Partnership HealthPlan of California

Medi-Cal Member Handbook

Combined Evidence of Coverage
and Disclosure Form

Calendar Year - 2021

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). The call is toll free. In this section of the Member Handbook, you can learn about language assistance services such as interpreter and translation services.

Other formats

You can get this information for free in other formats, such as braille, 18 point font large print and audio. Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). The call is toll free.

Interpreter services

You do not have to use a family member or friend as an interpreter. For free interpreter, linguistic and cultural services and help available 24 hours a day, 7 days a week, or to get this handbook in a different language, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).The call is toll free.

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (800) 863-4155) (TTY/TDD: (800) 735-2929 or 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) 번으로 전화해 주십시오.

繁體中文(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(800) 863-4155 (TTY/TDD: (800) 735-2929 or 711)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (800) 863-4155 (TTY/TDD (հեռատիպ)՝ (800) 735-2929 or 711):

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711 تماس بگیرید.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 863-4155 (رقم هاتف الصم والبكم: 735-2929 (800) or 711).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយខ្នកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បើអ្នក។ ចូរ ទូរស័ព្ទ (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) ។

ພາສາລາວ (Laotian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711)

Notice of non-discrimination

Discrimination is against the law. Partnership HealthPlan of California follows State and Federal civil rights laws. Partnership HealthPlan of California 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.

Partnership HealthPlan of California 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, 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 Partnership HealthPlan of California between 8 a.m. – 5 p.m. by calling (800) 863-4155. Or, if you cannot hear or speak well, please call (TTY/TDD (800) 735-2929) or 711 to use the California Relay Service.

HOW TO FILE A GRIEVANCE

If you believe that Partnership HealthPlan of California has failed to provide these services or unlawfully discriminated in another way on the basis 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, you can file a grievance with Partnership HealthPlan of California. You can file a complaint by phone, in writing, in person, online or by fax:

- By phone: Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711), Monday – Friday, 8 a.m. - 5 p.m. Our Member Services representative will help you with the grievance process.
- In writing: You can write us a letter. Or, we can mail you a form. Be sure to include your PHC ID number and the reason for your grievance. Tell us what happened and how we can fix it:

  Partnership HealthPlan of California
  ATTN: Grievance
  4665 Business Center Drive
  Fairfield, CA 94534

- Online: Visit our website at www.partnershiphp.org
- In person: You can visit your local PHC office or your doctor's office
- Fax: You can fax us at (707) 863-4351. Be sure to include your PHC ID number and the reason for your grievance. Tell us what happened and how we can fix it.

OFFICE OF CIVIL RIGHTS

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

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

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  1-916-440-7370 (TTY/TDD 711 California State Relay)

Complaint forms are available at www.dhcs.ca.gov/Pages/Language_Access.aspx.

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

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

- By phone: Call **(800) 368-1019**. If you cannot speak or hear well, please call **TTY/TDD/TDD (800) 537-7697** or 711 to use the California Relay Service.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services

  200 Independence Avenue, SW

  Room 509F, HHH Building

  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/cp

Welcome to Partnership HealthPlan of California!

Thank you for joining Partnership HealthPlan of California (PHC). PHC is a health plan for people who have Medi-Cal. We work with the State of California to help you get the health care you need. We partner with local medical providers to make sure that you and all of our members have quality health care.

Member Handbook

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

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. It is a summary of PHC rules and policies and based on the contract between us and the California Department of Health Care Services (DHCS).). If you would like more information, call PHC at (800-863-4155) (TTY/TDD (800-735-2929) or 711).

Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) to ask for a copy of the contract between PHC and DHCS. You may also ask for another copy of the Member Handbook at no cost to you or visit the PHC website at www.partnershiphp.org to view the Member Handbook. You may also request, at no cost, a copy of the PHC non-proprietary clinical and administrative policies and procedures, or how to access this information on the PHC website.

Contact us

We are here to help. If you have questions, call PHC at (800) 863-4155

(TTY/TDD: (800) 735-2929 or 711). We are here Monday – Friday, 8 a.m. – 5 p.m. The call is toll free.

You can also visit online at any time at www.partnershiphp.org.

Thank you,

Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, CA 94534

Table of contents

1. Getting started as a member

How to get help

Partnership HealthPlan of California (PHC) wants you to be happy with your health care. If you have any questions or concerns about your care, PHC wants to hear from you!

Member services

PHC member services is here to help you. PHC can:

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

If you need help, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). We are here Monday - Friday, 8 a.m. - 5 p.m. The call is toll free.

You can also visit online at any time at www.partnershiphp.org.

Who can become a member

You qualify for PHC because you qualify for Medi-Cal and live in one of these counties:

- Del Norte County (707) 464-3191
- Humboldt County (877) 410-8809
- Lake County (800) 628-5288
- Lassen County (530) 251-8152
- Marin County (877) 410-8817
- Mendocino County (707) 463-7700
- Modoc County (530) 233-6501

- Napa County (707) 253-4511
- Shasta County (877) 652-0731
- Siskiyou County (530) 841-2700
- Solano County (707) 784-8050
- Sonoma County (877) 699-6868
- Trinity County (800) 851-5658
- Yolo County (866) 226-5415

You may also qualify for Medi-Cal because you are receiving Supplemental Security Income/State Supplementary Payment (SSI/SSP). If you receive SSI, call the Social Security Administration (SSA) office at (800) 772-1213.

You can ask questions about qualifying for Medi-Cal at your local county health and human services office. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Transitional Medi-Cal

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

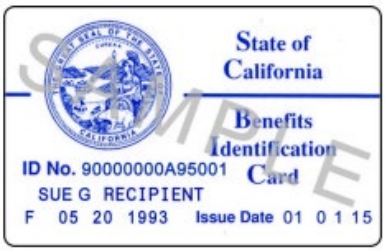
- You started earning more money.
- Your family started receiving more child or spousal support.

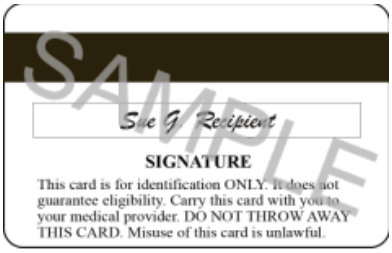
You can ask questions about qualifying for Transitional Medi-Cal at your local county health and human services office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

Identification (ID) cards

As a member of PHC, you will get a PHC ID card. You must show your PHC ID card and your Medi-Cal Benefits Identification Card (BIC) when you get any health care services or prescriptions. You should carry all health cards with you at all times.

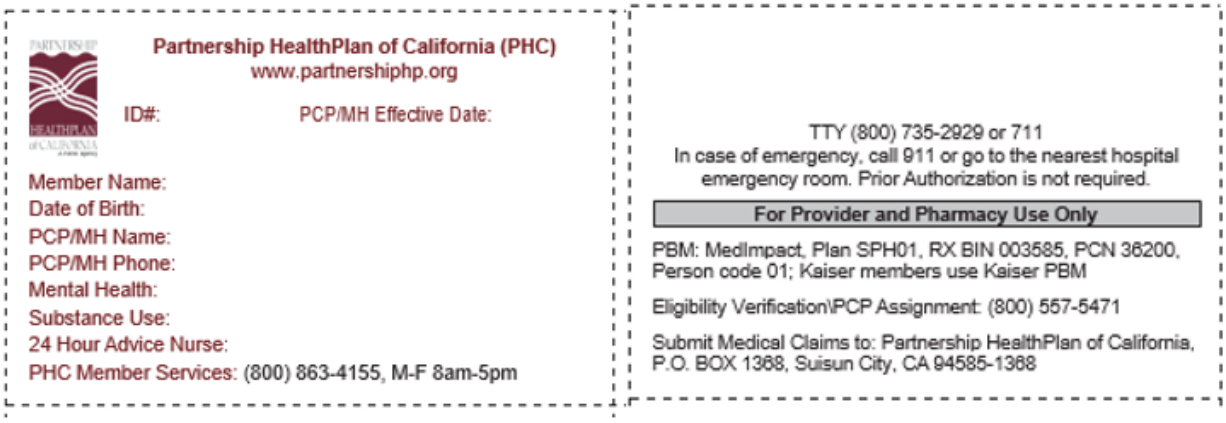
Here is a sample BIC and PHC ID card to show you what yours will look like:





Here is a sample PHC ID card to show you what yours will look like:

FRONT **BACK**



Showing your PHC ID card helps your provider know who to call for questions, prior approval, and coordinating your care. If you change your PCP, or move to another county served by PHC, you may get a new ID card from PHC. You can also Call PHC to ask for a new ID card at any time.

If you do not get your PHC ID card within a few weeks of enrolling, or if your card is damaged, lost or stolen, call PHC right away. We will send you a new card. Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). We are here Monday – Friday, 8 a.m. – 5 p.m. You may also be able to print your ID card from our member portal.

Ways to get involved as a member

PHC wants to hear from you. Each year we have meetings to talk about what is working well and how we can improve. Members are invited to attend. Come to a meeting!

Consumer Advisory Committee (CAC)

PHC has a group called the Consumer Advisory Committee (CAC). This group is made up of our members and community advocates who live in our counties. The group talks about how to improve PHC policies and is responsible for:

- Giving feedback on member materials for readability and cultural competency,
- Identifying member concerns and possible solutions
- Input on current and potential benefits

If you would like to be a part of this group, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Other Ways You Can Get Involved

Other Meetings

Our Commission meetings (also called Board meetings) and the Physician Advisory Committee (PAC) are open to the public. PHC posts the agenda and meeting locations at its offices in an easy to find place, right on the front door! You can attend one of these meetings.

If you need a list of PHC meeting dates, times and locations, call PHC or visit our website at www.partnershiphp.org.

The PHC Member Newsletter

PHC sends a member newsletter twice a year. The newsletter includes health education articles, updates to PHC benefits, and other helpful information.

If you want a copy of the most recent Newsletter, call PHC or visit our website at www.partnershiphp.org.

2. About your health plan

Health plan overview

PHC is a health plan for people who have Medi-Cal in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo counties. We work with the State of California to help you get the health care you need.

You may talk with one of the PHC member services representatives to learn more about the health plan and how to make it work for you. Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

When your coverage starts and ends

You are automatically enrolled into PHC based on the type of Medi-Cal you qualified for and the county you live in. Members cannot choose to leave PHC to go to State Medi-Cal or another Medi-Cal health plan. Your Medi-Cal coverage will need to be renewed every year. The county will send you a Medi-Cal renewal form. Complete this form and return it to your local county human services agency.

The first month of PHC eligibility, you can receive care from any Medi-Cal provider willing to bill us. As a new member, you will receive a PHC ID card, this Handbook and a Provider Directory, or information on how to see, print or request these materials on our website.

The second month of PHC eligibility you are assigned to a primary care provider (PCP). Your assigned PCP is printed on your ID card. You must see this PCP for primary care services. The start date to see your PCP is on your ID card. The Provider Directory helps you to choose a new PCP if you do not want the one that was chosen for you.

Prior authorization (also called pre-approval) may be required for certain services, even when you are not assigned to a PCP. If you need help getting pre-approval during your first month, call PHC at (800) 863-4155 (TTY/TDD (800) 735-2929 or 711).

PHC eligibility might change if you no longer have Medi-Cal or if you move out of the county. PHC coverage may also end if your local county health and human services

office receives information that changes your eligibility for Medi-Cal, this includes going to jail. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

If you are not sure if you are still covered by us, please call (800) 863-4155 (TTY/TDD (800) 735-2929) or 711.

If you no longer qualify for Medi-Cal benefits, call Covered California at (800) 300-1506, (TTY/TDD (888) 889-4500). Covered California can help you find out if you qualify for other health insurance options.

Managed Long-Term Services and Supports (MLTSS)

Individuals who are eligible for Medicare and Medi-Cal must join a Medi-Cal managed care plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

Special Considerations for American Indians in Managed Care

If you are an American Indian, you have the right to get health care services at any Indian health service facilities. To find out more, please call Indian Health Services at (**916) 930-3927** or visit the Indian Health Services website at www.ihs.gov.

How your plan works

PHC is a health plan contracted with the California Department of Health Care Services (DHCS). PHC is a managed care health plan. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. PHC works with doctors, hospitals, pharmacies and other health care providers in our service area to give health care to you, the member.

Member Services will tell you how PHC works, how to get the care you need, how to schedule provider appointments within standard access times, and how to find out if you qualify for transportation services.

To learn more, call PHC at (800) 863-4155

(TTY/TDD: (800) 735-2929 or 711). You can also find member service information online at www.partnershiphp.org.

Changing health plans

PHC is the health plan for Medi-Cal beneficiaries in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo counties. You will stop being a PHC member only if you lose your Medi-Cal eligibility or if you move out of the PHC service area. PHC coverage may also end if your local county health and human services office changes how you qualify for Medi-Cal. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

College students who move to a new county or out of California

If you move to a new county in California to attend college, PHC will cover emergency services in your new county.

If you are enrolled in Medi-Cal and will attend college in a different county, you do not need to apply for Medi-Cal in that county.

When you temporarily move away from home to go to college in another county in California there are two options available to you. You may:

- Notify your local county social services office that you are temporarily moving to attend college and provide your address in the new county. The county will update the case records with your new address and county code in the State's database. Use this choice if you want to get routine or preventive services in your new county. You may have to change your health plan. For questions, and to prevent any delays in enrolling in a new health plan enrollment, you should contact Health Care Options may be able to help you. Call health Care Options at (800) 430-4263 (TTY/TDD (800) 430-7077). You may be able to get your Medi-Cal services at the county where you go to college. You will be limited to emergency services when outside of the county where you go to college.

  OR

- Choose not to change your health plan when you temporarily move to attend college in a different county. You will only be able to access emergency room and urgent care services in the new county for some conditions. To learn more, go to Section 3, "How to get care." For routine or preventive health care, you would need to use the PHC regular network of providers located in the head of household's county of residence.

- If you are leaving California temporarily to attend college in another state and you want to keep your Medi-Cal coverage, contact your eligibility worker at your local county health and human services office. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx. As long as you

are eligible, Medi-Cal will cover emergencies in another state, and emergencies requiring hospitalization in Canada and Mexico if the service is approved and the doctor and hospital meet Medi-Cal rules. If you want Medicaid in another state, you will need to apply in that state. You will not be eligible for Medi-Cal and PHC will not pay for your healthcare.

Continuity of care

As a member of PHC, you will get your health care from providers in our network. In some cases, you may be able to go to providers who are not in the PHC network, which is called continuity of care. If you have continuity of care, you will be able to go to the provider for up to 12 months, or more in some cases. If your providers do not join the PHC network by the end of 12 months, you will need to switch to providers in the PHC network.

Continuity of care is subject to approval by us based on Medi-Cal guidelines. Continuity of care does not apply to services that are not covered by Medi-Cal, and does not extend to the following types of providers:

- Durable Medical Equipment
- Transportation

Ancillary Services and/or Carved out Services. Providers who leave PHC

If your provider stops working with PHC, you may be able to keep getting services from that provider for up to 12 months. This is another form of continuity of care. PHC provide continuity of care services including, but not limited to:

- Primary Care
- Specialists
- Behavioral Health Therapy
- Pregnancy and Postpartum Care
- Maternal mental health services
- Mild to Moderate Mental Health Services
- Acute conditions
- Chronic physical and behavioral conditions
- Terminal illness
- Care of a newborn child between birth and age 36 months
- Performance of a surgery or other procedure that your doctor and PHC agrees is medically necessary and has already been pre-approved

Continuity of care is not available if you have not seen your doctor at least once during

the last 12 months; your doctor is not willing to work with PHC or if PHC has documented quality of care concerns with your doctor.

To learn more about continuity of care and eligibility qualifications, and to hear about all available services, call (800-863-4155).

Costs

Member costs

PHC serves people who qualify for Medi-Cal. Our members do **not** have to pay for covered services. You will not have premiums or deductibles. For a list of covered services, see "Benefits and services."

For members with a share of cost

You may have to pay a share of cost each month. The amount of your share of cost depends on your income and resources and is set by your county Medi-Cal office. Each month that you use Medi-Cal services you will pay your own medical bills until the amount that you have paid equals your share of cost. After that, your care will be covered by PHC for that month. You will not be covered by PHC until you have paid your entire share of cost for the month. After you meet your share of cost for the month, you can go to any PHC provider. If you are a member with a share of cost, you do not need to choose a PCP.

How a provider gets paid

PHC pays providers in these ways:

- Capitation payments
    - PHC pays some providers a set amount of money every month for each of our members. This is called a capitation payment. PHC and providers work together to decide on the payment amount.
- Fee-for-service payments
    - Some providers give care to PHC members and then sends PHC a bill for the services they provided. This is called a fee-for-service payment. PHC and providers work together to decide how much each service costs.
- Quality Improvement Programs
    - This value based payment program rewards our contracted primary care providers, long-term care facilities, and specialists for meeting or

exceeding certain quality standards. This program improves member health care and encourages provider performance.

To learn more about how we pay our providers, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Asking PHC to pay a bill

If you get a bill for a covered service, do not pay the bill. Call PHC right away at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

If you pay for a service that you think we should cover, you can file a claim. Use a claim form and tell us in writing why you had to pay. Call PHC at (800) 863-4155

(TTY/TDD: (800) 735-2929 or 711) to ask for a claim form. We will review your claim to decide if you can get money back.

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 begin to get health care services on your effective date of coverage. Always carry your health insurance cards including your PHC ID card, Medi-Cal Benefits Identification Card (BIC), and any other health insurance cards you have, with you. Never let anyone else use your PHC ID card or BIC card.

New members must choose a primary care provider (PCP) in the PHC network. Our network is a group of doctors, hospitals and other providers who work with us. You must choose a PCP within 30 days from the time you become a PHC member. If you do not choose a PCP, we will choose one for you.

You may choose the same PCP or different PCPs for all family members enrolled with PHC.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in the Provider Directory. It has a list of all PCPs in our network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

You can also find the Provider Directory on our website at www.partnershiphp.org.

If you cannot get the care you need from a participating provider in the PHC network, your PCP must ask PHC for approval to send you to an out-of-network provider. This is called a referral.

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

Initial health assessment (IHA)

PHC recommends that, as a new member, you visit your new PCP within the first 120 days of becoming a PHC member for an initial health assessment (IHA). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP may ask you some 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 may help you.

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

Take your BIC card and your PHC ID card and any other health insurance cards to your appointment. It is a good idea to take a list of your medications 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.

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups, health education, and counseling. Children are able to receive much needed early preventive services like hearing and vision screening, assessments of developmental process and many more services that are recommended by pediatricians' Bright Futures guidelines. In addition to preventive care, routine care also includes care when you are sick. PHC covers routine care from your PCP.

Your PCP will:

- Give you all of your routine care, including regular checkups, shots, treatment, prescriptions and medical advice
- Keep your health records
- Refer (send) you to specialists if needed
- Order X-rays, mammograms or lab work if you need them

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

To learn more about health care and services PHC covers, and what we do not cover, read 'Benefits and Services' in this handbook.

Urgent care

Urgent care is **not** for an emergency or life-threatening condition. It is for services you need to prevent serious harm to your health from a sudden illness, injury or complication of a condition you already have. Urgent care appointments require care within 48 hours. If you are outside our service area, urgent care services may be covered. Urgent care needs could be a cold, sore throat, fever, ear pain, sprained muscle, or maternity services.

For urgent care, call your PCP. If you cannot reach your PCP, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). Or you can call our Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week. This is a toll free number to speak to a nurse about your health if you are unsure about going to the ER.

If you need urgent care out of the area, go to the nearest urgent care facility. You do not need pre-approval (prior authorization).

If you need urgent mental health care, you may call your county Mental Health Plan or Beacon Health Options (Beacon) any time, 24 hours a day, 7 days a week. For help finding urgent mental health care, you can call Beacon at (855) 765-9703 or TTY/TDD: (800) 735-2929 (24 hours a day, 7 days a week), or PHC Care Coordination at (800) 809-1350 or 711 (Monday – Friday, 8 a.m. - 5 p.m.). To find all counties' toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.**

Emergency care

For emergency care, call **911** or go to the nearest emergency room (ER). For emergency care, you do **not** need pre-approval (prior authorization) from PHC. You have the right to use any hospital or other setting for emergency care.

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a reasonable layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, your health (or your unborn baby's health) could be in danger, or a body function, body organ or body part could be seriously harmed. Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain
- 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. You should get routine care from your PCP, who knows you best. If you are not sure if your medical condition is an emergency, call your PCP. You may also call our Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week.

If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in PHC network. If you go to an ER, ask them to call PHC. You or the hospital to which you were admitted should call PHC within 24 hours after you get emergency care. PHC may cover emergencies requiring hospitalization in Canada and Mexico if the service is approved and the doctor and hospital meet Medi-Cal rules. If you are traveling outside the U.S., other than to Canada or Mexico, and need emergency care, PHC will **not** cover your care.

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

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

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

Sensitive care

Minor consent services

If you are under 18 years old and at least 12 years old, you can go to a doctor without consent from your parents or guardian for these types of care:

- Outpatient mental health for:
    - Sexual or physical abuse
    - When you may hurt yourself or others
    - When you have thoughts of hurting yourself or others
- Pregnancy
- For pregnancy testing, family planning services, birth control Sexual assault
- HIV/AIDS prevention, testing, treatment (only minors 12 years or older)
- Sexually transmitted infections prevention/testing/treatment (only minors 12 years or older)
- Substance Use Disorder Screening

The doctor or clinic does not have to be part of our network. For these services, you can choose any Medi-Cal provider and go to them without a referral from your PCP or pre-approval (prior authorization) from us. Services from an out-of-network provider **not** related to sensitive care may not be covered. For help finding a doctor or clinic giving these services, or for help getting to these services (including transportation), you can Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). You may also call our Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week.

Minors can talk to a representative in private about their health concerns by calling our Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week. Adult sensitive services

As an adult (18 years or older), you may not want to go to your PCP for certain sensitive or private care. If so, you may choose any doctor or clinic for the following types of care:

- Family planning and birth control (including sterilization)
- Pregnancy testing and counseling
- HIV/AIDS prevention and testing
- Sexually transmitted infections prevention, testing and treatment
- Sexual assault care
- Outpatient abortion services

The doctor or clinic does not have to be part of the PHC network. For these services, you can choose any Medi-Cal provider and go to them without a referral from your PCP or pre-approval (prior authorization) from us. Services from an out-of-network provider not related to sensitive care may not be covered. For help finding a doctor or clinic giving these services, you can call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). You may also call our Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week.

Advance directives

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

You can get an advance directive form at drugstores, hospitals, law offices and doctors' offices. You may have to pay for the form. You can also find and download a free form online by visiting our website at www.partnershiphp.org. 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. PHC will tell you about changes to the state law no longer than 90 days after the change.

For more information about advance directives, you can call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Organ and tissue donation

Adults can help save lives by becoming an organ or tissue donor. If you are between

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

Where to get care

You will get most of your care from your PCP. Your PCP will give you all of your routine preventive (wellness) care. You will also go to your PCP for care when you are sick. Be sure to call your PCP before you get non-emergency medical care. Your PCP will refer (send) you to specialists if you need them.

To get help with your health questions, you can also call our Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week.

If you need urgent care, call your PCP. Urgent care is care you need within 48 hours, but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain, sprained muscle, or maternity services.

For emergencies, call **911** or go to the nearest emergency room.

Moral objection

Some providers have a moral objection to some covered services. This means they have a right to **not** offer some covered services if they morally disagree with the services. These services might include:

- Family planning services
- Abortion

If your provider has a moral objection, they will help you find another provider for the needed services. We can also work with you to find a provider. If you need help getting a referral to a different provider, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Some hospitals and other providers do not offer one or more of the listed services. These services are available and PHC must ensure you or your family member sees a provider or is admitted to a hospital that will perform the following covered services:

- Family planning and contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Abortion

You should get more information before you select a provider. Call the new doctor,

medical group, independent practice association or clinic, or call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) to ensure that you can obtain the health care services that you need.

Provider Directory

The PHC Provider Directory lists providers that participate in the PHC network. The network is the group of providers that works with PHC.

The PHC Provider Directory lists hospitals, pharmacies, long term care facilities, skilled nursing facilities, urgent care sites, vision providers, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, hospitals, medical supply providers, physical and occupational therapists, behavior health therapists, Federally Qualified Health Centers (FQHCs), Indian Health Care (IHCs), and Rural Health Clinics (RHCs).

The Provider Directory has PHC network provider names, provider addresses, phone numbers, business hours and languages spoken. It tells if the provider is taking new patients. It gives the level of physical accessibility to the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars.

You can find the online Provider Directory at www.partnershiphp.org.

If you need a printed Provider Directory or want more information about a doctor's education, training, and board certification, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Provider network

The provider network is the group of doctors, hospitals and other providers that work with PHC. You will get your covered services through the PHC network.

Note: American Indians may choose an IHC as their PCP.

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 PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). For more information about moral objection, read the "Moral objection" section earlier in this chapter.

If your provider has a moral objection, they can help you find another provider who will give you the services you need. PCH can also work with you to find a provider who will perform the service. In network providers

You will use providers in the PHC network for your health care needs. You will get

preventive and routine care from your PCP. You will also use specialists, hospitals and other providers in the PHC network.

To get a Provider Directory of network providers, call PHC at (800) 863-4155) TTY/TDD: (800) 735-2929 or 711). You can also find the Provider Directory online at www.partnershiphp.org.

For emergency care, call **911** or go to the nearest emergency room.

Except for emergency care, you may have to pay for care from providers who are out of network.

Out of network providers who are inside the service area

Out-of-network providers are those that do not have an agreement to work with PHC. Except for emergency care, you may have to pay for care from providers who are out of the network. If you need covered health care services, you may be able to get them out of the network at no cost to you as long as they are medically necessary and not available in the network.

You may need a referral to go to an out-of-network provider if the services you need are not available in-network or are located very far from your home. Referrals to an out-of-network provider may require our pre-approval (prior authorization). Once we approve your referral, you may see this provider for care and we will pay for medically necessary care.

If you need help with out-of-network services, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Outside the service area

If you are outside of our service area and need care that is **not** an emergency or urgent, call your PCP right away, or Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

For emergency care, call **911** or go to the nearest emergency room. PHC cover out-of-network emergency care. If you travel to Canada or Mexico and need emergency services requiring hospitalization, PHC may cover your care. If you are traveling internationally outside of Canada or Mexico and need emergency care, we will **not** cover your care.

If you need health care services for a California Children's Services (CCS) eligible medical condition and PHC does not have a CCS-paneled specialist in the network who can provide the care you need, you may be able to go to a provider outside of the provider network at no cost to you. To learn more about the CCS program, read the Benefits and Services chapter of this handbook.

If you have questions about out-of-network or out-of-service area care, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) If the office is closed, and you want help from a representative, call PHC's Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week.

Members Assigned to Kaiser Permanente

Kaiser is a contracted provider with PHC in certain counties. To select Kaiser as your PCP in general, you must:

- Live in one of these counties: Marin, Sonoma, Napa, Solano, or Yolo
- Have full scope no share of cost Medi-Cal
- Meet Kaiser defined criteria
- Must be eligible for PCP assignment

If you want to pick Kaiser as your PCP, contact us at (800) 863-4155 (TTY/TDD (800) 735-2929 or 711) for assistance.

If Kaiser is your assigned PCP, you must receive all of your care at Kaiser. Please refer to Kaiser's Member Handbook for details on your health care plan.

If you are assigned to Kaiser you can contact Kaiser's Member Services at (800) 464-4000 (TTY/TDD (800) 777-1370). You can also contact the Kaiser Advice Nurse at (800) 464-4000.

Doctors

You will choose a primary care provider (PCP) from the PHC Provider Directory. Your PCP must be a participating provider. This means the provider is in PHC network. To get a copy of the Provider Directory, visit our website at www.partnershiphp.org or call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Note: American Indians may choose an Indian Health Clinic (IHC) as their PCP.

You can also call if you want to check to be sure the PCP you want is taking new patients.

If you had a doctor before you were a member of PHC, and that doctor is not part of our network, you may 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 *Section 2. About your health plan*. To learn more, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

If you need a specialist, your PCP can give you a referral to a specialist in the PHC network.

Remember, if you do not choose a PCP, will choose one for you. You know your health care needs best, so it is best if you choose.

If you want to change your PCP, you must choose a PCP from the PHC Provider Directory. Be sure the PCP is taking new patients. If you're a patient of a PCP that is not taking new patients, please contact us for assistance. To change your PCP, you can use our member portal by registering at www.partnershiphp.org or call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Hospitals

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

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in the network. The hospitals in the PHC network are listed in the Provider Directory. (Hospital services, other than emergencies, must have pre-approval (prior authorization).

Timely access to care

Appointment Type	Must Get Appointment Within
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Non-urgent primary care appointments	10 business days
Non-urgent specialist	15 business days
Non-urgent mental health provider (non-physician)	10 business days
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	15 business days
Telephone wait times during normal business hours	10 minutes
Triage – 24/7 services	24/7 services – No more than 30 minutes
Initial pre-natal care	10 business days

Travel time and distance to care

PHC must follow travel time and distance standards for your care. Those standards helps to make sure you are able to get care without having to travel too long or too far from where you live. Travel time and distance standards are different depending on the county you live in.

If PHC is not able to provide care to you within these travel time and distance standards, a different standard called an alternative access standard may be used. To see PHC's time and distance standards for where you live, please, visit www.partnershiphp.org or call PHC at (800) 863-4155 (TTY/TDD (800) 735-2929).

If you need care from a specialist and that provider is located far from where you live, you can call PHC Member Services (800) 863-4155 (TTY/TDD (800) 735-2929) to get help finding care with a specialist located closer to you. If we cannot find care for you with a closer specialist, you can request that PHC arrange transportation for you to see a specialist even if that specialist is located far from where you live.

It is considered far if you cannot get to that specialist within our travel time and distance standards for your county, regardless of any alternative access standard PHC may use for your ZIP Code.

Primary care provider (PCP)

You must choose a PCP within 30 days of PHC enrollment. Depending on your age and sex, you may 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 may also act as your PCP. If you choose an NP, PA or certified nurse midwife, you may be assigned a doctor to oversee your care.

You can also choose an Indian Health Clinic (IHC), Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as your PCP.

Depending on the type of the provider, you may be able to choose one PCP for your entire family who are members of PHC.

If you do not choose a PCP within 30 days of enrollment, PHC will assign you to a PCP. If you are assigned to a PCP and want to change, you can use our member portal by registering at www.partnershiphp.org or call PHC member services at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). The change is effective the first day of the next month. Your PCP will:

- Get to know your health history and needs
- Keep your health records
- Give you the preventive and routine health care you need

- Refer (send) you to a specialist if you need one
- Arrange for hospital care if you need it

You can look in the Provider Directory to find a PCP in our network. The Provider Directory includes IHCs, FQHCs and RHCs that work with PHC.

You can find the PHC Provider Directory online at www.partnershiphp.org. Or you can request a Provider Directory to be mailed to you by calling (800) 863-4155.

(TTY/TDD: (800) 735-2929 or 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 he or she 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 PHC provider network and is taking new patients. If you are a current patient of a PCP that has an “Accepting Existing Patients Only” or “Closed” status, please call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711) for assistance.

Your new choice will become your PCP on the first day of the next month after we process your request for change.

To change your PCP, you can use our member portal by registering at www.partnershiphp.org or call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

PHC may ask you to change your PCP selection if the PCP is not taking new patients, has left our network or does not give care to patients your age. PHC or your PCP may 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 you need to change your PCP, PHC will tell you in writing.

If you change PCP, you will get a new PHC member ID card in the mail. It will have the name of your new PCP. Call PHC if you have questions about getting a new ID card.

Appointments

When you need health care:

- Call your PCP
- Have your PHC ID number ready on the call
- Leave a message with your name and phone number if the office is closed

- Take your BIC, PHC ID and any other health insurance cards to your appointment
- Ask for transportation to your appointment, if needed
- Ask for language assistance or interpretation services, if needed
- Be on time for your appointment
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

If you have an emergency, call **911** or go to the nearest emergency room.

Payment

You do **not** have to pay for covered services from a certified Medi-Cal provider. You must present your Medi-Cal and PHC ID cards at the time of service. In most cases, you will not get a bill from a provider. You may 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 (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). Have your bill with you so you can tell PHC information about the bill such as; the amount charged, the date of service, and the reason for the bill. You are **not** responsible to pay a provider for any amount owed by PHC for any covered service. Except for emergency care or urgent care, you may have to pay for care from providers who are not in the network. If you need covered health care services, you may be able to get them form an out-of-network provider at no cost to you, as long as they are medically necessary and not available in the network. Pre-approval (prior authorization) may be required.

If you get a bill or are asked to pay a co-pay that you think you did not have to, you can also file a claim form. This is called the Medical Claim Form for Reimbursement. You will need to tell PHC in writing why you had to pay for the item or service. PHC will read your claim and decide if you can get money back. For questions or to ask for a claim form, call (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Referrals

Your PCP can give you a referral to send you to a specialist if you need one. A specialist is a doctor who has extra education in one area of medicine. Your PCP will work with you to choose a specialist. Your PCP’s office can help you set up a time to go to the specialist.

Other services that may require a referral include in-office procedures, X-rays and lab work and more services as appropriate.

Your PCP may 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 he or she thinks you need treatment.

If you have a health problem that needs special medical care for a long time, you may need a standing referral. This means you can see 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 our referral policy, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 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
- Acupuncture (the first two services per month; additional appointments will need a referral)
- Chiropractic services (when provided by FQHCs and RHCs)
- Podiatry services (when provided by FQHCs and RHCs)
- Eligible dental services
- Initial mental health assessment
- Family planning services (To learn more, call Office of Family Planning Information and Referral Service at (800) 942-1054)
- HIV testing and counseling (only minors 12 years or older)
- Treatment for sexually transmitted infections (only minors 12 years or older)

Minors also do not need a referral for:

- Outpatient mental health services for:
    - Sexual assault
    - Physical assault
    - When you have thoughts of hurting yourself or others (minors 12 years or older)
- Pregnancy care
- Sexual assault care
- Substance Use Disorder treatment (minors 12 years or older)

Pre-approval (prior authorization)

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

Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed

disease, illness or injury.

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

- Hospitalization, if not an emergency
- Services out of the PHC network service area except for sensitive services, emergency, or urgent, services
- Outpatient surgery
- Long-term care at a nursing facility
- Specialized treatments

For some services, you need pre-approval (prior authorization). Under Health and Safety Code Section 1367.01(h)(2), PHC will decide routine pre-approvals (prior authorizations) within 5 working days of when we get the information reasonably needed to make a decision.

For requests in which a provider indicates or PHC determines that following the standard timeframe could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function, we will make an expedited (fast) pre-approval (prior authorization) decision. We will give notice as quickly as your health condition requires and no later than 72 hours after getting the request for services.

PHC does **not** pay the reviewers to deny coverage or services. If we do not approve the request, we will send you a Notice of Action (NOA) letter. The NOA letter will tell you how to file an appeal if you do not agree with the decision.

PHC will contact you if we need more information or more time to review your request.

You never need pre-approval (prior authorization) for emergency care, even if it is out of the network and out of your service area. This includes labor and delivery if you are pregnant. You do not need pre-approval (prior authorization) for sensitive services, such as family planning, HIV/AIDS services, and outpatient abortions.

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 may want a second opinion if you are not sure you need a prescribed treatment or surgery or you have tried to follow a treatment plan and it has not worked.

If you want to get a second opinion, you can choose an in-network provider of your choice. For help choosing a provider, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

PHC will pay for a second opinion if you or your network provider asks for it and you get the second opinion from a network provider. You do not need permission from PHC to

get a second opinion from a network provider. However, if you need a referral, your network provider can help you get one.

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

If PHC denies your request for a second opinion, you may appeal. To learn more about appeals, see “Appeals” on page 75 in this handbook.

Women’s health specialists

You may go to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive health care services. You do not need a referral from your PCP to get these services. For help finding a women’s health specialist, you can call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

4. Benefits and services

What your health plan covers

This section explains all of your covered services as a member of PHC. Your covered services are at no cost to you as long as they are medically necessary and provided by an in-network provider. Services from an in-network provider may need pre-approval (prior authorization). Your provider must ask PHC for pre-approval (prior authorization) if the care is out-of-network except for sensitive services, emergencies or urgent care services. PHC may cover medically necessary services from an out-of-network provider but we must approve this before you are treated. Care must be medically necessary, reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed disease, illness or injury. For more details on your covered services, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

PHC offers services such as:

- Outpatient (ambulatory) services
- Telehealth services
- Emergency services
- Hospice and palliative care
- Hospitalization
- Maternity and newborn care
- Rehabilitative and habilitative (therapy) services and devices
- Laboratory and radiology services, such as X-Rays
- Preventive and wellness services
- Chronic disease management
- Diabetes Prevention Program
- Mild to moderate mental health services
- Substance use disorder treatment screening
- Pediatric services
- Vision services
- Non-emergency medical transportation (NEMT)

- Non-medical transportation (NMT)
- Long-term services and supports (LTSS)
- CCS-eligible services

Read each of the sections below to learn more about the services you can get.

Medi-Cal benefits offered by PHC

Outpatient (ambulatory) services

- ***Adult Immunizations***

  You can get adult immunizations (shots) from a network provider without pre-approval (prior authorization). PHC covers shots recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

- ***Allergy care***

  PHC covers allergy testing and treatment, including allergy desensitization, hyposensitization, or immunotherapy.

- ***Anesthesiologists services***

  PHC covers anesthesia services that are medically necessary when you get outpatient care.

  For dental procedures, PHC covers the following services with pre-approval (prior authorization):

  - Anesthesiologists, IV sedation or general anesthesia services administered by a medical professional
  - Facility services related to the sedation or anesthesia in an outpatient surgical center, Federally Qualified Health Center (FQHC), dental office, or hospital setting

- ***Chiropractic services***

  PHC covers two chiropractic services per month, up to 24 services per 12-month period, limited to the treatment of the spine by manual manipulation. PHC may pre-approve other services as medically necessary.

  The following members are eligible for chiropractic services:

- Children under age 21;
- Pregnant women through the end of the month that includes 60-days following the end of a pregnancy;
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility; or
- All members when services are provided at hospital outpatient departments, FQHC or RHC

- ***Dialysis/hemodialysis services***

  PHC covers dialysis treatments. PHC also covers hemodialysis (chronic dialysis) services if your PCP and PHC approve it.

- ***Outpatient surgery***

  PHC covers outpatient surgical procedures, other than those needed for diagnostic purposes, procedures considered to be elective; and specified outpatient medical procedures must have pre-approval (prior authorization).

- ***Physician services***

  PHC covers physician services that are medically necessary.

- ***Podiatry (foot) services***

  PHC covers podiatry services as medically necessary for diagnosis and medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

- ***Treatment therapies***

  PHC covers different treatment therapies, including:

  - Chemotherapy
  - Radiation therapy

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. Or telehealth may involve sharing information with your provider without a live conversation. You can receive many services through telehealth. It is important that both you and your provider agree that the use of telehealth for a particular service is

appropriate for you. You can contact your provider to learn which types of services may be available through telehealth.

Mental health services

- ***Outpatient mental health services***

  PHC covers a member for an initial mental health assessment without requiring pre-approval (prior authorization). You may get a mental health assessment at any time from a licensed mental health provider in the network without a referral.

  Your PCP or mental health provider will make a referral for additional mental health screening to a specialist within PHC's network to determine your level of impairment. If your mental health screening results determine you are in mild or moderate distress or have impairment of mental, emotional or behavioral functioning, PHC can provide mental health services for you. PHC 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 medication therapy
  - Outpatient laboratory, medications, supplies and supplements
  - Psychiatric consultation

To provide these outpatient mild to moderate health care services, PHC has partnered with Beacon Health Options (Beacon). For help finding more information on mental health services provided by Beacon, you can call (855) 765-9703 or TTY/TDD: (800) 735-2929 (24 hours a day, 7 days a week), or PHC at (800) 863-4155 TTY/TDD: (800) 735-2929 or 711 (Monday – Friday 8 a.m. – 5 p.m.). If your mental health screening results determine you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider will refer you to the county mental health plan to receive an assessment. To learn more, read "*Services you cannot get through PHC or FFS Medi-Cal*" on page 58.

Emergency services

- ***Inpatient and outpatient services needed to treat a medical emergency***

  PHC covers all services that are needed to treat a medical emergency that happens in the U.S. or requires you to be in a hospital 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 layperson could expect it to result in:

  - Serious risk to your health; ***or***
  - Serious harm to bodily functions; ***or***
  - Serious dysfunction of any bodily organ or part; ***or***
  - In the case of a pregnant woman 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 may pose a threat to your health or safety or to that of your unborn child.

  A pharmacist or hospital emergency room may give you a 72-hour emergency supply of a prescription drug if they think you need it. Medi-Cal RX or PHC will pay for the emergency supply.

- ***Emergency transportation services***

  PHC covers ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico.

Hospice and palliative care

PHC covers hospice care and palliative care for children and adults, which help reduce physical, emotional, social and spiritual discomforts for a member with a serious illness. Adults may not receive both hospice care and palliative care services at the same time.

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

Hospice care includes:

- Nursing services

- Physical, occupational or speech services
- Medical social services
- Home health aide and homemaker services
- Medical supplies and appliances
- Drugs and biological services
- Counselling services
- Continuous nursing services on a 24-hour basis during periods of crisis and as necessary to maintain the terminally ill member at home
- Inpatient respite care for up to five consecutive days at a time in a hospital, skilled nursing facility or hospice facility
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing facility or hospice facility

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

Hospitalization

- ***Anesthesiologist services***

  PHC 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 procedures.

- ***Inpatient hospital services***

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

- ***Surgical services***

  PHC covers medically necessary surgeries performed in a hospital.

Maternity and newborn care

PHC covers these maternity and newborn care services:

- Breastfeeding education and aids
- Breast pumps and supplies
- Delivery and postpartum care

- Prenatal care
- Birthing center services
- Certified Nurse Midwife (CNM)
- Licensed Midwife (LM)
- Diagnosis of fetal genetic disorders and counseling

Prescription drugs

Covered drugs

Your provider can prescribe you drugs that are on the PHC preferred drug list subject to exclusions and limitations. This drug list is also called a formulary. A group of doctors and pharmacists updates this list every three months

- Updating this list helps make sure the drugs on it are safe and effective.
- If your doctor thinks you need to take a drug that is not on this list, your doctor will need to contact us to ask for pre-approval before you get the drug.
- Pre-approvals are also known as TARs (Treatment Authorization Request).
- TARs may be sent to us by your pharmacy or by your prescriber (doctor, nurse practitioner, dentist, physician assistant).

To find out if a drug is on the formulary or to get a copy of the formulary, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711). You can also find our formulary online at www.partnershiphp.org.

Sometimes we need to approve a drug before a provider can prescribe it. The prescriber will send us a TAR to request the approval ahead of time. We will review and decide on these requests within 24 hours.

- A pharmacist may give you up to a 14-day emergency supply if they think you need it. We will pay the pharmacy for the emergency supply.
- A hospital emergency room may give you a 3-day supply if they think you need it. We will pay the hospital for the emergency supply.
- If we deny the request, we will send you a letter that lets you know why and what other drugs or treatments you can try.

Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with us. You can find a list of pharmacies that work with us in on our website at www.partnershiphp.org. You can also find a pharmacy near you by calling us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

Once you choose a pharmacy, take your prescription to the pharmacy. Your provider may

also send it to the pharmacy for you. Give the pharmacy your prescription with your PHC ID card and all other health insurance cards. Make sure the pharmacy knows about all medications you are taking and any allergies you have. If you have any questions about your prescription, make sure you ask the pharmacist.

Non-covered Drugs

Certain medications belonging to classes of antiviral (HIV/AIDS, Hepatitis B), antipsychotics, opioid antagonists and antihemophilic blood factors are covered by State Medi-Cal rather than PHC, therefore these are classified as "non-covered" or "carve-out" drugs. This classification is drug-specific, not diagnosis specific. For example, if a buprenorphine prescription is written to treat a condition other than dependency or addiction, the drug is still considered to be the responsibility of State Medi-Cal and is not covered by PHC. Claims and TARs for PHC Medi-Cal members must be submitted to State Medi-Cal.

For a list of non-covered drugs, visit our website at http://www.partnershiphp.org/Providers/Pharmacy/Pages/default.aspx. To request a list of non-covered drugs be mailed to you, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

The Provisional Postpartum Care Extension Program

The Provisional Postpartum Care Extension (PPCE) Program provides extended coverage for Medi-Cal members who have a maternal mental health condition during pregnancy or the time period after pregnancy.

PHC covers maternal mental health care for women during pregnancy and for up to two months after the end of pregnancy. The PPCE program extends that coverage for up to 12 months after the diagnosis or from the end of the pregnancy, whichever is later.

To qualify for the PPCE program, your doctor must confirm your diagnosis of a maternal mental health condition within 150 days after the end of pregnancy. Ask your doctor about these services if you think you need them. If your doctor thinks you should have the services from PPCE, your doctor completes and submits the forms for you.

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.

PHC covers:

- ***Acupuncture***

PHC covers acupuncture services to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. These services are subject to pre-approval (prior authorization) by PHC.

- ***Audiology (hearing)***

  PHC covers audiology that is medically necessary. You may have limitations on how many visits to an audiologist that you get every month. These services are subject to pre-approval (prior authorization) by PHC.

- ***Behavioral health treatments***

  Behavioral health treatment (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 an individual.

  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 and 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 physician, surgeon, or developed by a licensed psychologist, approved by the plan, and provided in a way that follows the approved treatment plan.

- ***Cancer clinical trials***

  PHC covers routine patient care costs for patients accepted into Phase I, Phase II, Phase III or Phase IV clinical trials when certain conditions are met and if it is related to the prevention, detection or treatment of cancer or other life-threatening conditions and if the study is conducted by the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS). Studies must be approved by the National Institutes of Health, the FDA, the Department of Defense or the Veterans Administration.

- ***Cardiac rehabilitation***

  PHC covers inpatient and outpatient cardiac rehabilitative services.

- ***Durable medical equipment***

  PHC covers the purchase or rental DME supplies, equipment and other services with a prescription from a doctor. Prescribed DME items may be covered as medically necessary to preserve bodily functions essential to activities of daily living or to prevent major physical disability. PHC does not cover comfort, convenience or luxury equipment, features supplies, and other items not generally used primarily for health care.

- ***Enteral and parenteral nutrition***

  These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. We cover enteral and parenteral nutrition products when medically necessary.

- ***Hearing aids***

  PHC covers hearing aids if you are tested for hearing loss and have a prescription from your doctor. PHC may also cover hearing aid rentals, replacements and batteries for your first hearing aid.

- ***Home health services***

  PHC covers health services provided in your home, when prescribed by your doctor and found to be medically necessary.

- ***Medical supplies, equipment and appliances***

  We cover medical supplies that are prescribed by a doctor

- ***Occupational therapy***

  PHC covers occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction and consultative services. PHC authorizes occupational therapy services for medical necessity on a case by case basis.

- ***Orthotics/prostheses***

  PHC covers orthotic and prosthetic devices and services that are medically necessary and prescribed by your doctor, podiatrist, dentist, or non-physician medical provider. This includes 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***

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

- ***Physical therapy***

  PHC covers physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications.

- ***Pulmonary rehabilitation***

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

- ***Reconstructive Services***

  PHC 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, or disease, or breast reconstruction after a mastectomy. Some limitations and exceptions may apply.

- ***Skilled nursing facility services***

  PHC 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 skilled nursing care on a 24-hour per day basis.

- ***Speech therapy***

  PHC covers speech therapy that is medically necessary. You may have limitations on how many visits to a speech therapist you get every month.

- ***Transgender Services***

  PHC covers transgender services (gender-affirming services) as a benefit when they are medically necessary or when the services meet the criteria for reconstructive surgery.

Laboratory and radiology services

PHC covers outpatient and inpatient laboratory and X-ray services when medically necessary. Various advanced imaging procedures, such as CT scans, MRI and PET scans, are covered based on medical necessity.

Preventive and wellness services and chronic disease management

The PHC covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- American Academy of Pediatrics Bright Futures recommendations
- 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 A and B recommended preventive services

Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a member, you pick a doctor who is located near you and will give you the services you need.

PHC's PCP and OB/GYN specialists are available for family planning services. For family planning services, you may also choose a doctor or clinic not connected with our network without having to get pre-approval (prior authorization) from us.

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The program lasts one year and can continue for an additional year for those members who qualify. The program uses approved lifestyle changes including, but not limited to the following:

- Provides a peer coach;
- Teaches self-monitoring and problem solving;
- Provides encouragement and feedback;
- Provides informational materials to support goals; and
- Tracks routine weigh-ins to help accomplish goals.

Members who are interested in DPP must meet program eligibility requirements. Contact PHC for additional program and eligibility information. Alcohol Misuse Screening and Counseling Services

Alcohol misuse screening, illicit-drug screenings, and counseling services are covered for all members ages 18 and older. Youth aged 18 – 21 are eligible for additional screening services through the early and periodic screening, diagnostic, and treatment services.

Pediatric services

PHC covers early and periodic screening, diagnostic and treatment (EPSDT) services that are recommended by pediatricians' Bright Futures guidelines to help you or your child stay healthy. These services are at no cost to you. These services include:

- If you or your child are under 21 years old, we cover well-child visits. Well-child visits are a comprehensive set of preventive, screening, diagnostic, and treatment services.
- PHC will make appointments and provide transportation to help children get the care they need.
- Preventive care can be regular health check-ups and screenings to help your doctor find problems early. Regular check-ups help you or your child's doctor look for any problems with your medical, dental, vision, hearing, mental health, and any substance use disorders. PHC covers certain screening services (including lead and blood level assessment) any time there is a need for them, even if it is not during your regular check-up. Also, preventive care can be shots you or your child need. We must make sure that all children enrolled get needed shots at the time of any health care visit. Preventive care services and screenings are available at no cost and without pre-approval (prior authorization).
- When a physical problem is found during a check-up or screening, we cover the care that is medically necessary to correct or help any physical or mental health issues. If the care is medically necessary and PHC is responsible for paying for the care, then PHC will cover the care at no cost to you. These services include:
    - Doctor, nurse practitioner, and hospital care
    - Shots to keep you healthy
    - Physical, speech/language, and occupational therapies
    - Home health services, which could be medical equipment, supplies, and appliances
    - Treatment and rehabilitative services for mild to moderate mental health conditions
    - Treatment for vision and hearing which could be eyeglasses and hearing aids.
    - Behavioral Health Treatment for 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.

- Care coordination to help you or your child get the right care, even if it is not covered by PHC under this Handbook. These services include:
  - Treatment and rehabilitative services for severe mental health and substance use disorders
  - Treatment for dental issues, which could be orthodontics

Vision services

To provide vision services, PHC has partnered with Vision Service Plan (VSP). For help finding more information on vision services provided by VSP, you can visit our website at www.partnershiphp.org or call (800) 877-7195 or TTY/TDD: (800) 428-4833 or PHC at (800) 863-4155 TTY/TDD: (800) 735-2929 or 711. Members assigned to Kaiser for primary care, should call Kaiser Member Services at (800) 464-4000 (TTY/TDD (800) 777-1370) for information on vision services.

PHC covers:

- Routine eye exam once every 24 months. PHC may pre-approve (prior authorize) additional services as medically necessary.
- Eyeglasses every 24 months or as medically necessary for members who qualify, as determined by PHC
- Contact lens when required for medical conditions such as aphakia, aniridia and keratoconus

Non-emergency medical transportation (NEMT)

You are entitled to use non-emergency medical transportation (NEMT) to get to your appointments when it's a Medi-Cal covered service. If you cannot get to your medical, dental, mental health, or substance use or pharmacy appointment by car, bus, train or taxi, you can ask your doctor for NEMT. Your doctor will prescribe the correct type of transportation to meet your medical condition.

NEMT is an ambulance, litter van, wheelchair van or air transport. NEMT is not a car, bus or taxi. That means, for example, if you are physically or medically able to be transported by a wheelchair van, we will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

NEMT must be used when:

- It is physically or medically needed as determined with a written authorization by a doctor; or you are not able to physically or medically use a bus, taxi, car or van to get to your appointment.
- You need help from the driver to get to and from your residence, vehicle or place of treatment due to a physical or mental disability.
- It is approved in advance by PHC with a written authorization by a doctor.

To ask for NEMT services that your doctor has prescribed, please call PHC Care Coordination at (800) 809-1350 (Monday-Friday, 8 a.m. - 5 p.m.) at least one business day before your appointment. For urgent appointments, please call as soon as possible. Please have your member ID card ready when you call.

Limits of NEMT

There are no limits for receiving NEMT to or from medical, dental, mental health, or substance use disorder appointments covered under PHC when a provider has prescribed it for you. Some pharmacy services are covered under NEMT such as pharmacy trips for medication. For more information or to ask for NEMT services related to pharmacy, please call PHC Care Coordination at (800) 809-1350 (Monday-Friday, 8 a.m. - 5 p.m.). If the appointment is covered by Medi-Cal but not through PHC, we will provide or help you schedule your transportation.

What does not apply?

Transportation will not be provided if your physical and medical condition allows you to get to your medical appointment by car, bus, taxi, or other easily accessible method of transportation. Transportation will not be provided if the service is not covered by Medi-Cal. A list of covered services is in this Member Handbook.

Cost to member

There is no cost when transportation is pre-approved (authorized) by PHC.

Non-medical transportation (NMT)

To provide transportation services, we have partnered with Medical Transportation Management (MTM).

You can use non-medical transportation (NMT) when you are:

- Traveling to and from an appointment for a Medi-Cal service approved by your provider

- Picking up prescriptions and medical supplies.

PHC allows you to use a car, taxi, bus or other public/private way of getting to your medical appointment for Medi-Cal-covered services. PHC provides mileage reimbursement when transportation is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

Before getting approval for mileage reimbursement, PHC must confirm that you tried to get all other reasonable transportation choices and could not get one. Mileage reimbursement is available only to friends and family. Members cannot drive themselves or be reimbursed directly. We allow the lowest cost NMT type that meets your medical needs.

Mileage reimbursement requires the following:

- Completed and signed Trip Log or verification of attendance on office letterhead
- The driver's license of the driver
- The vehicle registration of the driver
- Proof of car insurance for the driver
- All information must be received by MTM within 90 days of your visit.

For more information about mileage reimbursement or to request a trip log, call MTM Customer Service at (888) 828-1254.

To ask for NMT services that have been authorized, call Care Coordination at (800) 809-1350 or MTM at (888) 828-1254 (Monday - Friday, 8 a.m. - 5 p.m.) at least 5 business days before your appointment. Or call as soon as you can when you have an urgent appointment. Please have your PHC ID card ready when you call.

Note: American Indians may contact their local IHC to request NMT services.

Limits of NMT

There are no limits for getting NMT to or from medical, dental, mental health and substance use disorder appointments covered by PHC when a provider has authorized it for you. If the appointment type is covered by Medi-Cal but not through the health plan, your health plan will provide for or help you schedule your transportation. Members cannot drive themselves or be reimbursed directly.

What does not apply?

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.
- You need assistance 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.
- The service is not covered by Medi-Cal.

Cost to member

There is no cost when transportation is authorized by PHC.

Long-term services and supports (LTSS)

PHC covers these LTSS benefits for members who qualify:

- Skilled nursing facility services as approved by PHC
- Home and Community Based Services as approved by PHC

Care Coordination

PHC offers services to help you coordinate your health care needs at no cost to you. If you have questions or concerns about your health or the health of your child, call Care Coordination at (800) 809-1350 (TTY/TDD (800) 735-2929 or 711).

California Children's Services (CCS)/ Whole Child Model (WCM) Program

CCS is a state program that treats children under 21 years of age who have certain serious health conditions and who meet CCS program rules.

PHC is responsible for coordinating both CCS and Medi-Cal-covered services. Medi-Cal-covered services may include physicals, vaccines, and well-child checkups. This coordinated care is called the Whole Child Model (WCM) program.

The WCM program's purpose is to help CCS children and their families get better care coordination and access to care.

If PHC or your child's provider thinks your child has a CCS condition, he or she will be assessed for CCS eligibility by the county. Your county's CCS eligibility staff will decide if your child qualifies for CCS. If your child qualifies, he or she will receive CCS care through the WCM program.

CCS covers most health conditions that cause physical disabilities. CCS may also cover problems that require treatment with medicines, surgery or rehabilitation. CCS covers children with health conditions such as:

- 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
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

Medi-Cal pays for CCS services. If your child is not eligible for CCS program services, he or she will keep getting medically necessary care from PHC.

To learn more about CCS, you can visit the CCS website at www.dhcs.ca.gov/services/ccs. Or call us at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Drug Medi-Cal Organized Delivery System (DMC-ODS)/ Wellness and Recovery (W&R) Program

DMC-ODS is a state program that allows PHC to provide substance use disorder treatment services in coordination with other care such as physical and mental health services. This may include residential, intensive outpatient, or outpatient treatment, as well as, opiate and other medication assisted treatment, and recovery services.

PHC administers these substance use services for members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. We call this the Wellness and Recovery (W&R) Program.

The W&R program's purpose is to provide substance use disorder treatment services for people who struggle with alcohol and/or drug addictions. If you think you need substance use disorder treatment services, you can request an assessment from your PCP or by calling Beacon at (855) 765-9703.

If you are a PHC member and do not live in one of PHC's W&R counties, contact your

local county:

- Del Norte

  (707) 464-4813

- Lake
  (707) 274-9101 (North Lake area)

  (707) 994-6494 (South Lake area)

- Napa
  (707) 253-4412 Adults
  (707) 255-1855 Teens

- Marin
  (888) 818-1115

- Sonoma
  (707) 565-7450

- Trinity
  (530) 623-1362

- Yolo
  (916) 403-2970

See “Substance use disorder services” on page 54 for more information about services offered by the county.

Other Medi-Cal programs and services

Other services you can get through Fee-For-Service (FFS) Medi-Cal

Sometimes PHC does not cover services, but you can still get them through FSS Medi-Cal. This section lists these services. To learn more, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Specialty mental health services

County mental health plans provide specialty mental health services (SMHS) to Medi-Cal beneficiaries who meet medical necessity rules. SMHS may include these outpatient, residential and inpatient services:

- Outpatient services:
  - Mental health services (assessments, plan development, therapy,

rehabilitation and collateral)
    - Medication support services
    - Day treatment intensive services
    - Day rehabilitation services
    - Crisis intervention services
    - Crisis stabilization services
    - Targeted case management services
    - Therapeutic behavioral services
    - Intensive care coordination (ICC)
    - Intensive home-based services (IHBS)
    - Therapeutic foster care (TFC)
- Residential services:
    - Adult residential treatment services
    - Crisis residential treatment services
- Inpatient services:
    - Acute psychiatric inpatient hospital services
    - Psychiatric inpatient hospital professional services
    - Psychiatric health facility services

To learn more about specialty mental health services the county mental health plan provides, you can call your county mental health plan. To find all counties' toll-free telephone numbers online, visit www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Dental services

Medi-Cal covers some dental services for children up to age 21, including:

- Dental Screenings & Referrals to dentist or specialists
- Topical application of fluoride for children younger than 6 years old
- Diagnostic and preventive dental hygiene (such as examinations, X-rays and teeth cleanings)
- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planning
- Periodontal maintenance
- Complete and partial dentures
- Orthodontics for children up to age 21

If you have questions or want to learn more about dental services, call Denti-Cal at (800) 322-6384 (TTY/TDD (800) 735-2922 or 711). You may also visit the Denti-Cal website at denti-cal.ca.gov.

Substance use disorder services

The county provides substance use disorder services to Medi-Cal members who meet medical necessity rules. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. To find all counties' telephone numbers online, visit www.dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

For members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties, see "Drug Medi-Cal Organized Delivery System (DMC-ODS)/ Wellness and Recovery (W&R) Program" on page 53 to learn more about SUD services offered by PHC.

Institutional long-term care

PHC covers long-term care for the month you enter a facility and the month after that. PHC does **not** cover long-term care if you stay longer.

FFS Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Services you cannot get through PHC or FFS Medi-Cal

There are some services that neither PHC nor Medi-Cal will cover, including:

- Services that are excluded from Medi-Cal under state and federal law
- Same day surgery or hospital admission solely for the purpose of routine circumcision
- Substance Use Disorder Treatment Services sometimes called Drug Medi-Cal Organized Delivery System (DMC-ODS) in Del Norte, Lake, Napa, Marin, Sonoma, Trinity, and Yolo counties
- Cosmetic surgery (surgery that is done to change your body to improve how you look)
- Custodial care. Some custodial care may be covered by State Medi-Cal. For more information about custodial care covered by State Medi-Cal, call your Home County Medi-Cal eligibility office.
- Experimental and investigational services except in certain circumstances and always requires pre-approval from PHC.
- Infertility, including reversing sterilization
- Shots for sports (for adults), work or travel

- Personal comfort items like a phone, TV or guest tray when you are in the hospital
- Services that are not medically necessary

Read each of the sections below to learn more. Or call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Coordination of benefits

If you have another insurance, like Medicare or commercial coverage through your work or your family (with a company like Blue Cross of California, Blue Shield of California, Health Net, or Kaiser Permanente) you must get your care covered by your "primary" insurance first. This is called Coordination of Benefits.

Medi-Cal is the "payer of last resort" by state and federal law. This means that Medi-Cal cannot pay for health care services if another insurance plan you have could pay for that same health care first.

PHC will not pay for health care unless your primary insurance has paid their part, or has denied the health care as not a covered benefit.

We offer services to help you coordinate your health care at no cost to you. If you have questions or concerns about how your Medi-Cal works with your other insurance, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Evaluation of new technology

Evaluation of New Technology, also known as experimental or investigational treatment, is a change or advancement in health care. PHC's medical staff studies new treatments, medicines, procedures and devices. Usually New Technology is not covered by Medi-Cal or PHC, but your provider can ask PHC to look at a request for coverage of New Technology.

If you would like PHC to look at a request for coverage of New Technology, ask your PCP or specialist to ask for pre-approval from PHC. PHC will look into information about the New Technology, including the recommended use and safety of the New Technology. After review by medical specialists, PHC will let you know if the request will be approved or denied.

5. Rights and responsibilities

As a member of PHC, you have certain rights and responsibilities. This chapter will explain those rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of PHC.

Your rights

PHC members have these rights:

- To be treated with respect and recognition, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To have the right to be free of any form of restraint or seclusion used as a means of coercion, discipline, or retaliation.
- To be provided with information about PHC, our services, practitioners and providers, including Covered Services and member rights and responsibilities.
- To make recommendations regarding PHC's member rights and responsibilities policy.
- To be able to choose a primary care provider within PHC's network.
- To have timely access to network providers.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or benefit coverage.
- To voice grievances, either verbally or in writing about PHC or the care you got.
- To ask assistance from a patient advocate, provider, ombudsperson or any other person you choose.
- To ask for an expedited grievance in instances that may involve a serious threat to your health such as severe pain, loss of limb and or life.
- To get care coordination.
- To get a review and resolution of an appeal within 60 days when PHC or a PHC delegated entity denies, delays or modifies a requested service. The appeal can

be requested orally, but must be followed by a written appeal. You may also request an expedited appeal in instances that may involve a serious threat to your health such as severe pain, loss of limb and or life will cause severe harm to your health.

- To get free oral interpretation services for your language. You have the right to ask for an interpreter at no charge to you. You should not use children to interpret for you.
- To receive written member informing materials in alternative formats (including Braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To get 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 PHC and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days. You also have the right to information about how to get an Expedited State Hearing.
- To access Minor Consent Services.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the Contractor, providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and Emergency Services outside our network pursuant to the federal law.

Your responsibilities

PHC members have these responsibilities:

- You are responsible for treating your provider(s) and their staff in a respectful and courteous way.
- You are responsible for showing up to your appointments on time. If you are unable to make an appointment, you must call your provider at least 24 hours before the appointment, to cancel or reschedule.
- You are responsible for treating PHC staff in a respectful and courteous way.
- You are responsible for making requests, such as for transportation, in advance, and calling PHC to cancel any transportation if you have to cancel or reschedule your medical appointment.
- Play an active part in your care. You are responsible to provide, to the extent possible, information that PHC and its medical providers need in order to care for you. You are responsible for talking to your medical provider about things you can do to improve your overall health.
- Understanding treatment options. You are responsible to understand treatment options and participate in developing mutually agreed upon treatment goals to the degree possible.
- Calling your provider. You are responsible for calling your provider for appointments when you need medical care, including routine checkups.
- Listen and cooperate with your provider. You are responsible for telling your medical provider about your medical condition and any medications you are taking. You are also responsible for following instructions for the care you have received from your medical provider.
- Use the Emergency Room (ER) only in an emergency. You are responsible for using the emergency room in cases of an emergency or as directed by your provider or the PHC Advice Nurse.
- You are responsible for reporting fraud or wrongdoing to PHC. You can do this without giving your name by calling PHC's hotline at (800) 601-2146, 24 hours a day, 7 days a week. You can also call the Department of Health Care Services (DHCS) Medi-Cal Fraud and Abuse Hotline toll-free at (800) 822-6222.

Notice of Privacy Practices

A STATEMENT DESCRIBING PHC POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Effective Date of this Notice

This notice has been updated and is effective November 8, 2017.

Why am I receiving this Notice?

Partnership HealthPlan of California is required by law to provide you with adequate notice of the uses and disclosures of your protected health information that PHC may make, and of your rights and our legal duties and to notify you following a breach of your unsecured health information where your protected health information (PHI) is concerned. PHI is health information that contains identifiers, such as your name, Social Security number, or other information that reveals who you are.

We agree to follow the terms of this Notice of Privacy Practices. We also have the right to change the terms of this notice if it becomes necessary, and to make the new notice effective for all health information we maintain. If we need to make any changes, we will post it on our website and notify you via mail in our next annual mailing to you at your address in our records. If you received this notice electronically, you have the right to request a paper copy from us at any time.

How does Partnership HealthPlan of California (PHC) use and disclose my health information?

PHC stores health-related records about you, including your claims history, health plan enrollment information, case management records, and prior authorizations for treatment you receive. We use this information and disclose it to others for the following purposes:

- **Treatment.** PHC uses your health information to coordinate your health care, and we disclose it to hospitals, clinics, physicians and other health care providers to enable them to provide health care services to you. For example, PHC maintains your health information in electronic form, and allows pharmacies to have on-line access to it to provide appropriate prescriptions for you.
- **Payment.** PHC uses and discloses your health information to facilitate payment for health care services you receive, including determining your eligibility for benefits, and your provider's eligibility for payment. For example, we inform providers that you are a member of our plan, and tell them your eligible benefits.
- **Health Care Operations.** PHC uses and discloses your health information as necessary to enable us to operate our health plan. For example, we use our members' claims information for conducting quality assessment and improvement activities, patient safety activities, business management and

general administrative activities, and reviewing competence or qualifications of health care professionals.

- **Underwriting**. For underwriting or related purposes, such as premium rating or other activities related to the creation, renewal or replacement of a contract of health insurance or benefits as required by law, but may not include genetic information.

- **Business Associates**. PHC may contract with business associates to perform certain functions or activities on our behalf, such as facilitating a health-information exchange, where your health information can be quickly accessed by your doctors or to provide appointment reminders.

- **Health Information Exchange (HIE)**. PHC participates in multiple Health Information Exchange's (HIE's), which allow providers to coordinate care and provide faster access to our members. HIE's assist providers and public health officials in making more informed decisions, avoiding duplicate care (such as tests), and reducing the likelihood of medical errors. By participating in an HIE, PHC may share your health information with other providers and participants as permitted by law. If you do not want your medical information shared in the HIE, you must make this request directly to PHC. The 'Individual Rights' section below tells you how.

  (Note: In some circumstances, your health information may not be disclosed. For example, mental health diagnosis and treatment, diagnosis or treatment for drug or alcohol abuse, and STD; birth control; or HIV test results are all considered 'Protected Records' and require your direct authorization to be shared.

  When working to process payment, provide care to our members, or within our daily operations, PHC may disclose your health information to our contractors. Before we make any disclosures for payment or operational purposes, we obtain a confidentiality agreement from each contractor. For example, companies that provide or maintain our computer services may have access to health information within the course of providing services. PHC works to ensure that our providers have as minimal contact with your health information as possible.

- **Communication and Marketing:** PHC will not use your health information for marketing purposes for which we receive payment without your prior written authorization. PHC may use your health information for case management or care coordination purposes and related functions without your authorization. PHC may provide appointment or prescription refill reminders or describe a product or

service that is included in your benefit plan, such as our health provider network. PHC may also discuss health-related products or services available to you that add value, but are not part of your benefit plan.

- **Sale of your health information:** We will not sell your health information for financial payment without your prior written authorization.
- **Fundraising:** PHC may use, or disclose to a business associate or to an institutionally related foundation, for the purpose of raising funds for the benefit of PHC, certain information without your authorization for fundraising purposes, including your name, address, contact information, age, gender, date of birth, dates of health care provided, treatment of service information, treating physician, outcome information and health insurance status. However, we will provide you with a clear and conspicuous opportunity to opt out of receiving further fundraising communications in a way that does not cause you undue burden or cost, and will honor that request. We will not condition treatment or payment on your choice with respect to the receipt of fundraising communications. PHC may provide you with a way to opt back in to receive such communications if you later prefer.

Can my health information ever be released without my permission?

Yes, PHC may disclose health information without your authorization to government agencies and private individuals and organizations in a variety of circumstances in which we are required or authorized by law to do so. Certain health information may be subject to restrictions by federal or state law that may limit or prevent some uses or disclosures. For example, there are special restrictions on the disclosure of health information relating to HIV/AIDS status, genetic information, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Examples of the types of disclosures PHC may be required or allowed to make without your authorization include:

- **When Legally Required:** PHC will disclose your health information when it is required to do so by any federal, state or local law.
- **When there are Risks to Public Health:** PHC may disclose your health information:
  - To public health authorities or to other authorized persons in connection with public health activities, such as for preventing or controlling disease, injury or disability or in the conduct of public health surveillance or investigations

  - To collect information or report adverse events related to the quality, safety or effectiveness of FDA regulated products or activities
  - To Report Abuse, Neglect, or Domestic Violence: PHC is mandated to notify government agencies if we believe a member is the victim of abuse, neglect or domestic violence.
- **In Connection with Judicial and Administrative Proceedings:** PHC may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when PHC makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.
- **For Law Enforcement Purposes:**
  - As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena, summons or similar process
  - For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
  - Under certain limited circumstances, when you are the victim of a crime
  - To a law enforcement official if PHC has a suspicion that your death was the result of criminal conduct including criminal conduct at PHC
  - In an emergency in order to report a crime
- **To Coroners and Medical Examiners:** PHC may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.
- **To Funeral Directors:** PHC may disclose your health information to funeral directors consistent with applicable law and, if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, PHC may disclose your health information prior to, and in reasonable anticipation of, your death.
- **For Organ, Eye or Tissue Donation:** PHC may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation, if you so desire.
- **In the Event of a Serious Threat to Health or Safety:** PHC may, consistent with applicable law and ethical standards of conduct, disclose your health

information if PHC, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

- **For Specified Government Functions:** PHC may make disclosure to authorized federal officials in national security activities or for the provision of protective services to officials.
- **For Workers Compensation:** PHC may release your health information for worker's compensation or similar programs.
- **To a Correctional Institution or to a Law Enforcement Official:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, PHC may release health information about you to the institution or official.

  To other agencies administering government health benefit programs, as authorized or required by law.
- **For Immunization Purposes:** To a school, about a member who is a student or prospective student of the school, but only if: (1) the information that is disclosed is limited to proof of immunization; (2) the school is required by the State or other law to have such proof of immunization prior to admitting the member; and (3) there is documented agreement by the member or the member's guardian.
- **For Disaster Relief Purposes:** PHC may make disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.
- **For Research Purposes:** PHC may use or disclose protected health information for research purposes.

Can others involved in my care receive information about me?

Yes, PHC may release health information to a friend or family member who is involved in your care, or who is paying for your care, to the extent we judge it necessary for their participation unless you specifically ask us not to and we agree to that request. This includes responding to telephone enquiries about eligibility and claim status.

OTHER THAN WHAT IS STATED ABOVE, PHC WILL NOT DISCLOSE YOUR HEALTH INFORMATION OTHER THAN WITH YOUR WRITTEN AUTHORIZATION. IF YOU OR YOUR REPRESENTATIVE AUTHORIZES PHC TO USE OR DISCLOSE YOUR HEALTH INFORMATION, YOU MAY REVOKE THAT AUTHORIZATION IN WRITING AT ANY TIME.

Are there instances when my health information is not released?

We will not permit other uses and disclosures of your health information without your written permission, or authorization which you may revoke at any time in the manner described in our authorization form.

Except as described above (How does Partnership HealthPlan of California use and disclose my health information), disclosures of psychotherapy notes, marketing and the sale of your information require your written authorization and a statement that you may revoke the authorization at any time in writing.

YOUR INDIVIDUAL RIGHTS

What rights do I have as a PHC member?

As a PHC member you have the following rights with respect to your health information:

- To ask us to restrict certain uses and disclosures of your health information. PHC is not required to agree to any restrictions requested by its members unless the disclosure is for the purpose of carrying out payment or health care operations and the request is solely for a health care item or service for which you, or another person other than PHC, has paid for the service(s) out of pocket.
- To receive confidential communications from PHC at a particular phone number, P.O. Box, or some other address that you specify to us.
- To see and copy any of your health records that PHC maintains on you, including billing records, we must receive your request in writing. We will respond to your request within 30 days. PHC may charge a fee to cover the cost of copying, assembling and mailing your records, as applicable. You may also request PHC to transmit the information directly to another person if your written request is signed by you and clearly identifies both the designated person and where to send the information. In some situations, PHC may ask if you would agree to receive a summary or an explanation of the requested information and to any fees that might be imposed to create it. Under certain circumstances, PHC may deny your request. If your request is denied, we will tell you the reason why in writing. You have the right to appeal a denial.
- If you feel the information in our records is wrong, you have the right to request us to amend the records. PHC may deny your request in certain circumstances. If your request is denied, you have the right to submit a statement for inclusion in the record.

- You have the right to receive a list of our non-routine disclosures that we have made of your health information, up to six years prior from the date of your request. Non-routine disclosures do not include, for example, disclosures to carry out treatment, payment, health care operations, disclosures made with your authorization; disclosures made for the purposes of health care treatment, determining payment for health services, or conducting the health plan operations of PHC; disclosures made to you; and certain other disclosures. You are entitled to one disclosure list in any 12-month period at no charge. If you request any additional lists less than 12 months later, PHC may charge you a fee.
- If you received this notice electronically, you have the right to request a paper copy from us at any time.

How do I exercise these rights?

You can exercise any of your rights by sending a written request to our Privacy Official at the address below. To facilitate processing of your request, we encourage you to use our request form, which you can obtain from our Internet website at www.partnershiphp.org or by calling us at the telephone number below. You can also obtain a complete statement of your rights, including our procedures for responding to requests to exercise your rights, by calling or writing to the Privacy Official at the address below.

How do I file a complaint if my privacy rights are violated?

As a PHC member, you or your personal representative have the right to file a complaint with our Privacy Official if you believe your privacy rights have been violated. You or your representative must provide us with specific written information to support your complaint; see contact information below. You may also file a complaint with the Secretary of Health and Human Services on their website or use the contact information listed below:

http://www.hhs.gov/ocr/privacy/hipaa/complaints/

PHC encourages you to contact us with any concerns you have regarding the privacy of your information. PHC will not retaliate against you in any way for filing a complaint. Filing a complaint will not adversely affect the quality health care services you receive as a PHC member.

Contact us at:

Mailing address:

Partnership HealthPlan of California

Attn: Privacy Officer

4665 Business Center Drive

Fairfield, CA 94534

Phone: **(800) 863-4155** or

TTY/TDD/TDD: **(800) 735-2929** or call **711**

Or visit http://www.partnershiphp.org/Members/Medi-Cal/Pages/Notice-of-Privacy-Practices---HIPPA.aspx

PHC's Complaint Hot-Line is (800) 601-2146 and is operated 24 hours a day, 7 days a week

California's Department of Health Care Services:

DHCS Privacy Officer

California Dept. of Health Care Services

1501 Capitol Avenue, MS 4721

PO Box 997413

Sacramento, CA 95899-7413

Email: Privacyofficer@dhcs.ca.gov

Phone: (916) 445-4646

TTY/TDD/TDD: (877) 735-2929

Contact the Secretary of United States Departments of Health and Human Services at:

Centralized Case Management Operations

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Room 509F HHH Bldg.

Washington, D.C. 20201

Email: OCRComplaint@hhs.gov

Phone: (877) 696-6775

Or visit http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

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

Sometimes someone else has to pay first for the services PHC provided to you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

The California Department of Health Care Services (DHCS) has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. If you are injured, and someone else is liable for your injury, you or your legal representative must notify DHCS within 30 days of filing a legal action or a claim. Submit your notification online:

- Personal Injury Program at http://dhcs.ca.gov/PI
- Workers Compensation Recovery Program at http://dhcs.ca.gov/WC.

To learn more, call 1-916-445-9891.

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

Medi-Cal members may also have other health coverage (OHC) provided to them at no cost. By law, members are required to exhaust all services provided by the OHC before using services through PHC. If you do not apply for or keep no-cost or state-paid OHC, your Medi-Cal benefits and/or eligibility will be denied or stopped. Federal and state laws require Medi-Cal members to report private health insurance. To report or change private health insurance, go to http://dhcs.ca.gov/mymedi-cal. Or go through your health plan. Or call 1-800-541-5555 (TTY/TDD 1-800-430-7077 or 711). Outside of California, call 1-916-636-1980.If you do not report changes to your OHC promptly, and because of this, get Medi-Cal benefits that you are not eligible for, you may have to repay DHCS.

Notice about estate recovery

The Medi-Cal program must seek repayment from the estates of certain deceased Medi-Cal members from payments made, including managed care premiums, nursing

facility services, home and community-based services, and related hospital and prescription drug services provided to the deceased Medi-Cal member on or after the member's 55th birthday. If a deceased member does not leave an estate or owns nothing when they die, nothing will be owed.

To learn more about estate recovery, go to http://dhcs.ca.gov/er. Or call 1-916-650-0490 or get legal advice.

Notice of Action

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

About Legal Assistance

You may be able to get free legal help. California Department of Consumer Affairs at (800) 952-5210, or (TTY/TDD (800) 326-2297). You may also call the local Legal Aid Society in your county at (888) 804-3536.

You may seek legal counsel to represent you at a State Hearing. For more information on obtaining free legal aid, contact your local legal aid office or welfare rights group.

6. Reporting and solving problems

There are two kinds of problems that you may have with PHC:

- A **complaint** (grievance) is when you have a problem with PHC or a provider, or with the health care or treatment you got from a provider for a covered service
- An **appeal** is when you don't agree with PHCs decision not to cover or change your services

You have the right to file complaints and appeals with PHC to let us know about your problem. This does not take away any of your legal rights and remedies. PHC will not discriminate or retaliate against you for filing a complaint or appeal. Letting PHC know about your problem will help improve care for all members.

You should always contact PHC first to let us know about your problem. A friend or family member can also file a grievance or appeal on your behalf. They must have permission from you first. You can contact member services get permission for someone to speak on your behalf.

Call PHC Monday - Friday, 8 a.m. - 5 p.m. at (800) 863-4155
(TTY/TDD: (800) 735-2929 or 711) to tell us about your problem.

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 - Friday, between 8 a.m. - 5 p.m. at (888) 452-8609.

You can also file a complaint with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your complaint with, call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711)

To report incorrect information about your additional health insurance, please call Medi-Cal Monday - Friday, between 8 a.m. - 5 p.m. at (800) 541-5555.

Complaints

A complaint is when you have a problem or are unhappy with the services you received from PHC or a provider for a covered service. There is no time limit to file a complaint. You can file a complaint with PHC at any time by phone, in writing, in person, online or by fax:

- By phone: Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711), Monday – Friday, 8 a.m. - 5 p.m. Our Member Services representative will help you with the complaint process.
- In writing: You can write PHC a letter. Or, we can mail you a form. Be sure to include your PHC ID number and the reason for your complaint. Tell us what happened and how we can fix it:

  Partnership HealthPlan of California
  ATTN: Grievance
  4665 Business Center Drive
  Fairfield, CA 94534

- Online: Visit our website at www.partnershiphp.org
- In person: You can visit your local PHC office or your doctor's office
- Fax: You can fax us at (707) 863-4351. Be sure to include your PHC ID number and the reason for your complaint. Tell us what happened and how we can fix it.

If you need help filing your complaint, we can help you. We can give you language services at no cost to you. Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711)

Within 5 days of getting your complaint, PHC will send you a letter letting you know PHC received it. Within 30 days, PHC will send you another letter that tells you how your problem was resolved. If you call PHC about a complaint that is not about health care coverage, medical necessity, or experimental or investigational treatment, and your complaint is resolved by the end of the next business day, you may not get a letter.

If you want PHC to make a fast decision because the time it takes to resolve your complaint 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 PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). PHC will make a decision within 72 hours of receiving your complaint.

Appeals

An appeal is different from a complaint. An appeal is a request for PHC to review and change a decision PHC made about coverage for a requested service. If PHC 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 the decision, you can file an appeal. Your PCP or other provider can also file an appeal for you with your written permission.

You must file an appeal within 60 calendar days from the date on the NOA you got from PHC. If you are currently getting treatment and you want to continue getting the same treatment, you must ask PHC for an appeal within 10 calendar days from the date the NOA was delivered to you, or before the date PHC says services will stop. When you request an appeal, under these circumstances, treatment will continue upon your request. PHC may require you to pay for the cost of services if the final decision denies or changes a service.

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

- By phone: Call us at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711), Monday – Friday, 8 a.m. - 5 p.m. Our Member Services representative will help you with the appeal process.
- In writing: You can write us a letter. Or, we can mail you a form. Be sure to include your PHC ID number and describe what decision you do not agree with:

  Partnership HealthPlan of California
  ATTN: Grievance
  4665 Business Center Drive
  Fairfield, CA 94534

- Online: Visit our website at www.partnershiphp.org
- In person: You can visit your local PHC office or your doctor's office
- Fax: You can fax us at (707) 863-4351. Be sure to include your PHC ID number and describe what decision you do not agree with.

If you need help filing your appeal, PHC can help you. PHC can give you free language services. Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

Within 5 days of getting your appeal, PHC will send you a letter letting you know it was received. Within 30 days, PHC will send you a Notice of Appeal Resolution (NAR) to tell you the appeal decision. If PHC does not tell you the appeal decision within 30 days you can request a State Hearing.

If you or your doctor wants PHC to make a fast decision because the time it takes to

resolve 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 PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711). PHC will make a decision within 72 hours of receiving your appeal about whether PHC will expedite your appeal.

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

If you filed an appeal and received a letter from PHC telling you that we did not change the decision, or you did not receive a letter telling you of the decision 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. You will not have to pay for a State Hearing.

State Hearings

A State Hearing is a meeting with people from the California Department of Social Services (CDSS). A judge will help to resolve your problem or tell you that PHC made the correct decision. You have the right to ask for a State Hearing only if you have already filed an appeal with PHC and you are still not happy with the 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 PHC's Notice of Appeal Resolution (NAR) telling you of the appeal decision. Your PCP can ask for a State Hearing for you with your written permission.

If you want the 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 or your PCP can contact the CDSS and ask for an expedited (fast) State Hearing. CDSS must make a decision no later than three (3) business days after it gets your complete case file from PHC.

You can ask for a State Hearing by phone or mail.

- **By phone:** Call the CDSS Public Response Unit at 1-800-952-5253

  (TTD 1-800-952-8349).
- **By mail:** Fill out the form provided with your appeals resolution notice. Send it to:
    - California Department of Social Services
      State Hearings Division
      P.O. Box 944243, MS 09-17-37
      Sacramento, CA 94244-2430

If you need help asking for a State Hearing, PHC can help you. We can also give you free language services. Call PHC at (800) 863-4155 (TTY/TDD: (800) 735-2929 or 711).

At the hearing, you will give your side, and we will give PHC's side. It could take up to 90 calendar days for the judge to decide your case. PHC must follow what the judge decides.

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 right to report it by calling the confidential toll-free number 1-800-822-6222 or submitting a complaint online at www.dhcs.ca.gov/.

Provider fraud, waste and abuse includes:

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

Fraud, waste and abuse by a person who gets benefits includes:

- 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

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

You can make a report by

Mail:

Partnership HealthPlan of California
ATTN: Regulatory Affairs
4665 Business Center Dr.
Fairfield, CA 94534

Phone:

PHC's Compliance Hotline at (800) 601-2146. 24 hours a day, 7 days a week.

7. Important numbers and words to know

Important PHC Numbers

PHC's Member Services The toll-free number to call PHC's Member Services Department	(800) 863-4155 8 a.m. to 5 p.m., Monday – Friday
PHC's 24 hour Advice Nurse The toll-free number to speak to a nurse about your health if you're unsure about going to the ER	(866) 778-8873 24 hours a day, 7 days a week
PHC's Compliance Hotline The toll-free number to report fraud, privacy concerns and other compliance issues	(800) 601-2146 24 hours a day, 7 days a week
Disability Services	
California Relay Service (CRS) – TTY/TDD/TDD The toll-free number for the hearing impaired	(800) 735-2929 or 711 24 hours a day, 7 days a week
Important State Numbers	
Medi-Cal Managed Care Ombudsman The State office that helps with your Managed Care concerns	(888) 452-8609 8 a.m. to 5 p.m., Monday – Friday

Premium Payment for Medi-Cal for Families The State phone number to call if you have questions about premiums for Medi-Cal	(800) 880-5305 8 a.m. to 8 p.m., Monday – Friday, or 8 a.m. to 5 p.m. Saturday
Denti-Cal Services The State phone number to learn more about covered dental services	(800) 322-6384 8 a.m. to 5 p.m., Monday – Friday
Vision Services PHC's vision services are covered through Vision Services Plan (VSP).	(800) 877-7195 5 a.m. to 8 p.m., Monday – Friday 7 a.m. to 8 p.m. Saturday 7 a.m. to 7 p.m. Sunday Kaiser Members call (800) 464-4000
Mental Health Services PHC covers the treatment of mild to moderate mental health conditions and are covered through Beacon Health Options.	(855) 765-9703 24 hours a day, 7 days a week Kaiser members call (800) 464-4000
Department of Social Services (State Hearings) The State office that helps you file a State Hearing	(800) 952-5253
Medi-Cal Fraud and Elder Abuse Hotline The State office that helps you with concerns about fraud in the Medi-Cal program	(800) 722-0432
U.S. Office for Civil Rights (Privacy Complaints) The federal office that helps you with privacy questions and concerns	(866) 627-7748

Words to know

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

Acute: A medical condition that is sudden requires fast medical attention and does not last a long time.

American Indian: An individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

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

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

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

California Health and Disability Prevention (CHDP): A public health program that reimburses public and private health care providers for early health assessments to detect or prevent disease and disabilities in children and youth. The program helps children and youth access regular health care. Your PCP can provide CHDP services.

Case manager: Registered Nurses, Social Workers, or other licensed professionals who can help you understand major health problems and arrange care with your providers.

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

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

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

Clinic: Clinic is 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 Clinic (IHC) or other primary care facility.

Community-based adult services (CBAS): Outpatient, facility-based services for skilled nursing care, social services, therapies, personal care, family and caregiver

training and support, nutrition services, transportation, and other services for members who qualify.

Complaint: A member's verbal or written expression of dissatisfaction about PHC, a provider, or the quality of services provided. 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 provider for up to 12 months, if the provider and PHC agree.

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

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

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

Coverage (covered services): The health care services provided to members of PHC, subject to the terms, conditions, limitations and exclusions of the Medi-Cal contract and as listed in this EOC and any amendments.

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

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

Early and periodic screening, diagnostic and treatment (EPSDT): EPSDT services are a benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early.

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 knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

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

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

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

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

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

Family planning services: Services to prevent or delay pregnancy.

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

Fee-For-Service (FFS): This means you are not enrolled in a managed care health plan. Under FFS, your doctor must accept “straight” Medi-Cal and bills Medi-Cal directly for the services you got. FFS may also be used to explain how out-of-network providers may bill PHC.

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

Formulary: A list of drugs or items that meet certain criteria and are approved for members.

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

Freestanding Birth Centers (FBCs): Health facilities where childbirth is planned to occur away from the pregnant woman’s residence that are licensed or otherwise 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 PHC, a provider, or the services provided. A complaint is an example of a grievance.

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

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

You usually need a referral from your PCP go to a specialist.

You do **not** need a referral from your PCP for some types of service, such as family planning, emergency care, ob/gyn care or sensitive services.

Types of health care providers include, but are not limited to:

- Audiologist is a provider who tests hearing.
- Certified nurse-midwife is a nurse who cares for you during pregnancy and childbirth.
- Family practitioner is a doctor who treats common medical issues for people of all ages.
- General practitioner is a doctor who treats common medical issues.
- Internist is a doctor who treats common medical issues in adults.
- Licensed vocational nurse is a licensed nurse who works with your doctor.
- A counselor is a person who helps you with family problems.
- Medical assistant or certified medical assistant is a non-licensed person who helps your doctors give you medical care.
- Mid-level practitioner is a name used for health care providers, such as nurse-midwives, physician assistants or nurse practitioners.
- Nurse anesthetist is a nurse who gives you anesthesia.
- Nurse practitioner or physician's assistant is a person who works in a clinic or doctor's office who diagnoses, treats and cares for you, within limits.
- Obstetrician/gynecologist (ob/gyn) is a doctor who takes care of a woman's health, including during pregnancy and birth.
- Occupational therapist is a provider who helps you regain daily skills and activities after an illness or injury.
- Pediatrician is a doctor who treats children from birth through the teen years.
- Physical therapist is a provider who helps you build your body's strength after an illness or injury.
- Podiatrist is a doctor who takes care of your feet.
- Psychologist is a person who treats mental health issues but does not prescribe drugs.
- Registered nurse is a nurse with more training than a licensed vocational nurse and who has a license to do certain tasks with your doctor.
- Respiratory therapist is a provider who helps you with your breathing.
- Speech pathologist is a provider who helps you with your speech.

Health insurance: Insurance coverage that pays for medical and surgical expenses by repaying the insured for expenses from illness or injury or paying the care provider directly.

Home health care: Skilled nursing care and other services given at home.

Home health care providers: Providers who give you skilled nursing care and other services at home.

Hospice: Care to reduce physical, emotional, social and spiritual discomforts for a member with a terminal illness who has a life expectancy of 6 months or less.

Hospital: A place where you get inpatient and outpatient care from doctors and nurses.

Hospitalization: Admission to a hospital for treatment as an inpatient.

Hospital outpatient care: Medical or surgical care performed at a hospital without admission as an inpatient.

Inpatient care: When you have to stay the night in a hospital or other place for the medical care you need.

Indian Health Clinic (IHC): A health clinic operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Long-term care: Care in a facility for longer than the month of admission.

Managed care plan: A Medi-Cal plan that uses only certain doctors, specialists, clinics, pharmacies and hospitals for Medi-Cal recipients enrolled in that plan. PHC is a managed care plan.

Medical home: A place where a member's medical information is kept and care is available, constant, inclusive and culturally competent.

Medically necessary (or medical necessity): Medically necessary care is an important service that is reasonable and protect life. This care is needed to keep patients from getting seriously ill or disabled. This care reduces severe pain by treating the disease, illness or injury. For members under the age of 21, Medi-Cal services includes care that is medically necessary to fix or help a physical or mental illness or condition, including substance use disorders, as set forth in Section 1396d(r) of Title 42 of the United States Code.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

Member: Any eligible Medi-Cal member enrolled with PHC who is entitled to receive covered services

Mental health services provider: Licensed individuals who provide mental health and behavioral health services to patients.

Midwifery services: Prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn, provided by certified nurse midwives (CNM) and licensed midwives (LM).

Network: A group of doctors, clinics, hospitals and other providers contracted with PHC to provide care.

Network provider (or in-network provider): See "Participating provider" below.

Non-covered service: A service that PHC does not cover.

Non-emergency medical transportation (NEMT): Transportation when you cannot get to a covered medical appointment and/or to pick up prescriptions by car, bus, train or taxi. PHC pays for the lowest cost NEMT for your medical needs when you need a ride to your appointment.

Non-formulary drug: A drug not listed on our drug formulary.

Non-medical transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by your provider and when picking up prescriptions and medical supplies.

Non-participating provider: A provider not in the PHC network.

Other health coverage (OHC): Other health coverage (OHC) refers to private health insurance and service payers other than Medi-Cal. Services may include medical, dental, vision, pharmacy and/or Medicare supplemental plans (Part C & D).

Orthotic device: A device used as a support or brace affixed externally to the body to support or correct an acutely injured or diseased body part and that is medically necessary for the medical recovery of the member.

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

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

Outpatient care: When you do not have to stay the night in a hospital or other place for the medical care you need.

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.

Participating hospital: A licensed hospital that has a contract with PHC to offer services to members at the time a member receives care. The covered services that some participating hospitals may offer to members are limited by PHC's utilization review and quality assurance policies or PHC'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 PHC to offer covered services to members at the time a member receives care.

Physician services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while you are admitted in a hospital that are charged in the hospital bill.

Plan: Go to "Managed care plan."

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition. Post-stabilization care services are covered and paid for.

Pre-approval (or prior-authorization): Your PCP or other providers must get approval from PHC before you get certain services. PHC will only approve the services you need. PHC will not approve services by non-participating providers if we believe you can get comparable or more appropriate services through our providers. A referral is not an approval. You must get approval from PHC.

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: See routine care.

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need. Some care needs to be approved first, unless:

- You have an emergency.
- You need Ob/gyn care.
- You need sensitive services.
- You need family planning services/birth control.

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- Ob/gyn
- Indian Health Clinic (IHC)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Nurse practitioner

- Physician assistant
- Clinic

Prior authorization (pre-approval): A formal process requiring a health care provider to get approval to provide specific services or procedures.

Prosthetic device: An artificial device attached to the body to replace a missing body part.

Provider Directory: A list of providers in the PHC network.

Psychiatric emergency medical condition: A mental disorder in which the symptoms are serious or severe enough to either an immediate danger to yourself or others or you are immediately unable to provide for or use food, shelter or clothing due to the mental disorder.

Public health services: Health services targeted at the population as a whole. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified provider: Doctor qualified in the area of practice appropriate to treat your condition.

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 birth defect, developmental abnormalities, trauma, infection, tumors, or disease

Referral: When your PCP says you can get care from another provider. Some covered care and services require a referral and pre-approval (prior authorization).

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.

Rehabilitative and habilitative therapy services and devices: Services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

Rural Health Clinic (RHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an RHC.

Sensitive services: Services for family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault, and abortions.

Serious illness: A disease or condition that must be treated and could result in death.

Service area: The geographic area PHC serves. This includes the counties of Del

Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo counties.

Skilled nursing care: Covered services provided by licensed nurses, technicians and/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 may give.

Specialist (or specialty doctor): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a referral from your PCP to go to a specialist.

Specialty mental health services: Services for members who have mental health services needs that are a higher level of impairment than mild to moderate.

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.

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

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

Partnership HealthPlan of California

Address: 4665 Business Center Drive
Fairfield, CA 94534

Phone: (800) 863-4155 (Toll-free)
(800) 735-2929 or 711 TTY/TDD

Hours: Monday – Friday, 8 a.m. to 5 p.m.

Website: www.partnershiphp.org

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