex needs. Because children and youth with complex needs are often already served by one or more case managers or other service providers within a fragmented delivery system, ECM offers coordination between systems. Children and youth populations of focus eligible for this benefit include:

- Children and youth experiencing homelessness
- Children and youth at risk for avoidable hospital or emergency room utilization
- Children and youth with serious mental health and/or substance use disorder (SUD) needs
- Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition
- Children and youth involved in child welfare
- Children and youth transitioning from a youth correctional facility

Additional information on ECM can be found at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Children-And-Youth-POFs-Spotlight.pdf

In addition, ECM Lead Care Managers are strongly encouraged to screen ECM members for needs for Community Supports services provided by MCPs as cost-effective alternatives to traditional medical services or settings and refer to those Community Supports when eligible and available. Children and youth may benefit from many of the Community Supports services, including asthma remediation, housing navigation, medical respite, and sobering centers.

Community Supports are services provided by Medi-Cal managed care plans (MCPs) and are available to eligible Medi-Cal members regardless of whether they qualify for ECM services.

More information on Community Supports can be found at: https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf

Some of the services available through Medi-Cal for Kids and Teens, such as PDN, are considered supplemental services. These are not available to Medi-Cal members age 21 and older. To keep getting these services for free, you or your child may have to enroll in a 1915(c) Home and Community-Based Services (HCBS) waiver or other long-term services and supports (LTSS) on or before turning the age of 21. If you or your child is getting supplemental services through Medi-Cal for Kids and Teens and will be turning 21 years of age soon, contact Health Plan to talk about choices for continued care.

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 immunizations (shots) you or your child need. Health Plan must make sure all enrolled children are up to date with all the immunizations (shots) they need when they have their visits with their doctor. Preventive care services and screenings are available for free and without pre-approval (prior authorization).

Your child should get check-ups at these ages:

- 2-4 days after birth
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 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 immunizations (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, if age-appropriate or needed
- Health education
- Vision and hearing screening
- Oral health screening
- Behavioral health assessment

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 further medical care. Health Plan will cover that care for free, including:

- Doctor, nurse practitioner, and hospital care
- Immunizations (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 California Children's Services (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 24 and 72 months of age if they were not tested earlier. Children can get a blood lead screening if a parent or guardian requests one. 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
- Help coordinate care for services not covered by Health Plan, but that may be available through Fee-for-Service (FFS) Medi-Cal, such as:
  - Treatment and rehabilitative services for mental health and substance use disorders (SUD)
  - 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's 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 services for:

Babies age 0-3

- Baby's first dental visit
- Baby's first dental exam
- Dental exams (every six months, and sometimes more)
- X-rays
- Teeth cleaning (every six months, and sometimes more)
- Fluoride varnish (every six months, and sometimes more)
- Fillings
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Kids age 4-12

- Dental exams (every six months, and sometimes more)
- X-rays
- Fluoride varnish (every six months, and sometimes more)
- Teeth cleaning (every six months, and sometimes more)
- Molar sealants

- Fillings
- Root canals
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Youths age 13-20

- Dental exams (every six months, and sometimes more)
- X-rays
- Fluoride varnish (every six months, and sometimes more)
- Teeth cleaning (every six months, and sometimes more)
- Orthodontics (braces) for those who qualify
- Fillings
- Crowns
- Root canals
- Partial and full dentures
- Scaling and root planing
- 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 Customer Service Line 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
- 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 may be able to make a custom plan that will best help your child.

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.

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 do not 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. and 5:00 p.m. Monday through Friday 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 DMHC 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, 8:00 a.m. to 5:00 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

(7526), TTY 711.

To report incorrect information about your health insurance, call Medi-Cal Monday through Friday, 8:00 a.m. to 5:00 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 by mail, 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. and 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 the Health Plan website at www.hpsj-mvhp.org.

If you need help filing your complaint, we can help you. We can give you free language services. Call Customer Service at 1-888-936-PLAN (7526), TTY 711.

Within five calendar days of getting your complaint, Health Plan 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 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, Health Plan does not respond to you within the 72-hour period, or if you are unhappy with Health Plan's decision.

Complaints related to Medi-Cal Rx pharmacy benefits are not subject to the Health Plan grievance process or eligible for Independent Medical Review with the Department of Managed Health Care (DMHC). Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY 1-800-977-2273) and pressing 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 review through the Health Plan grievance and appeal process and an Independent Medical Review with DMHC. 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 https://www.dmhc.ca.gov/.

Appeals

An appeal is different from a complaint. An appeal is a request for Health Plan 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 Health Plan. 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 the date on the NOA or before the date we said your service will stop, whichever is later. When you request an appeal under these circumstances, your

service will continue while you wait for your appeal decision.

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

- **By phone:** Call Health Plan at 1-888-936-PLAN (7526), TTY 711 between 8:00 a.m. and 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 the 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 free language services. Call 1-888-936-PLAN (7526), TTY 711.

Within five days of getting your appeal, Health Plan 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 the Department of Managed Health Care (DMHC).

But if you ask for a State Hearing first, and the hearing to address your specific issues has already happened, you cannot ask for an IMR with DMHC on the same issues. In this case, the State Hearing has the final say. But you may still file a complaint with DMHC if your issues do not qualify for an IMR, even if the State Hearing has already happened.

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 (7526), TTY 711. We will decide within 72 hours of receiving your appeal. If there is an urgent health care concern, such as those involving a serious threat to your health, you do not need to file an appeal with Health Plan before filing a complaint with DMHC.

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 (TTY1-800-952-8349). You can also ask for a State Hearing online at https://www.cdss.ca.gov. More ways of asking for a State Hearing can be found in "State hearings" later in this chapter.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have Health Plan's decision reviewed. 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 IMR/Complaint form and instructions online at https://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 to address your specific issues has already happened, you cannot ask for an IMR with DMHC on the same issues. In this case, the State Hearing has the final say. But you may still file a complaint with DMHC if the issues do not qualify for IMR, even if the State Hearing has already happened.

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. To submit complaints and appeals about Medi-Cal Rx pharmacy benefits, call 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) with DMHC.

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.

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 Health Plan reviews your case. If you want an IMR, you must first file an appeal with Health Plan for non-urgent concerns. If you do not hear from Health Plan within 30 calendar days, or if you are unhappy with Health Plan's decision, then you may request an IMR. You must ask for an IMR within six 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 to address your specific issues has already happened, you cannot ask for an IMR with DMHC on the same issues. In this case, the State Hearing has the final say. But you may still file a complaint with DMHC if the issues do not qualify for IMR, even if the State Hearing has already happened.

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.

State Hearings

A State Hearing is a meeting with Health Plan and a judge from the California Department of Social Services (CDSS). The judge will help to resolve your problem and decide whether Health Plan made the correct decision or not. You have the right to ask for a State Hearing if you already asked for an appeal with Health Plan 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. and 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 Health Plan 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 an 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 an NOA letter
- We did not give you an 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:

- **By phone:** Call CDSS' State Hearings Division at 1-800-743-8525 (TTY 1-800-952-8349 or 711)
- **By mail**: Fill out the form provided with your appeals resolution notice and mail it to:

  California Department of Social Services
  State Hearings Division
  744 P Street, MS 9-17-433
  Sacramento, CA 95814

- **Online:** Request a hearing online at **www.cdss.ca.gov**
- **By email:** Fill out the form that came with your appeals resolution notice and email it to **Scopeofbenefits@dss.ca.gov**
  - Note: If you send it by email, there is a risk that someone other than the State Hearings Division could intercept your email. Consider using a more secure method to send your request.
- **By Fax:** Fill out the form that came with your appeals resolution notice and fax it to the State Hearings Division toll-free at 1-833-281-0903

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call 1-888-936-PLAN (7526), TTY 711.

At the hearing, you will tell the judge why you disagree with Health Plan's decision. Health Plan will tell the judge how we made our decision. 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 three 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 is 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

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 there is no medical appointment or prescriptions to pick up

To report fraud, waste, or 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: Program Integrity Unit/FWA
7751 South Manthey Road
French Camp, CA 95231

Compliance Hotline: 1-855-400-6002, TTY 711

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 such as medical history, mental and physical condition or treatment, and reproductive or sexual health
- To be provided with information about the health plan and its services, including covered services, providers, 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 (end), 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 free interpreting and translation services for your language
- To ask for free legal help at your local legal aid office or other groups

- 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 free 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 Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency care outside Health Plan’s network pursuant to federal law

Your responsibilities

Health Plan 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.
- 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, follow instructions, and cooperate with the providers, 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 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 doctor's 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, 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)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters

- Information written in other languages

If you need these services, contact Health Plan between 8:00 a.m. and 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 by phone, by mail, in person, or online:

- **By phone**: Contact Health Plan's Healthy Equity Officer between 8:00 a.m. and 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.
- **By mail:** Fill out a complaint form or write a letter and mail 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 grievance.
- **Online:** Go to 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 (DHCS), Office of Civil Rights by phone, by mail, or online:

- **By phone:** Call 1-916-440-7370. If you cannot speak or hear well, call 711 (Telecommunications Relay Service).
- **By mail:** Fill out a complaint form or mail a letter to:

  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.

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

Office of Civil Rights – United States 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 United States Department of Health and Human Services, Office for Civil Rights by phone, by mail, or online:

- **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.
- **By mail:** Fill out a complaint form or mail 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.
- **Online:** Go to the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/cp.

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!

Community Advisory Committee

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

- Health education and policies or programs related to health equity and quality
- Member materials and provider directory
- Member satisfaction survey results
- Plan marketing materials and campaigns
- Community needs assessments or improvement plans

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.

- Development of Non-Specialty Mental Health Services (NSMHS) outreach and education plan

Other plan programs and services 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. To learn more about sensitive services, read "Sensitive care" in Chapter 3 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 consent to care, 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.

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 another location of your choice. Your request for confidential communications lasts until you cancel it or submit a new request for confidential communications.

You can make a request for confidential communications by submitting a Request for Confidential Communication form to Health Plan of San Joaquin/Mountain Valley Health Plan and mailing to Customer Service at 7751 South Manthey Road, French Camp, CA 95231. You can request a copy of the form by calling Customer Service or by accessing the form on our website at www.hpsj-mvhp.org.

Health Plan's statement of its policies and procedures for protecting your medical information (called a "Notice of Privacy Practices") is included below:

This notice describes how your medical and personal information, including information about your race/ethnicity, language, gender identity and sexual orientation about you

may be used and disclosed. This notice also tells you how you can get access to this information. **Please review it carefully.**

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. • 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. • If you are a senior person with disability (SPD) and have a physical or mental incapacity, you do not need to complete an authorization form.
Ask us to limit what we share about you	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it will 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 healthcare 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	• 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.
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 U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW Room 509F HHH Building, Washington, D.C. 20201, calling 1-877-696-6755, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints • We will not retaliate against you for filing a complaint.

Request Your Health Information Be Sent to an Application of Your Choice	• Interoperability Rules require us to provide up to five years of certain health care data when you request it directly with us or through a third-party application. • When you request it through a third-party application, Health Plan reserves the right to approve the third-party application based on a security analysis. • You can make this request directly with us by accessing the Request to Access Health Information form online (www.hpsj-mvhp.org), requesting it over the phone with a Customer Service Representative, or on a walk-in basis. • You must complete the entire form and mail or bring it to Health Plan's office located at 7751 South Manthey Road, French Camp, CA 95231. You may also fax the form to: (209) 461-2550 or send to Health Plan through a secured email. • We are not responsible for the third-party application that you select and are not responsible for your data once transferred to the third-party application per your request.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will not share or use your information in the following ways without your written permission:

- Use your information for marketing purposes.
- Sell your information.
- Use race/ethnicity, language, gender identity or sexual orientation to make decisions for underwriting, denial of coverage or benefits or require you to give up your rights to enroll in or be covered under Health Plan.

- Release your medical or personal information about abortion services if the request comes from another state, even if it is a subpoena. You are protected by the California Reproductive Privacy Act.
- Release medical or personal information for children who receive gender-affirming health or mental health care in response to any civil, foreign subpoena, or out of state action.
- Share your information on services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections and diseases, substance use disorder, gender affirming care, and intimate partner violence.

Our Uses and Disclosure

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the*

		premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues	• We can share health information about you for certain situations such as: o Preventing disease o Helping with product recalls o Reporting adverse reactions to medications o Reporting suspected abuse, neglect, or domestic violence o Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address worker's compensation,	We can use or share health information about you: • For worker's compensation claims • For law enforcement purposes or with law enforcement officials

law enforcement, and other government requests	• With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective service
Respond to lawsuits and legal actions	• We can share health information about in response to a court or administrative order, or in response to a subpoena

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have comprised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

How We Protect Your Protected Health Information

Health Plan is committed to protecting your PHI. We keep the PHI of our current and former members private and secure as required by law and accreditation standards. We follow these procedures to protect your PHI:

- We use physical and electronic safeguards.
- We regularly train our staff in the appropriate use and sharing of PHI.
- We secure our offices and lock our desks and filing cabinets.
- We protect our computers and electronic devices with passwords and only give access to PHI to staff that need it to do their jobs.
- Our Business Partners are also required to protect the privacy of any PHI we share with them, and they are not allowed to give PHI to others except as allowable by law, and by our Notice of Privacy Practices.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to:

Health Plan of San Joaquin/Mountain Valley Health Plan, 7751 South Manthey Road, French Camp, CA 95231

Contact our Customer Service Department for any questions or concerns regarding your privacy at piu@hpsj.com or 1-888-936-PLAN (7526), TTY 711 or visit www.hpsj-mvhp.org.

For More Information

Please contact us to request a copy of this notice in other languages or to get a copy in another format, such as large print or braille.

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.

Notice about Medi-Cal as a payer of last resort, other health coverage (OHC), 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. Medi-Cal members with OHC must use their OHC for covered services before using their Medi-Cal benefits. As a condition of Medi-Cal eligibility, you must apply for or retain any available OHC when it is available at 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 do not report OHC timely. Submit your OHC online at http://dhcs.ca.gov/OHC.

If you do not have access to the internet, you can report OHC to Health Plan by calling 1-888-936-PLAN (7526), TTY 711. Or you can call DHCS' OHC Processing Center at 1-800-541-5555 (TTY 1-800-430-7077 or 711) or 1-916-636-1980.

The following is a partial list of insurance that is **not** considered to be OHC:

- Personal injury and/or medical payment coverage under automobile insurance. Note: Read about notification requirements for the personal injury and workers' compensation programs below.
- Life insurance
- Workers' compensation
- Homeowner's insurance
- Umbrella insurance
- Accident insurance
- Income replacement insurance (for example, Aflac)

DHCS has the right and responsibility to be paid back 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 for your health care or pay back Medi-Cal if Medi-Cal paid for the services.

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 to:

- Personal Injury program at https://dhcs.ca.gov/PIForms
- Workers' Compensation Recovery program at https://dhcs.ca.gov/WC

To learn more, go to the DHCS Third Party Liability and Recovery Division website at 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 and managed care premiums or capitation payments for nursing facility services, home and community-based services, and related hospital and 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 program 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 in Chapter 6 of this handbook 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, modifications, terminations, suspensions, or reductions to your services 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 your 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, modify, terminate, suspend, or reduce a request for health care services.

If translation in 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.

8. Important numbers and words to know

Important phone numbers

- Health Plan Customer Service at 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 at 1-800-655-8294, TTY 711
- Health Plan Compliance Hotline at 1-855-400-6002
- Vision Services – Health Plan provides vision benefits through Vision Service Plan (VSP). Contact VSP for help with vision services and finding an optometrist at 1-888-321-7526
- County Mental Health Plans for Specialty Mental Health and Substance Use Disorder Treatment Services:
  - San Joaquin County at 1-209-468-3800, TTY 711
  - Stanislaus County at 1-888-376-6246, TTY 711
  - Alpine County at 1-530-694-1816, TTY 711
  - El Dorado County at 530-621-6290, TTY 711

Words to know

Active labor: The time period when a pregnant member 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 member 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
- Is an Eskimo or Aleut or other Alaska Native
- Is considered by the Secretary of the Interior to be an Indian for any purpose

- Is determined to be an Indian under regulations issued by the Secretary of Health and Human Services
- Is considered by the Secretary of the Interior to be an Indian for any purpose
- 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.

Behavioral health services: Include specialty mental health services (SMHS), non-specialty mental health services (NSMHS), and substance use disorder (SUD) treatment services to support members' mental and emotional well-being. NSMHS are provided through the health plan for members experiencing mild-to-moderate mental health conditions. SMHS are provided through county Mental Health Plans (MHPs) for members who have severe impairment or a high risk of functional deterioration due to a mental health disorder. Emergency mental health services are covered, including assessments and treatment in emergency settings. Your county also provides services for alcohol or drug use, called SUD services.

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 a member understand major health problems and arrange care with the member's 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 the member does 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.

Community Supports: Community Supports are services that help improve members' overall health. They provide services for health-related social needs like housing, meals, and personal care. They help members in the community, with a focus on promoting health, stability, and independence.

Complaint: A member's verbal or written expression of dissatisfaction about a service, which can include, but is not limited to:

- The quality of care or services provided;
- Interactions with a provider or employee;
- The member's right to dispute an extension of time proposed by Health Plan, a county mental health or substance use disorder program, 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 Plan agree.

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

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.

Copayment (co-pay): A payment a member makes, usually at the time of service, in addition to Health Plan's payment.

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, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form).

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

Disenroll: To stop using a health plan because the member no longer qualifies or changes to a new health plan. The member must sign a form that says they no longer want to use the health plan or call Health Care Options and disenroll by phone.

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

Doula services: Doula services include health education, advocacy, and physical, emotional, and nonmedical support. Members can get doula services before, during, and after childbirth or end of a pregnancy, including the postpartum period. Doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner.

Durable medical equipment (DME): Medical equipment that is medically necessary and ordered by a member's doctor or other provider that the member uses in the home, community, or facility that is used as a home.

Early and periodic screening, diagnostic, and treatment (EPSDT): Go to "Medi-Cal for Kids and Teens."

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

- Place the member's health or the health of their unborn baby in serious danger
- Cause impairment to a bodily function
- Cause a body part or organ to not work right
- Result in death

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

Enhanced Care Management (ECM): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs.

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.

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. Services are provided to members of childbearing age to enable them to determine the number and spacing of children.

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

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

Follow-up care: Regular doctor care to check a member'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 member's residence and that are licensed or otherwise 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 a service, which can include, but is not limited to:

- The quality of care or services provided;
- Interactions with a provider or employee;
- The member's right to dispute an extension of time proposed by Health Plan, a county mental health or substance use disorder program, or a Medi-Cal provider.

A complaint is the same as a grievance.

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

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

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 members 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 six months or less.

Hospital: A place where a member gets 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 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 a member has to stay the night in a hospital or other place for medical care that is needed.

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 Food and Drug Administration (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.

Long-term services and supports (LTSS): Services that help people with long-term health problems or disabilities live or work where they choose. This could be at home, at work, in a group home, a nursing home, or another care facility. LTSS includes programs for long-term care and services provided at home or in the community, also called home and community-based services (HCBS). Some LTSS services are provided by health plans, while others are provided separately.

Managed care plan: A Medi-Cal health 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 for Kids and Teens: 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. They must get treatment to take care of or help the conditions that might be found in the check-ups. This benefit is also known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit under federal law.

Medi-Cal Rx: A pharmacy benefit service that is part of FFS Medi-Cal and 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 provides the main functions of primary health care. This includes comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

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 diagnosing or 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 (SUD).

Medical transportation: Transportation that a provider prescribes for a member when the member is not physically or medically able to use a car, bus, train, taxi, or other form of public or private transportation to get to a covered medical appointment or to pick up prescriptions. 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 End-

Stage Renal Disease (ESRD).

Member: Any eligible Medi-Cal member enrolled with Health Plan who is entitled to get covered services.

Mental health services provider: Health Care professionals who provide mental health to patients.

Midwifery services: Prenatal, intrapartum, and postpartum care, including family planning services 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 a member’s provider and when picking up prescriptions and medical supplies.

Non-participating provider: A provider not in the Health Plan network.

Orthotic device: A device used outside the body to support or correct a badly injured or diseased body part, that is medically necessary for the member to recover.

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, Medicare Advantage plans (Part C), Medicare drug plans (Part D), or Medicare supplemental plans (Medigap).

Out-of-area services: Services while a member is anywhere outside of the Health Plan service area.

Out-of-network provider: A provider who is not part of the Health Plan network.

Outpatient care: When a member does not have to stay the night in a hospital or other place for the medical care that is needed.

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 six 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 a member is 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 a member or their 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.

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 a member has for most of their health care. The PCP helps the member get the care they need.

A 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 a member or their 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 the 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 the member or others or the member is 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: A doctor qualified in the area of practice appropriate to treat a member's condition.

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 a member's PCP says the member 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 members 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 providers. Members can get primary and preventive care at an RHC.

Sensitive services: Services related to mental, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder (SUD), 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, a member will need a referral from their PCP to go to a specialist.

Specialty mental health services (SMHS): 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 comprehensive care for medically fragile members who 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.

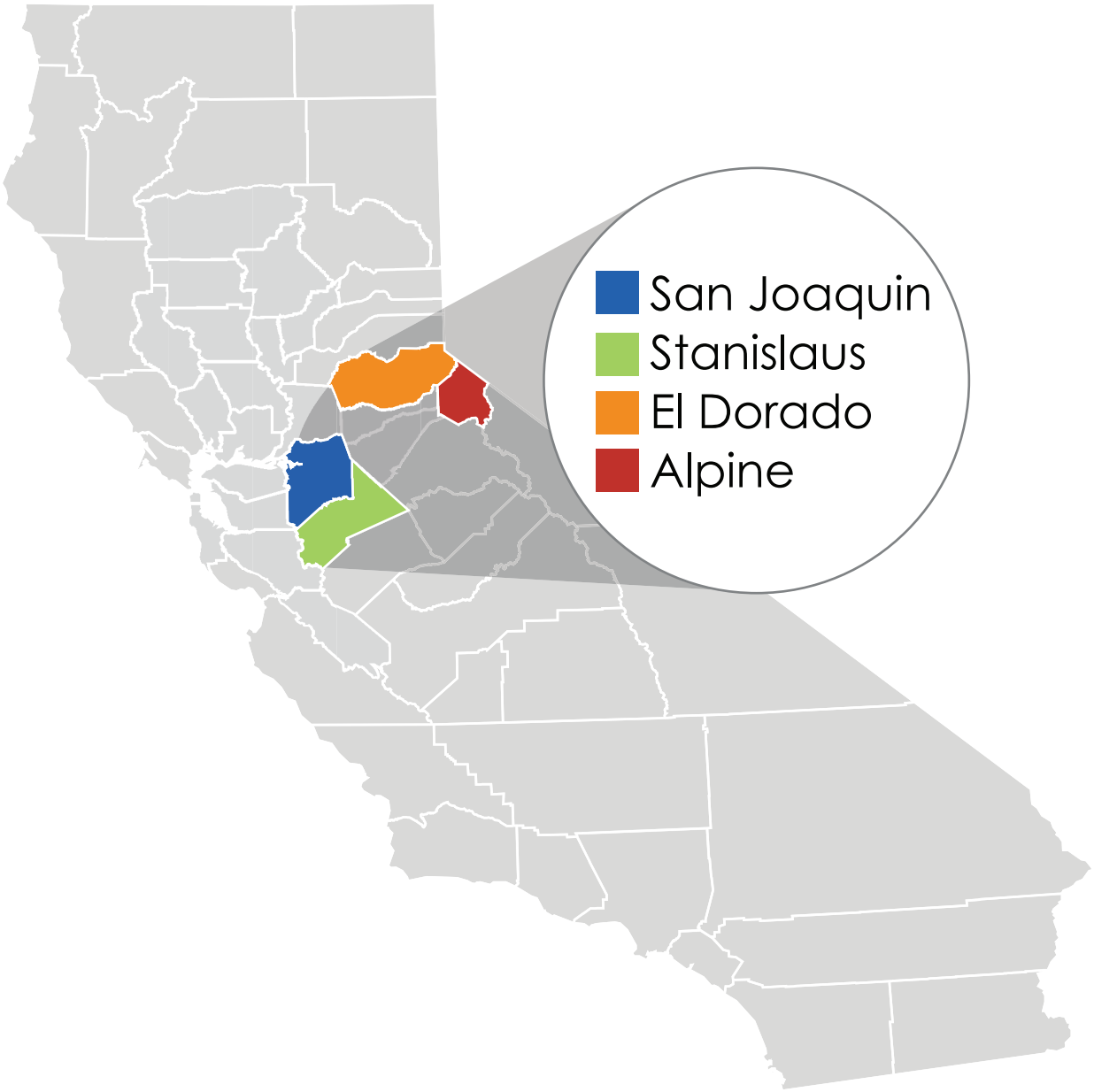
Triage (or screening): The evaluation of a member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of your need for care.

Urgent care (or urgent services): Services provided to treat a non-emergency illness, injury or condition that requires medical care. Members can get urgent care from an out-of-network provider if in-network providers are temporarily not available or accessible.

1915(c) Home and Community-Based Services (HCBS) waiver: This is a special government program for persons who are at risk of being placed in a nursing home or an institution. The program allows DHCS to provide HCBS to these persons so that they can stay in their community-based home. HCBS include case management, personal care, skilled nursing, habilitation, and homemaker or home health aide services. They also include adult day programs and respite care. Medi-Cal members must apply separately and qualify to be enrolled in a waiver. Some waivers have waiting lists.

Our Service Area

Alpine, El Dorado, San Joaquin, and Stanislaus Counties



1-888-936-PLAN (7526) TTY 711

www.hpsj-mvhp.org

7751 South Manthey Road, French Camp, CA 95231