Partnership HealthPlan of California

Medi-Cal Member Handbook

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call us at (800) 863-4155 (TTY: (800) 735-2929 or 711). The call is toll free.

Other formats

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

한국어 (Korean)

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

Հայ երեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (800) 863-4155 (TTY (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: (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: (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: (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: (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: (800) 735-2929 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: (800) 735-2929 or 711) पर कॉल करें।

ภาษาไทย (Thai)

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

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយឌ្ឌនកភាសា ដោយមិនគិតឈ្ល គឺអាចមានសំរាវ់រំបើអ្នក។ ចូរ ទូរស័ព្ទ (800) 863-4155 (TTY: (800) 735-2929 or 711) ។

ພາສາລາວ (Laotian)

ໂປດຊາບ: ຖ ້າວ ່າ ທ ່ານເວ ົ ້າພາສາ ລາວ,

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Notice of non-discrimination

Discrimination is against the law. Partnership HealthPlan of California complies with applicable federal and State civil rights laws and does not discriminate (exclude or treat people differently) on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and Partnership HealthPlan of California will provide all Covered Services in a culturally and linguistically appropriate manner.

Partnership HealthPlan of California provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ü Qualified sign language interpreters
  - ü 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:
  - ü Qualified interpreters
  - ü 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 (800) 735-2929) or 711.

HOW TO FILE A GRIEVANCE

If you believe that Partnership HealthPlan of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Partnership HealthPlan of California. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: 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 (800) 735-2929 or 711.
- In writing: Fill out a complaint form or write a letter and send it to:

Partnership HealthPlan of California ATTN: Grievance 4665 Business Center Drive Fairfield, CA 94534	**Or**	Partnership HealthPlan of California ATTN: Grievance 3688 Avtech Parkway Redding, CA 96002

- In person: Visit your doctor's office or Partnership HealthPlan of California and say you want to file a grievance.
- Electronically: Visit website Partnership HealthPlan of California at www.partnershiphp.org

OFFICE OF CIVIL RIGHTS

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 (800) 537-7697.
- 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/portal/lobby.jsf.

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 us. 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 to learn exact terms and conditions of coverage, you may request a copy of the complete contract from Member Services.

Call us at (800) 863-4155 (TTY: (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 us at (800) 863-4155
(TTY: (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

Table of contents

1. Getting started as a member

How to get help

We want you to be happy with your health care. If you have any questions or concerns about your care, we want to hear from you!

Member services

PHC member services is here to help you. We 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
- Offer interpreter services if you do not speak English
- Offer information in other languages and formats
- Assist you with getting your prescriptions filled

If you need help, call us at (800) 863-4155 (TTY: (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 (415) 473-3400

- 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 (800) 400-6001
- Sonoma County (877) 699-6868
- Trinity County (800) 851-5658
- Yolo County (866) 226-5415

You may also qualify for Medi-Cal through Social Security. 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.

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 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 us 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 us right away. We will send you a new card. Call us at (800) 863-4155 (TTY: (800) 735-2929 or 711). We are here Monday – Friday, 8 a.m. – 5 p.m.

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 us at (800) 863-4155 (TTY: (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 us 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 us 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 us at (800) 863-4155 (TTY: (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.

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.

The second month of PHC eligibility you are assigned to a primary care provider (PCP). Your assigned doctor is printed on your ID card. You must see this doctor for primary care services. The start date to see your doctor is on your ID card. The Provider Directory helps you to choose a new doctor 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 doctor. If you need help getting pre-approval during your first month, call us at (800) 863-4155 (TTY (800) 735-2929 or 711).

PHC eligibility may end if:

- You move out of one of the counties we serve or are in prison
- You no longer have Medi-Cal
- You qualify for certain waiver programs
- Your Medi-Cal coverage changes to a category not covered by PHC

If you no longer qualify for Medi-Cal benefits, call Covered California at (800) 300-1505, (TTY (888) 889-4500). Covered California can help you find out if you qualify for other health insurance options.

If you are an American Indian, you have the right to get health care services at any Indian health service facilities. You may also choose to be assigned to a primary care provider or be placed in an unrestricted (special member) status to get services from **any** Indian health service facility. 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). We are 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. We work 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, and how to find out if you qualify for transportation services.

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

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

Changing health plans

College students who move to a new county

If you move to a new county in California to attend college, we will cover emergency services in your new county. Emergency services are available to all Medi-Cal enrollees statewide regardless of county of residence.

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. There is no need for a new Medi-Cal application as long as you are still under 21 years of age, are only temporarily out of the home and are still claimed as a tax dependent in the household.

When you temporarily move away from home to attend college 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. If PHC does not operate in the new county, you will have to change your health plan to the available options in the new county. For additional questions, and in order to prevent a delay in the new health plan enrollment, you should contact Health Care Options at (800) 430-4263 (TTY (800) 430-7077) for assistance with enrollment.

  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 services in the new county. For routine or preventive health care, you would need to use our regular network of providers located in the county of residence where your family gets benefits. An exception to this is if we operate in your new county of residence, as described above.

Continuity of care

If you currently see providers who are not in the PHC network or have certain ongoing medical conditions you may be able to continue treatment for up to 12 months. If your providers do not join our network by the end of 12 months, you will need to switch to one of the providers in our 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 us, you may be able to keep getting services from that provider. This is another form of continuity of care. We provide continuity of care services for:

- Primary Care
- Specialists
- Behavioral Health Therapy for Autism
- Pregnancy and Postpartum Care

- Mild to Moderate Mental Health Services

We provide continuity of care services to newly enrolled members. You, your authorized representative, or your provider can make a direct request to us for continuity of care by contacting Care Coordination at (800) 809-1350.

We do **not** provide continuity of care services with an out-of-network provider when the provider:

- Does not want to join our network at the end of 12 months
- No longer wishes to provide you with treatment or service
- Has a quality of care issue
- Is not willing to submit a bill to us for services provided for you
- PHC is unable to establish that you have a pre-existing relationship with the provider

If your request is denied, our Care Coordination Department will assist you in locating an in-network provider and coordinating needed services. For help call Care Coordination at (800) 809-1350.

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."

You may have to pay a share of cost each month. The amount of your share of cost depends on your income and resources. Each month 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 us for that month. You will not be covered by us 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 doctor. You do not need to pick a PCP.

How a provider gets paid

PHC pays providers in these ways:

- Capitation payments
  - We pay 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 our members and then sends us 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, pharmacies, 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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

Asking PHC to pay a bill

If you get a bill for a covered service, call us right away at (800) 863-4155 (TTY: (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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711) to ask for a claim form. We will review your claim to see 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 PHC ID card and Medi-Cal benefits identification card (BIC) card with you. Never let anyone else use your PHC ID card or BIC card.

New members must choose a primary care provider (PCP) in our 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 our 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 us.

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 us at (800) 863-4155 (TTY: (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 our network, your PCP must ask us 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 see your new PCP in the next 90 days 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, tell the person who answers the phone that you are a member of PHC. Give them your PHC ID number.

Take your BIC and your PHC ID 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 and health education and counseling. In addition to preventive care, routine care also includes care when you are sick. We cover 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, you will call your PCP for an appointment. Be sure to call your PCP before you get medical care, unless it is an emergency. For an emergency, call **911** or go to the nearest emergency room.

To learn more about health care and services your PHC covers, and what it does not cover, read Chapter 4 in this handbook.

Urgent care

Urgent care is care you need within 24 hours, but it is **not** an emergency or life threatening. Urgent care needs could be a cold or sore throat, fever, ear pain or a sprained muscle.

For urgent care, call your PCP. If you cannot reach your PCP, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711). Alternatively, 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 your care is a mental health urgent care concern, contact the county Mental Health Plan's toll-free telephone number that is available 24 hours a day, 7 days a week. To locate 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).

Emergency care is for emergency medical conditions. It 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 include:

- Active labor
- Broken bone
- Severe pain, especially in the chest
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency condition

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 it 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 our network. If you go to an ER, ask them to call us. You or the hospital to which you were admitted should call us within 24 hours after you get emergency care.

If you need emergency transportation, call **911**. You do not need to ask your PCP or us 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 us.

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

You can see 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
- Pregnancy
- Family planning (except sterilization)
- Sexual assault
- HIV/AIDS testing (only minors 12 years or older)
- Sexually transmitted infections (only minors 12 years or older)
- Substance Use Disorder Screening

The doctor or clinic does not have to be part of our network and you do not need a referral from your PCP to get these services. For help finding a doctor or clinic giving these services, you can call us at (800) 863-4155 (TTY: (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, you may not want to see your PCP for sensitive or private care. If so, you may choose any doctor or clinic for these types of care:

- Family planning
- HIV/AIDS testing
- Sexually transmitted infections

The doctor or clinic does not have to be part of our network. Your PCP does not have to refer you for these types of service. For help finding a doctor or clinic giving these services, you can call us at (800) 863-4155 (TTY: (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. We will tell you about changes to the state law no longer than 90 days after the change.

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 see your PCP for care when you are sick. Be sure to call your PCP before you get 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 soon, but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain or sprained muscle.

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; or abortion. You should obtain more information before you select your provider. Call your prospective doctor, medical group, independent practice association, or clinic, or call us at (800) 863-4155 (TTY (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 our network. The network is the group of providers that work with us.

Our Provider Directory lists hospitals, long term care facilities, skilled nursing facilities, urgent care sites, vision providers, pharmacies, 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) and Rural Health Clinics (RHCs).

The Provider Directory has 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.

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

If you need a printed Provider Directory, call us at (800) 863-4155 (TTY: (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 our network.

If your provider in the network, including a PCP, hospital or other provider, has a moral objection to providing you with a covered service, such as family planning or abortion, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711). See Chapter 4 for more about moral objections.

If your provider has a moral objection, he or she can help you find another provider who will give you the services you need. We can also work with you to find a provider.

In network

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 our network.

To get a Provider Directory of network providers, call us at (800) 863-4155 (TTY: (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

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 network. If you need covered health care services, you may be able to get them out of

network at no cost to you as long as they are medically necessary and not available in the network. Prior authorization may be required.

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

If you are outside of our service area and need care that is **not** an emergency, call your PCP right away to get authorization to be treated. Alternatively, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

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

If you have questions about out-of-network or out-of-area care, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711) If the office is closed, or you want help from a representative, call our 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 (800) 735-2929 or 711) for assistance.

If Kaiser is assigned as your 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 (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 our network. To get a copy of the Provider Directory, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

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

If you were seeing a doctor before you were a member of PHC, you may be able to keep seeing 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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

If you need a specialist, your PCP will give you a referral to a specialist in our network.

Remember, if you do not choose a PCP, we 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 our Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call us at (800) 863-4155 (TTY: (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 our network are listed in the Provider Directory. [Hospital services, other than emergencies, require pre-approval (prior authorization)].

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 primary care physician. A nurse practitioner (NP), physician assistant (PA) or certified nurse midwife may also act as your primary care provider. If you choose a NP, PA or certified nurse midwife, you may be assigned a physician to oversee your care.

You can also choose a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as your PCP. These health centers are located in areas that do not have many health care services.

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, we will assign you a PCP. If you are assigned to a PCP and want to change, call us at (800) 863-4155 (TTY: (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 FQHCs and RHCs that work with us.

You can find the PHC Provider Directory online at www.partnershiphp.org. You can also call (800) 863-4155 (TTY: (800) 735-2929 or 711). You can also call to find out if the PCP you want is taking new patients.

Choice of physicians and 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 Current Patients Only” or “Closed” status, please call us at (800) 863-4155 (TTY: (800) 735-2929 or 711) for assistance.

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

To change your PCP, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

We 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, we will tell you in writing.

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

Appointments and visits

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 and PHC ID card to your appointment
- 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. 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: (800) 735-2929 or 711). Tell PHC 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.

If you get a bill or are asked to pay a co-pay when you feel you should not have to, you can also file a claim form. You will need to tell PHC in writing why you had to pay for the item or service. We 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: (800) 735-2929 or 711).

Referrals

Your PCP will 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 see the specialist.

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

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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

You do not need a referral for:

- PCP visits
- OB/GYN visits
- Urgent or emergency care visits
- Family planning (To learn more, call California 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 for:
  - Sexual or physical abuse
  - When you may hurt yourself or others
- Pregnancy care
- Sexual assault care
- Substance Use Disorder Screening

Pre-approval

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 alleviates severe pain.

The following services always need pre-approval, even if you receive them from a provider in our network:

- Hospitalization
- Services out of the PHC service area (except for sensitive services)
- Outpatient surgery
- Long-term therapy
- Specialized treatments

You never need pre-approval for emergency care, even if it is out of network. This includes having a baby.

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

For requests in which a provider indicates or we determine 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) authorization decision. We will give notice as quickly as your health condition requires and no later than 3 working days after receiving 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.

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

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.

To get a second opinion, call your PCP and tell them you would like a referral for a second opinion. Your PCP can refer you to a network provider for a second opinion. You may also call us (800) 863-4155 (TTY: (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 us to get a second opinion from a network provider.

If there is no provider in our 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. If you have a chronic illness or could lose your life, limb or major body part, we will decide within 72 hours.

If we deny your request for a second opinion, you may appeal. To learn more about appeals, see *Section 6. Reporting and solving problems*.

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 us at 800) 863-4155 (TTY: (800) 735-2929 or 711) You may also call our Advice Nurse at (866) 778-8873, 24 hours a day, 7 days a week.

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

Appointment Type	Must Get Appointment Within
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

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 free as long as they are medically necessary. Care is medically necessary if it is reasonable and necessary to protect life, keeps you from becoming seriously ill or disabled, or reduces pain from a diagnosed disease, illness or injury.

We offer these types of services:

- Outpatient (ambulatory) services
- Emergency services
- Hospice and palliative care
- Hospitalization
- Maternity and newborn care
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Mild to moderate mental health services
- Substance use disorder screening
- Pediatric services
- Vision services
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)
- Long-term services and supports (LTSS)

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

Medi-Cal benefits

Outpatient (ambulatory) services

- ***Allergy care***

  We cover allergy testing and treatment, including allergy desensitization, hyposensitization, or immunotherapy.

- ***Chiropractic services***

  We cover two chiropractic services per month, up to 24 services per 12-month period, limited to the treatment of the spine by manual manipulation.

- ***Dialysis/hemodialysis services***

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

- ***Outpatient surgery***

  We cover outpatient surgical procedures, other than those needed for diagnostic purposes or for emergency care, procedures considered to be elective; and specified outpatient medical procedures require pre-approval (prior authorization).

- ***Anesthesiologist services***

  We cover anesthesia services that are medically necessary when you receive outpatient care.

- ***Physician services***

  We cover physician services that are medically necessary.

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

  We cover podiatry services that are medically necessary. Podiatry services may require approval from PHC and/or your doctor. Podiatry services are limited to medical and surgical services to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or affect your ability to walk.

- ***Treatment therapies***

  We cover different treatment therapies, including:

  - Chemotherapy
  - Radiation therapy

Emergency services

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

  We cover all services that are needed to treat a medical emergency. 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, anyone with an average knowledge of health and medicine 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.

- ***Emergency transportation services***

  We cover 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.

- ***Emergency room services***

  We cover emergency room services that are needed to treat a medical emergency. Remember, 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, it could result in serious harm to your health or body.

Hospice and palliative care

We cover hospice care as well as palliative care, which reduces physical, emotional, social and spiritual discomforts for a member with a serious illness.

Hospitalization

- ***Anesthesiologist services***

  We cover anesthesiologist services during 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***

  We cover inpatient hospital care when you are admitted to the hospital.

- ***Surgical services***

  We cover surgeries performed in a hospital.

Maternity and newborn care

We cover these maternity and newborn care services:

- Breastfeeding education
- Delivery and postpartum care
- Nurse midwife services
- Prenatal care
- Birthing center services

Prescription drugs

Covered drugs

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

- Updating this list helps to make sure that the drugs on it are safe and work.
- 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 5-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 our Provider Directory 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. Give the pharmacy your prescription with your PHC ID card. 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.

Rehabilitative and habilitative services and devices

The PHC covers:

- ***Acupuncture***

  We cover acupuncture services to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of the needles) are limited to two services in any one month, and additional services can be provided through our pre-approval (prior authorization) as medically necessary.

- ***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 through the use of 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.

Cardiac rehabilitation

We cover inpatient and outpatient cardiac rehabilitative services.

§ ***Durable medical equipment***

We cover the purchase or rental of medical supplies, equipment and other services with a prescription from a doctor.

§ ***Hearing aids***

We cover hearing aids if you are tested for hearing loss and receive a prescription from your doctor. [MCP] may also cover hearing aid rentals, replacements and batteries for your first hearing aid.

§ ***Home health services***

We cover health services provided in your home, when prescribed by your doctor.

§ ***Medical supplies, equipment and appliances***

We cover medical supplies that are approved by a doctor, including implanted hearing devices.

§ ***Occupational therapy***

We cover occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction and consultative services.

§ ***Orthotics/prostheses***

We cover orthotic and prosthetic appliances and services that are medically necessary and prescribed by your doctor.

§ ***Physical therapy***

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

- ***Pulmonary rehabilitation***

  We cover pulmonary rehabilitation that is medically necessary and prescribed by a doctor.

- ***Skilled nursing facility services***

  We cover 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***

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

Laboratory services

We cover outpatient and inpatient laboratory and x-ray services. Various advanced imaging procedures 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
- Health Resources and Service Administration's Bright Futures recommendations
- Preventive services for women recommended by the Institute of Medicine
- 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 Food and Drug Administration. As a member, you pick a doctor who is located near you and will give you the services you need.

The plan’s PCP and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with our network without having to get pre-approval from us. We will pay that doctor or clinic for the family planning services you get.

Mental health services

PHC covers:

- ***Outpatient mental health services***
  - We cover mental health services. Your PCP can make a referral for additional mental health screening to a specialist within our network to determine your level of need. If your mental health screening results determine your needs are mild or moderate or you struggle with mental, emotional, or behavioral functioning, we can provide mental health services. We cover these mental health services:
    - Outpatient mental health service
    - Individual, family, and group psychotherapy
    - Psychological and neuropsychological testing to evaluate mental health conditions;
    - Outpatient services that include lab work, drugs, and supplies;
    - Outpatient services to monitor drug therapy; and
    - Psychiatric consultation and medication management.

- To provide these outpatient mild to moderate health care services, we have 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: (800) 735-2929 (24 hours a day, 7 days a week), or PHC at (800) 863-4155 TTY: (800) 735-2929 or 711 (Monday – Friday 8 a.m. – 5 p.m.)
  - If your mental health screening results determine you need specialty mental health services (SMHS), the PCP will refer you to the county mental health plan to receive an assessment.

- ***Specialty mental health services***
  - County mental health plans provide specialty mental health services (SMHS) to Medi-Cal beneficiaries who meet medical necessary criteria. SMHS may include the following inpatient and outpatient 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)

ú Residential services:

- Adult residential treatment services
- Crisis residential treatment services

ú Inpatient services:

- Acute psychiatric inpatient hospital services
- Psychiatric inpatient hospital professional services
- Psychiatric health facility services

§ For help finding more information on specialty mental health services, provided by the county mental health plan, you can call the county. To locate all counties toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.**

Substance use disorder services

We cover certain outpatient substance use disorder services, including residential treatment services

Pediatric services

We cover early and periodic screening, diagnostic and treatment (EPSDT) services

§ These services are also called well-child visits. These visits include health screens, diagnosis, treatment and shots for children through the month of their 21st birthday. These services include:

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Immunizations
- Laboratory tests, including lead screenings
- Health Education
- Diagnosis and treatment for vision problems, including eye glasses
- Diagnosis and treatment for hearing problems, including hearing aids
- Other services or supplies when medically necessary to treat, correct or ameliorate illness and conditions found through examination
- Vision services

EPSDT does not cover:

- Experimental or investigational treatments except in certain circumstances and always requires prior approval from PHC.

- Services or items not generally accepted as effective, and/or not within the normal course and duration of treatment for the condition
- Services for a caregiver or provider convenience

Vision services

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

The PHC covers:

- Eyeglasses every 24 months or as medically necessary for members who qualify, as determined by PHC
- Eyeglasses for pregnant women through postpartum
- Routine eye exam once in 24 months

Non-emergency medical transportation (NEMT)

You are entitled to use non-emergency medical transportation (NEMT) when you physically or medically are not able to get to your medical appointment by car, bus, train or taxi, and the plan pays for your medical or physical condition. Before getting NEMT, you need to request the service through your doctor and they 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. PHC allows the lowest cost NEMT for your medical needs when you need a ride to your appointment. 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 not possible.

NEMT must be used when:

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

To ask for NEMT services that your provider has prescribed, please call Care Coordination at (800) 809-1350 (Monday-Friday, 8 a.m. to 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 appointments covered under PHC when a provider has prescribed 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.

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 authorized by PHC.

Non-medical transportation (NMT)

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

- Traveling to and from an appointment for a Medi-Cal service

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. We provide 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. Mileage reimbursement is available only to friends and family, members cannot be reimbursed directly. We allow the lowest cost NMT type that meets your medical needs. To request NMT services that have been authorized by your provider, please call Care Coordination at (800) 809-1350 OR MTM at (888) 828-1254 (Monday-Friday, 8 a.m. to 5 p.m.) at least five 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.

Limits of NMT

There are no limits for receiving NMT to or from medical 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.

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 and from the residence, vehicle or place of treatment due to a physical or medical condition.
- 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 (91+ days)
- Personal care services
- Self-directed personal assistance services
- Community First Choice Option
- Home and Community Based Services

Moral objection

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

- Family planning services
- Abortion

If your provider has a moral objection, he or she 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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

Some hospitals and other providers do not offer one or more of the following services that may be covered under your plan contract and that you or your family member might need:

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

You should obtain more information before you select a provider. Call your prospective doctor, medical group, independent practice association or clinic, or call us at

(800) 863-4155 (TTY: (800) 735-2929 or 711).to ensure that you can obtain the health care services that you need.

What your health plan does not cover

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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711)

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

Medical services needed for a dental procedure such as medications, laboratory services, pre-admission physical exams, and/or dental anesthesia. If you have questions or want to learn more about dental services, call Denti-Cal at (800) 322-6384 (TTY (800) 735-2922 or 711). You may also visit the Denti-Cal website at denti-cal.ca.gov.

Institutional long-term care

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

Regular Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call us at (800) 863-4155 (TTY: (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:

- California Children's Services (CCS) (Del Norte, Humboldt, Mendocino, Modoc, Lake, Lassen, Shasta, Siskiyou, Sonoma and Trinity counties)
- 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
- 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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

California Children's Services (CCS)

CCS is a state program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems and who meet the CCS program rules. If PHC or your PCP believes your child has a CCS condition, he or she will be referred to the CCS program.

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

We do not cover services provided by the CCS program. For CCS to cover these services, CCS must approve the provider, services and equipment.

CCS does not cover all health conditions. CCS covers most health conditions that physically disable or that need to be treated with medicines, surgery or rehabilitation (rehab). 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

The State 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, call us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

Other programs and services for people with Medi-Cal

There are other programs and services for people with Medi-Cal, including:

- Organ and tissue donation

Read each of the sections below to learn more about other programs and services for people with Medi-Cal.

Organ and tissue donation

Anyone 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 organdonor.gov.

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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

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.

Transitional Medi-Cal

Transitional Medi-Cal (TMC) is for members who lose their cash aid or Medi-Cal eligibility because they make more money from their work, from a marriage or a spouse returning to work. Medi-Cal members who qualify for TMC may keep their Medi-Cal for up to 12 months and keep their membership in PHC.

If you lose eligibility for Medi-Cal because you have more income, you should contact your Medi-Cal eligibility worker right away. For more information about the Medi-Cal TMC program, contact the Department of Health Care Office phone number toll free at (800) 880- 5305 or contact your Home County eligibility office.

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

Our members have these rights:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a primary care provider within the Contractor's network.
- To participate in decision making regarding their own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer, or limit services or benefits.
- To receive oral interpretation services for their language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record.
- To access Minor Consent Services.

- § 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 W & I Code Section 14182 (b)(12).
- § To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- § To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- § To 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.

Your responsibilities

Our members have these responsibilities:

- o You are responsible for treating your provider(s) and their staff in a respectful and courteous way.
- o 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.
- o You are responsible for treating PHC staff in a respectful and courteous way.
- o 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.
- o 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.
- o Understanding treatment options. You are responsible to understand treatment options and participate in developing mutually agreed upon treatment goals to the degree possible.
- o Calling your provider. You are responsible for calling your provider for appointments when you need medical care, including routine checkups.
- o 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.
- Report wrongdoing. 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 we 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 web site 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. We may use your health information for case management or care coordination purposes and related functions without your authorization. We 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. We 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: We 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. We 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, we 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 we 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, we 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, we 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. We 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, we 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. We 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, we 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: **(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: (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 provides 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 has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer.

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 beneficiaries. PHC will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

Notice about estate recovery

The State of California must seek repayment from the estate of a deceased PHC member for:

- Services the member got on or after his or her 55th birthday and who own assets at the time of death.
- Payments made including; managed care premiums, nursing facility services, home and community based services, and related services received when the member was inpatient in a nursing facility or received community-based services.
- Any other payments for services the member got from providers not with PHC.

To learn more about estate recovery, call (916) 650-0590.

Notice of Action

PHC will send you a Notice of Action (NOA) letter any time we deny, delay, terminate or modify a request for health care services. If you disagree with the plan's decision, you can always file an appeal with us.

About Legal Assistance

You may be able to get free legal help. California Department of Consumer Affairs at (800) 952-5210, or (TTY (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** (or **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 our decision not to cover or change your services

You should always contact us first to let us know about your problem. Call us Monday – Friday, 8 a.m. – 5 p.m.at (800) 863-4155 (TTY: (800) 735-2929 or 711) to tell us about your problem. This will not take away any of your legal rights. We will also not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all members.

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

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

Complaints

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

- **By phone:** Call us at (800) 863-4155 (TTY: (800) 735-2929 or 711), Monday – Friday, 8 a.m. to 5 p.m. Give your health plan ID number, your name and the reason for your complaint.
- **By mail:** Call us at (800) 863-4155 (TTY: (800) 735-2929 or 711), Monday –

Friday, 8 a.m. to 5 p.m. and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the reason for your complaint. Tell us what happened and how we can help you.

Mail or bring the form in person to:

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

OR

Partnership HealthPlan of California
ATTN: Grievance
3688 Avtech Parkway
Redding, CA 96002

Your doctor's office will have complaint forms available.

- **Online:** Visit our website at www.partnershiphp.org

If you need help filing your complaint, we can help you. We can give you free language services. Call us at (800) 863-4155 (TTY: (800) 735-2929 or 711)

Within 5 calendar days of getting your complaint, we will send you a letter letting you know we received it. Within 30 calendar days, we will send you another letter that tells you how we resolved your problem.

If you want us 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 us at (800) 863-4155
(TTY: (800) 735-2929 or 711). We 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 us to review and change a decision we made about coverage for a requested service. If we sent you a Notice of Action (NOA) letter telling you that we are denying, delaying, changing or ending a service, and you do not agree with our decision, you can file an appeal. Your PCP 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 received. If you are currently getting treatment and you want to continue getting treatment, then you must ask 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 the appeal, please tell us that you want to continue receiving services.

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

- **By phone:** Call us at (800) 863-4155 (TTY: (800) 735-2929 or 711), Monday – Friday, 8 a.m. – 5 p.m. Give your health plan ID number, your name and the reason for your complaint.

- **By mail:** Call us at (800) 863-4155 (TTY: (800) 735-2929 or 711), Monday – Friday, 8 a.m. – 5 p.m. and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the reason for your complaint. Tell us what happened and how we can help you.

Mail or bring the form in-person to:

Partnership HealthPlan of California
ATTN: Grievance
4665 Business Center Drive
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OR

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ATTN: Grievance
3688 Avtech Parkway
Redding, CA 96002

Your doctor's office will have complaint forms available.

- **Online:** Visit our website at www.partnershiphp.org

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

Within 5 calendar days of getting your appeal, we will send you a letter letting you know we received it. Within 30 calendar days, we will send you a notice of appeal resolution (NAR) to tell you our appeal decision.

If you or your doctor wants us 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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711). We will make a decision within 72 hours of receiving your appeal.

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

If you filed an appeal and received a letter from us telling you that we did not change our decision, or you never received a letter telling you of our decision and it has been past 30 calendar 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 CDSS. A judge will help to resolve your problem. You can ask for a State Hearing only if you have already filed an appeal with us and you are still not happy with the decision, or if you have not received a decision on

your appeal after 30 calendar days.

You must ask for a State Hearing within 120 calendar days from the date on the 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 and if he or she gets approval from CDSS. You can also call CDSS to ask the State to approve your PCP's request for a State Hearing.

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

- **By phone:** Call the DSS 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 us at (800) 863-4155 (TTY: (800) 735-2929 or 711).

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

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 request.

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.

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

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 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.

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 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 who qualify have access to regular health care. Your PCP can provide CHDP services.

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

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), American Indian Health Clinic 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 care or 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 without a break in service, if the provider and PHC agree.

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

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Enrolled recipients choose their health care provider from among all COHS providers.

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, diagnosis and treatment (EPSDT): A federal program to help find and prevent the health problems of Medi-Cal children from birth to 21 years of age. In California, this program is called the Child Health and Disability Prevention (CHDP) program.

Emergency medical condition: A medical or psychiatric (mental) condition with such severe symptoms, such as active labor (see definition above) or severe pain, that someone with a reasonable 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 not covered by PHC; non-covered services.

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.

Grievance: A member's verbal or written expression of dissatisfaction about PHC, a provider, or the quality of care or services provided. A complaint is the same as 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 our network. Our network providers must have a license to practice in California and give you a service we cover.

You usually need a referral from your PCP to see 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:

- 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 with special training in internal medicine, including diseases.
- 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's 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 (not expected to live for more than 6 months).

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 Service Facility: A health center that can provide primary and other types of health care. American Indian members are able to access services at an Indian Health Service Facility without pre-approval from PHC. See *Section 2. About your health plan*, for more information.

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): Reasonable and necessary types of service to protect life; keep the patient from getting seriously ill or disabled; or reduce severe pain through the diagnosis or treatment of disease, illness or injury.

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 beneficiary 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.

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 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. NEMT must be prescribed by a licensed physician, dentist, podiatrist, mental health, or substance use disorder provider.

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.

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

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: See managed care plan.

Post-stabilization services: Services you receive after an emergency medical condition is stabilized.

Pre-approval (or prior-authorization): Your PCP must get approval from PHC before you get certain services. We will only approve the services you need. We 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.

Premium: An amount paid for coverage; cost for coverage.

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.

Preferred drug list (PDL): A chosen list of drugs approved by this health plan from which your doctor may order for you. Also called a formulary.

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 care.

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- OB/GYN
- FQHC or 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 where the symptoms are serious or severe enough to cause an immediate danger to yourself or others or you are immediately unable to provide for or use food, shelter or clothing due to the mental disorder.

Psychiatric emergency services may include moving a member to a psychiatric unit inside a general hospital or to an acute psychiatric hospital. This move is done to avoid or lessen a psychiatric emergency medical condition. In addition, the treating provider believes the move would not result in making the member's condition worse.

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 when there is a problem with a part of your body. This problem could be caused by a birth defect, disease or injury. It is medically necessary to make that part look or work better.

Referral: When your PCP says you can get care from another provider. Some covered care and services require a referral and pre-approval. You do **not** need a referral from your PCP for these services:

- Emergency care

- OB/GYN care from providers in the PHC network
  - The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, abortion and abortion-related procedures.
- Sensitive services
  - The screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases.
  - The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault.
  - The screening, prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV).
- Family planning care
- Outpatient professional behavioral health services

Routine care: Medically necessary services and preventive care, well child visits, or care such as routine follow-up care. The goal of routine care is to prevent health problems.

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

Sensitive services: Medically necessary 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 physician): 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 see a specialist.

Specialty mental health 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

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

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

Website: www.partnershiphp.org

Last Updated: November 30, 2018