Partnership HealthPlan of California

Medi-Cal Member Handbook

What You Need to Know About Your Benefits

Combined Evidence of Coverage and Disclosure Form

Calendar Year - 2025

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages for free. Partnership provides written translations from qualified translators. Call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711). The call is free. You can also use our Member Portal by registering at https://member.partnershiphp.org. Read this Member Handbook to learn more about health care language assistance services such as interpreter and translation services.

Other formats

You can get this information in other formats such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call 1-800-863-4155 (TTY 1-800-735-2929 or 711). The call is free.

Interpreter services

Partnership provides oral interpretation services, including sign language, from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters unless it is an emergency. Interpreter, linguistic, and cultural services are available for free. Help is available 24 hours a day, 7 days a week. For help in your language, or to get this handbook in a different language, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). The call is free.

English Attention: If you need help in your language call 1-800-863-4155 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-863-4155 (TTY: 1-800-735-2929). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-863-4155 (TTY: 1-800-735-2929) . تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-863-4155 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-863-4155 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-863-4155 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-863-4155 (TTY: 1-800-735-2929)។
ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ
ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។
ទូរស័ព្ទមកលេខ 1-800-863-4155 (TTY: 1-800-735-2929)។
សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Simplified Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-863-4155 (TTY: 1-800-735-2929)。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 1-800-863-4155 (TTY: 1-800-735-2929)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-863-4155 (TTY: 1-800-735-2929) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-863-4155 (TTY: 1-800-735-2929) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-863-4155 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-863-4155 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-863-4155 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-863-4155 (TTY:1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は 1-800-863-4155 (TTY: 1-800-735-2929)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-863-4155 (TTY: 1-800-735-2929)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-863-4155 (TTY: 1-800-735-2929) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-863-4155 (TTY: 1-800-735-2929) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ:ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາ ບໍ 1-800-863-4155 (TTY: 1-800-735-2929).
ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາບໍ 1-800-863-4155 (TTY: 1-800-735-2929).
ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-863-4155 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-863-4155 (TTY: 1-800-735-2929). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-863-4155 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-863-4155 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-863-4155 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-863-4155 (линия TTY:1-800-735-2929). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-863-4155 (TTY: 1-800-735-2929). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-863-4155 (TTY:1-800-735-2929). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-863-4155 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-863-4155 (TTY: 1-800-735-2929). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ

กรุณาโทรศัพท์ไปที่หมายเลข 1-800-863-4155 (TTY: 1-800-735-2929) นอกจากนี้
ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ
สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ
ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่
กรุณาโทรศัพท์ไปที่หมายเลข 1-800-863-4155 (TTY: 1-800-735-2929) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-863-4155 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-863-4155 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-863-4155 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-863-4155 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.

Welcome to Partnership HealthPlan of California!

Thank you for joining Partnership HealthPlan of California. Partnership is a health plan for people who have Medi-Cal. Partnership works 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 Partnership. Please read it carefully and completely. It will help you understand your benefits, the services available to you, and how to get the care you need. It also explains your rights and responsibilities as a member of Partnership. If you have special health needs, be sure to read all sections that apply to you.

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. This EOC and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. To learn more, call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

To ask for a copy of the contract between Partnership and the California Department of Health Care Services (DHCS), call 1-800-863-4155 (TTY 1-800-735-2929 or 711). You may ask for another copy of the Member Handbook for free. You can also find the Member Handbook on the Partnership website at www.partnershipHP.org. You can also ask for a free copy of the Partnership non-proprietary clinical and administrative policies and procedures. They are also on the Partnership website.

Contact us

Partnership is here to help. If you have questions, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). Partnership is here Monday – Friday, 8 a.m. – 5 p.m. The call is free.

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

Thank you,

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

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1. Getting started as a member

How to get help

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

Member services

Partnership's member services is here to help you. Partnership can:

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

If you need help, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). Partnership is here Monday – Friday, 8 a.m. – 5 p.m. The call is free. Partnership must make sure you wait less than 10 minutes when calling.

You can also visit Member Services online at any time at www.partnershipHP.org or use our member portal by registering at https://member.partnershiphp.org.

Who can become a member

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

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

- Butte County 1-877-410-8803
- Colusa County 1-530-458-0250
- Del Norte County 1-707-464-3191
- Glenn County 1-530-934-6514
- Humboldt County 1-877-410-8809
- Lake County 1-800-628-5288
- Lassen County 1-530-251-8152
- Marin County 1-877-410-8817
- Mendocino County 1-707-463-7700
- Modoc County 1-530-233-6501
- Napa County 1-707-253-4511
- Nevada County 1-530-265-1340
- Placer County 1-916-784-6000
- Plumas County 1-530-283-6350
- Shasta County 1-877-652-0731
- Sierra County 1-530-993-6700
- Siskiyou County 1-530-841-2700
- Solano County 1-707-784-8050
- Sonoma County 1-877-699-6868
- Sutter County 1-530-822-7327
- Tehama County 1-530-527-1911
- Trinity County 1-800-851-5658
- Yolo County 1-866-226-5415
- Yuba County 1-530-749-6311

You might also qualify for Medi-Cal through Social Security because you are getting SSI or SSP.

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

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

Transitional Medi-Cal

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

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

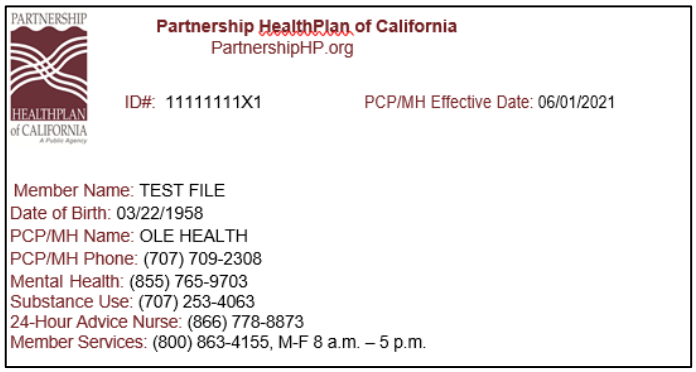
http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

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

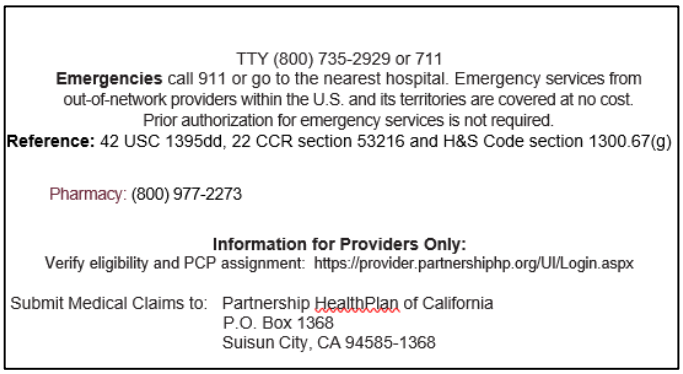
Identification (ID) cards

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

FRONT



BACK



If you do not get your Partnership ID card within a few weeks after your enrollment date, or if your Partnership ID card is damaged, lost, or stolen, call Member Services right away. Partnership will send you a new card for free. Call 1-800-863-4155 (TTY 1-800-735-2929 or 711). If you do not have a Medi-Cal BIC card or if your card is damaged, lost, or stolen, call the local county office. To find your local county office, go to http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

2. About your health plan

Health plan overview

Partnership is a health plan for people who have Medi-Cal in these counties: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba counties. Partnership works with the State of California to help you get the health care you need.

Talk with one of the Partnership's member services representatives to learn more about the health plan and how to make it work for you. Call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

When your coverage starts and ends

You are enrolled into Partnership based on the type of Medi-Cal you qualified for and the county you live in. Members cannot choose to leave Partnership to go to State Medi-Cal. When you enroll in Partnership, we will send your Partnership Identification (ID) card within two weeks of your enrollment date. You must show both your Partnership ID card and your Medi-Cal Benefits Identification Card (BIC) when you get health care services or prescriptions.

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

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

these materials on our website.

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

Prior authorization (also called pre-approval) may be required for certain services, even when you are not assigned to a PCP. If you need help getting pre-approval during your first month, call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Partnership is a health plan for Medi-Cal members in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba counties . Find your local county office at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

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

- You move out of Partnership's service area
- You no longer have Medi-Cal
- You are in jail or prison

If you lose your Partnership Medi-Cal coverage, you may still qualify for FFS Medi-Cal coverage. If you are not sure if you are still covered by Partnership, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Special considerations for American Indians in managed care

If you are an American Indian, you have the right to get health care services at an Indian Health Care Provider (IHCP). To find out more, please call Indian Health Services at 1-916-930-3927 or visit the Indian Health Services website at www.ihs.gov.

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

How your plan works

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

Member Services will tell you how Partnership works, how to get the care you need, how to schedule provider appointments during office hours, how to request free interpreting and translation services or written information in alternative formats, and how to find out if you qualify for transportation services.

To learn more, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). You can also find member service information online at www.partnershipHP.org.

Changing health plans

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

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

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

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

You can ask to leave Partnership by contacting your local county office. Find your local county office at:

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

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

Call Member Services at 1-800-863-4155 (TTY 1-800-735-2929).
We are here Monday – Friday, 8 a.m. – 5 p.m. The call is free.
Or call the California Relay Line at 711. Visit online at www.partnershipHP.org.

Students who move to a new county or out of California

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

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

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

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

  Or

- If Partnership does not serve the new county where you attend college, and you do not change your health plan to one that serves that county, you will only get emergency room and urgent care services for some conditions in the new county. To learn more, read Chapter 3, “How to get care.” For routine or preventive health care, you would need to use the Partnership network of providers located in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba.

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

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

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

Continuity of care

Continuity of care for an out-of-network provider

As a member of Partnership, you will get your health care from providers in Partnership's network. To find out if a health care provider is in the Partnership network, call us. Visit our website to view the Partnership Provider Directory at www.partnershiphp.org/Members/Medi-Cal/Pages/Find-a-Primary-Care-Provider.aspx. Providers not listed in the directory may not be in the Partnership network.

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

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

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

To learn more, call member services at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

If your providers do not join the Partnership network by the end of 12 months, do not agree to Partnership payment rates, or do not meet quality of care requirements, you will need to change to providers in the Partnership network. To discuss your choices, call member services at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Partnership is not required to provide continuity of care for an out-of-network provider for certain ancillary (supporting) services such as radiology, laboratory, dialysis centers, or transportation. You will get these services with a provider in Partnership's network.

To learn more about continuity of care and if you qualify, call 1-800-863-4155.

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

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

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

Health condition	Time period
Acute conditions (a medical issue that needs fast attention)	For as long as your acute condition lasts
Serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time)	For up to 12 months from the coverage start or the date the provider's contract ends with Partnership
Pregnancy and postpartum (after birth) care	During your pregnancy and up to 12 months after the end of pregnancy
Maternal mental health services	For up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later
Care of a newborn child between birth and 36 months old	For up to 12 months from the start date of the coverage or the date the provider's contract ends with Partnership
Terminal illness (a life-threatening	For as long as your illness lasts. You may

medical issue)	still get services for more than 12 months from the date you enrolled with Partnership or the time the provider stops working with Partnership
Performance of a surgery or other medical procedure from an out-of-network provider as long as it is covered, medically necessary, and authorized by Partnership as part of a documented course of treatment and recommended and documented by the provider	The surgery or other medical procedure must take place within 180 days of the provider's contract termination date or 180 days from the effective date of your enrollment with Partnership

For other conditions that might qualify, call 1-800-863-4155.

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

For help choosing a contracted provider to continue with your care or if you have questions or problems getting covered services from a provider who is no longer in Partnership's network, call member services at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Partnership is not required to provide continuity of care for services Medi-Cal does not cover or that are not covered under Partnership's contract with DHCS. To learn more about continuity of care, eligibility, and available services, call 1-800-863-4155.

Costs

Member costs

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

If you are an American Indian, you do not have to pay enrollment fees, premiums, deductibles, co-pays, cost sharing, or other similar charges. Partnership must not charge any American Indian member who gets an item or service directly from an IHCP

or through a referral to an IHCP or reduce payments due to an IHCP by the amount of any enrollment fee, premium, deductible, copayment, cost sharing, or similar charge.

If you are enrolled in Medi-Cal for Families, you might have a monthly premium and co-pays.

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

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

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

How a provider gets paid

Partnership pays providers in these ways:

- Capitation payments
  - Partnership pays some providers a set amount of money every month for each Partnership member. This is called a capitation payment. Partnership and providers work together to decide on the payment amount.
- FFS payments
  - Some providers give care to Partnership members and send Partnership a bill for the services they provided. This is called an FFS payment. Partnership and providers work together to decide how much each service costs.
- Quality Improvement Programs
  - This value-based payment program rewards our contracted primary care providers, long-term care facilities, and specialists for meeting or exceeding certain quality standards. This program improves member health care and encourages provider performance.

To learn more about how Partnership pays providers, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

If you get a bill from a health care provider

Covered services are health care services that Partnership must pay. If you get a bill for any Medi-Cal covered services, do not pay the bill. Call member services right away at 1-800-863-4155 (TTY 1-800-735-2929 or 711). Partnership will help you figure out if the bill is correct.

If you get a bill from a pharmacy for a prescription drug, supplies, or supplements, call Medi-Cal Rx Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week. TTY users can call 711, Monday through Friday, 8 a.m. to 5 p.m. You can also go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Asking Partnership to pay you back for expenses

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

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

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

If the provider is enrolled in Medi-Cal but is not in the Partnership network and refuses to pay you back, Partnership will pay you back, but only up to the amount that FFS Medi-Cal would pay. Partnership will pay you back for the full out-of-pocket amount for

emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval (prior authorization). If you do not meet one of the above conditions, Partnership will not pay you back.

Partnership will not pay you back if:

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

If you pay for a service that you think we should cover, you can file a claim. Use our claim form, called Member Reimbursement Request Form and tell us in writing why you had to pay. This form is available on our website or call us at 1-800-863-4155 (TTY 1-800-735-2929 or 711) to ask for the Member Reimbursement Request Form to be mailed to you. We will review your request to decide if you can get money back.

3.How to get care

Getting health care services

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

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

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

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

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

If you have a doctor you want to keep, or you want to find a new PCP, go to the Provider Directory for a list of all PCPs and other providers in the Partnership network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). You can also find the Provider Directory on the Partnership website at www.partnershipHP.org.

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

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

provider network.

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

Primary care provider (PCP)

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

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

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

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

If you do not choose a PCP within 30 days of enrollment, Partnership will assign you to a PCP. If you are assigned to a PCP and want to change, call 1-800-863-4155 (TTY1-800-735-2929 or 711). The change happens the first day of the next month. You can also use our member portal by registering at https://member.partnershiphp.org.

Your PCP will:

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

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

You can find the Partnership Provider Directory online at www.partnershipHP.org. Or you can request a Provider Directory to be mailed to you by calling 1-800-863-4155 (TTY 1-800-735-2929 or 711). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

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

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

To change your PCP, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). You can also use our member portal by registering at https://member.partnershiphp.org.

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

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

Some things to think about when picking a PCP:

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

Initial Health Appointment (IHA)

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

When you call to schedule your first health appointment, tell the person who answers the phone that you are a member of Partnership. Give your Partnership ID number.

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

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

If you have questions about your first health appointment, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Routine care

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

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

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

Your PCP will:

- Give you most of your routine care, including regular check-ups, immunizations (shots), treatment, prescriptions, required screenings, and medical advice

- Keep your health records
- Refer you to specialists if needed
- Order X-rays, mammograms, or lab work if you need them

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

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

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

Provider network

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

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

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

If your PCP, hospital, or other provider has a moral objection to providing you with a covered service, such as family planning or abortion, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). For more about moral objections, read “Moral objection” later in this chapter.

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

can also help you find a provider who will perform the service.

In-network providers

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

To get a Provider Directory of in-network providers, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). You can also find the Provider Directory online at www.partnershipHP.org. To get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

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

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

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

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

Out-of-network providers are providers that do not have an agreement to work with Partnership. Except for emergency care, family care, sensitive care, and care pre-approved by Partnership, you might have to pay for any care you get from out-of-network providers in your service area.

If you need medically necessary health care services that are not available in the network, you might be able to get them from an out-of-network provider for free. Partnership may approve a referral to an out-of-network provider if the services you need are not available in-network or are located very far from your home. If we give you a referral to an out-of-network provider, we will pay for your care.

For urgent care inside the Partnership service area, you must go to a Partnership in-network urgent care provider. You do not need pre-approval (prior authorization) to get urgent care from an in-network provider. You do need to get pre-approval (prior authorization) to get urgent care from an out-of-network provider inside the Partnership service area.

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

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

If you need help with out-of-network services, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Outside the service area

If you are outside of the Partnership service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

If you paid for emergency care requiring hospitalization in Canada or Mexico, you can ask Partnership to pay you back. Partnership will review your request. To learn more about being paid back, read Chapter 2, “About your health plan” in this handbook.

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

Ask the hospital to make copies of your Partnership ID card. Tell the hospital and the doctors to bill Partnership. If you get a bill for services you got in another state, call

Partnership right away. We will work with the hospital and/or doctor to arrange for Partnership to pay for your care.

If you are outside of California and have an emergency need to fill outpatient prescription drugs, have the pharmacy call Medi-Cal Rx at 1-800-977-2273.

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

The California Children's Services (CCS) program is a state program that treats children under 21 years of age who have certain health conditions, diseases, or chronic health problems and meet the CCS program rules. If you need health care services for a CCS-eligible medical condition and Partnership does not have a CCS-paneled specialist in the network who can provide the care you need, you may be able to go to a provider outside of the provider network for free. To learn more about the CCS program, read Chapter 4, "Benefits and services" in this handbook.

If you have questions about out-of-network or out-of-service-area care, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). If the office is closed and you want help from a Partnership representative, call our Advice Nurse line at 1-866-778-8873, 24 hours a day, 7 days a week .

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

How managed care works

Partnership is a managed care health plan. Partnership provides care to members who live in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba counties. In managed care, your PCP, specialists, clinic, hospital, and other providers work together to care for you.

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

When you join Partnership, you choose or are assigned to a PCP. Your PCP is part of a medical group. Your PCP and medical group direct the care for all of your medical needs. Your PCP may refer you to specialists or order lab tests and X-rays. If you need

services that require pre-approval (prior authorization), Partnership or your medical group will review the pre-approval (prior authorization) and decide whether to approve the service.

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

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

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

Members who have both Medicare and Medi-Cal

If you have both Medicare and Partnership, Medicare is your primary insurance and pays for your care before Partnership pays. Partnership is payer of last resort. This means if you have Medicare, it must be used first.

If you have Medicare and Medi-Cal, you should access providers who are part of your Medicare coverage as well as providers included in Partnership's network or any other Medi-Cal provider willing to bill Partnership as payer of last resort.

If you are enrolled in a Medicare plan, please see your Medicare plan's handbook and Provider Directory for information about covered services and providers.

Doctors

You will choose a doctor or other provider from the Partnership Provider Directory as your PCP. The PCP you choose must be an in-network provider. To get a copy of the Partnership Provider Directory, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). Or find it online at PartnershipHP.org.

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

If you had a doctor before you were a member of Partnership, and that doctor is not part of the Partnership network, you might be able to keep that doctor for a limited time. This

is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

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

If you want to change your PCP, you must choose a PCP from the Partnership Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call 1-800-863-4155 (TTY 1-800-735-2929 or 711) or you can also use our member portal at https://member.partnershiphp.org.

Hospitals

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

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

Women's health specialists

You can go to a women's health specialist in Partnership's network for covered care necessary to provide women's preventative and routine care services. You do not need a referral or authorization from your PCP to get these services. For help finding a women's health specialist, you can call 1-800-863-4155 (TTY 1-800-735-2929 or 711). You can also call our Advice Nurse line at 1-866-778-8873, 24 hours a day, 7 days a week.

For family planning services, your provider does not have to be in the Partnership provider network. You can choose any Medi-Cal provider and go to them without a referral or pre-approval (prior authorization). For help finding a Medi-Cal provider outside the Partnership provider network, call 1-800-863-4155.

Provider Directory

The Partnership Provider Directory lists providers in the Partnership network. The

network is the group of providers that work with Partnership.

The Partnership Provider Directory lists hospitals, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, FQHCs, outpatient mental health providers, managed long-term services and supports (MLTSS), Freestanding Birth Centers (FBCs), IHCPs, and RHCs. Types of health care providers include, but are not limited to:

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

The Provider Directory has Partnership in-network provider names, specialties, addresses, phone numbers, business hours, and languages spoken. It tells you if the provider is taking new patients. It also gives the physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars.

To learn more about a doctor's education, professional qualifications, residency completion, training, and board certification, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

If you need a printed Provider Directory, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

Timely access to care

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

Appointment type	You should be able to get an appointment within:
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent (routine) primary care appointments	10 business days
Non-urgent (routine) specialist care appointments	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days

Appointment type	You should be able to get an appointment within:
Non-urgent (routine) mental health provider (non-doctor) follow-up care appointments	10 business days of last appointment
Non-urgent (routine) appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness, or other health condition	15 business days

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

Sometimes waiting longer for an appointment is not a problem. Your provider might give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health. You can choose to wait for a later appointment or call Partnership to go to another provider of your choice. Your provider and Partnership will respect your wish.

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

Tell us if you need interpreter services, including sign language, when you call Partnership or when you get covered services. Interpreter services are available for free. We highly discourage the use of minors or family members as interpreters. To learn more about interpreter services we offer, call 1-800-863-4155.

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

Travel time or distance to care

Partnership must follow travel time or distance standards for your care. Those standards help make sure you can get care without having to travel too far from where

you live. Travel time or distance standards depend on the county you live in.

If Partnership is not able to provide care to you within these travel time or distance standards, DHCS may allow a different standard, called an alternative access standard. For Partnership's time or distance standards for where you live, visit www.partnershipHP.org. Or call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

If you need care from a provider located far from where you live, call member services at 1-800-863-4155 (TTY 1-800-735-2929 or 711). They can help you find care with a provider located closer to you. If Partnership cannot find care for you from a closer provider, you can ask Partnership to arrange transportation for you to go to your provider, even if that provider is located far from where you live.

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

Appointments

When you need health care:

- Call your PCP
- Have your Partnership ID number ready on the call
- Leave a message with your name and phone number if the office is closed
- Take your Medi-Cal BIC card and Partnership ID card to your appointment
- Ask for transportation to your appointment, if needed
- Ask for needed language assistance or interpreting services before your appointment to have the services at the time of your visit
- Be on time for your appointment, arrive a few minutes early to sign in, fill out forms, and answer any questions your PCP may have
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready

If you have an emergency, call **911** or go to the nearest emergency room. If you need help deciding how urgently you need care and your PCP is not available to speak with you, call the Partnership Advice Nurse Line at1-866-778-8873, 24 hours a day, 7 days a week.

Getting to your appointment

If you don't have a way to get to and from your appointments for covered services, Partnership can help arrange transportation for you. Depending on your situation, you may qualify for either Medical Transportation or for Non-Medical Transportation. These transportation services are not for emergencies and may be available for free.

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

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

Canceling and rescheduling

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

Payment

You do **not** have to pay for covered services unless you have a share of cost for long-term care. To learn more, read "For members with long-term care and a share of cost" in Chapter 2. In most cases, you will not get a bill from a provider. You must show your Partnership ID card and your Medi-Cal BIC card when you get health care services or prescriptions, so your provider knows who to bill. You can get an Explanation of Benefits (EOB) or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). If you get a bill for prescriptions, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Tell Partnership the amount you are being charged, the date of service, and the reason for the bill. Partnership will help you figure out if the bill was for a covered service or not. You do not need to pay providers for any amount owed by Partnership for any covered service. If you get care from an out-of-network provider and you did not get pre-approval (prior authorization) from Partnership, you might have to pay for the care you got.

You must get pre-approval (prior authorization) from Partnership before you visit an out-

of-network provider except when:

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

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

If you get a bill or are asked to pay a co-pay you do not think you have to pay, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). If you pay the bill, you can file a claim form with Partnership. You will need to tell Partnership in writing about the item or service you paid for. Partnership will read your claim and decide if you can get money back.

For questions or to ask for a member reimbursement request form, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

Partnership will not pay you back if:

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

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.

Partnership 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.

To report changes to your other health insurance information, please contact your local county office and Partnership.

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 Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Referrals

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

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

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

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

If you have trouble getting a standing referral or want a copy of the Partnership referral policy, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

- PCP visits
- Obstetrics/Gynecology (OB/GYN) visits
- Urgent or emergency care visits
- Adult sensitive services, such as sexual assault care

- Family planning services (to learn more, call the Office of Family Planning Information and Referral Service at 1-800-942-1054)
- HIV testing and counseling (12 years or older)
- Sexually transmitted infection services (12 years or older)
- Initial mental health assessment

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

California Cancer Equity Act referrals

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

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

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

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

To learn more, go to https://www.kickitca.org/.

Pre-approval (prior authorization)

For some types of care, your PCP or specialist will need to ask Partnership for permission before you get the care. This is called asking for pre-approval or prior

authorization. It means Partnership must make sure the care is medically necessary (needed).

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

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

- Hospitalization, if not an emergency
- Services out of the Partnership service area, if not an emergency or urgent care
- Outpatient surgery
- Long-term care or skilled nursing services at a nursing facility (including adult and pediatric Subacute Care Facilities contracted with the Department of Health Care Services Subacute Care Unit) or intermediate care facilities (including Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N))
- Specialized treatments, imaging, testing, and procedures
- Medical transportation services when it is not an emergency

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

Partnership has 5 business days from when Partnership gets the information reasonably needed to decide (approve or deny) pre-approval (prior authorization) requests. When a pre-approval (prior authorization) request is made by a provider and Partnership finds that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, Partnership will make a pre-approval (prior authorization) decision in no longer than 72 hours. This means that after getting the request for pre-approval (prior authorization), Partnership will give you notice as quickly as your health condition requires and no later than 72 hours or 5 days after the request for services. Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

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

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

You never need pre-approval (prior authorization) for emergency care, even if it is out of

the Partnership network or out of your service area. This includes labor and delivery if you are pregnant. You do not need pre-approval (prior authorization) for certain sensitive care services. To learn more about sensitive care services, read “Sensitive care” later in this chapter.

For questions about pre-approval (prior authorization), call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you might want a second opinion if you want to make sure your diagnosis is correct, you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan and it has not worked. Partnership will pay for a second opinion if you or your in-network provider asks for it, and you get the second opinion from an in-network provider. You do not need pre-approval (prior authorization) from Partnership to get a second opinion from an in-network provider, but a referral is required. If you want to get a second opinion, we will refer you to a qualified in-network provider who can give you one.

To ask for a second opinion and get help choosing a provider, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). Your in-network provider can also help you get a referral for a second opinion if you want one.

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

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

Sensitive care

Minor consent services

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

permission. These services are called minor consent services.

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

- Services for rape and other sexual assaults
- Pregnancy testing and counseling
- Contraception services such as birth control (excludes sterilization)
- Abortion services

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

- Outpatient mental health services and counseling, or residential shelter services, based on your maturity and ability to participate in your own health care
- HIV/AIDS counseling, prevention, testing, and treatment
- Sexually transmitted infection prevention, testing, and treatment including sexually transmitted diseases like syphilis, gonorrhea, chlamydia, and herpes simplex
- Substance use disorder treatment for drug and alcohol abuse including screening, assessment, intervention, and referral services
  - To learn more, read "Substance use disorder treatment services" in Chapter 4 of this handbook.

For pregnancy testing, contraception services, or services for sexually transmitted infections the provider or clinic does not have to be in the Partnership network. You can choose any Medi-Cal provider and go to them for these services without a referral or pre-approval (prior authorization).

Services from an out-of-network provider that are not related to sensitive care may not be covered. To find a Medi-Cal provider who is outside the Partnership Medi-Cal network, or to ask for transportation help to get to a provider, call 1-800-863-4155. For more information related to contraceptive services, read "Preventive and wellness services and chronic disease management" in Chapter 4 of this handbook.

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

Partnership does not cover minor consent services that are specialty mental health services. The county mental health plan for the county where you live covers minor consent services that are specialty mental health services. For specialty mental health services, call your county mental health plan or your Partnership Behavioral Health Organization any time, 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, go to:

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

Minors can talk to a representative in private about their health concerns by calling the 24/7 Advice Nurse line at 1-866-778-8873.

If you are able to consent to your own care without the consent of a parent or guardian under the law, Partnership will not give information on your sensitive care services to your Partnership plan policyholder or primary subscriber or to any Partnership enrollees without your written permission. You can also ask to get private information about your medical services in a certain form or format, if available, and have it sent to you at another location. To learn more about how to ask for confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7 of this handbook.

Adult sensitive care services

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

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

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

If you need help finding a doctor or clinic for these services, or help getting to these services (including transportation), call 1-800-863-4155 (TTY 1-800-735-2929 or 711). Or call the 24/7 Advice Nurse line at 1-866-778-8873.

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

Moral objection

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

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

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

To make sure you choose a provider who can give you the care you and your family needs, call the doctor, medical group, independent practice association, or clinic you want. Ask if the provider can and will provide the services you need. Or call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

These services are available to you. Partnership will make sure you and your family members can use providers (doctors, hospitals, and clinics) who will give you the care you need. If you have questions or need help finding a provider, call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Urgent care

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

For urgent care, call your PCP. If you cannot reach your PCP, call 1-800-863-4155 (TTY 1-800-753-2929 or 711). Or you can call the Advice Nurse line at 1-866-778-8873 to learn the level of care that is best for you.

If you need urgent care out of the area, go to the nearest urgent care facility.

Urgent care needs could be:

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

When you are inside Partnership's service area and need urgent care, you must get the urgent care services from an in-network provider. You do not need pre-approval (prior authorization) for urgent care from in-network providers inside Partnership's service area.

If you are outside the Partnership service area, but inside the United States, you do not need pre-approval (prior authorization) to get urgent care outside the service area. Go to the nearest urgent care facility.

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

If you need mental health urgent care, call your county mental health plan or Member Services at 1-800-863-4155 (TTY 1-800-735-2929 or 711). Call your county mental health plan or your Partnership Behavioral Health Organization any time, 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, go to: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

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

Emergency care

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

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

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

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you do not get care right away, you would place your health (or your unborn baby's health) in serious danger. This includes risking serious harm to your bodily functions, body organs, or body parts. Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain
- Trouble breathing
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts

Do **not** go to the ER for routine care or care that is not needed right away. You should get routine care from your PCP, who knows you best. You do not need to ask your PCP or Partnership before you go to the ER. However, if you are not sure if your medical condition is an emergency, call your PCP. You can also call our Advice Nurse line at 1-866-778-8873, 24 hours a day, 7 days a week.

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

If you need emergency transportation, call **911**.

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

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

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

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

Our Advice Nurse Line gives you free medical information and advice 24 hours a day, every day of the year. Call 1-866-778-8873.

Advice Nurse Line 1-866-778-8873

Partnership's Advice Nurse Line can give you free medical information and advice 24 hours a day, every day of the year. Call 1-866-778-8873 (TTY 1-800-735-2929 or 711) to:

- Talk to a nurse who will answer medical questions, give care advice, and help you decide if you should go to a provider right away
- Get help with medical conditions such as diabetes or asthma, including advice about what kind of provider may be right for your condition

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

Advance health care directives

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

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

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

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

To learn more, you can call Partnership at 1-800-863-4155.

Organ and tissue donation

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

4. Benefits and services

What benefits and services your health plan covers

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

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under the age of 21, Medi-Cal services include care that is medically necessary to fix or help relieve a physical or mental illness or condition. For more on your covered services, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

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

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

Definitions and descriptions of covered services are in Chapter 8, “Important numbers and words to know” in this handbook.

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

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

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

Medically necessary services do not include:

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

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

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

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

For members younger than 21 years old, medically necessary services include all

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

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

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

Medi-Cal benefits covered by Partnership

Outpatient (ambulatory) services

Adult immunizations (shots)

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

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

Allergy care

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

Anesthesiologist services

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

Chiropractic services

Partnership covers chiropractic services, limited to the treatment of the spine by manual manipulation. Partnership covers two chiropractic services per month, up to 24 services per 12-month period. Chiropractic services beyond these limits may be approved if medically necessary. Visit limits do not apply to children under age 21. Partnership may pre-approve other services as medically necessary.

These members qualify for chiropractic services:

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

Cognitive health assessments

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

Community health worker services

Partnership covers community health worker (CHW) services for individuals when recommended by a doctor or other licensed practitioner to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. CHW services have no service location limits and members can receive services in settings, such as the emergency department. Services may include:

- Health education and individual support or advocacy, including control and

prevention of chronic or infectious diseases; behavioral, perinatal, and oral health conditions; and violence or injury prevention
- Health promotion and coaching, including goal setting and creating action plans to address disease prevention and management
- Health navigation, including providing information, training, and support to help get health care and community resources
- Screening and assessment services that help connect a member to services to improve their health.

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

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

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

Dialysis and hemodialysis services

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

Medi-Cal coverage does not include:

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

Doula services

Partnership covers doula services provided by in-network doula providers during a member's pregnancy; during labor and delivery, including stillbirth, miscarriage, and abortion; and within one year of the end of a member's pregnancy. Medi-Cal does not cover all doula services.

Doula providers are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during, stillbirth, miscarriage, and abortion.

As a preventive benefit, doula services require a written recommendation from a physician or other licensed practitioner of the healing arts within their scope of practice. DHCS issued a standing recommendation for doula services that fulfills the requirement for an initial recommendation. The initial recommendation for doula services includes the following authorizations:

- One initial visit
- Up to 8 additional visits that can be a mix of prenatal and postpartum visits
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage
- Up to 2 extended 3-hour postpartum visits after the end of a pregnancy

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

Partnership must coordinate for out-of-network access to doula services for members if an in-network doula provider is not available.

Dyadic services

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

Dyadic care services include:

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

Outpatient surgery

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

Physician Administered Drugs

While most medications by your provider are dispensed at a pharmacy, Partnership covers certain drugs that you get from your doctor at the doctor's office or hospital. These drugs are sometimes called Physician Administered Drugs or the Medical Drug Benefit. Some drugs do not need a Treatment Authorization Request (TAR). Your doctor can send a TAR for a drug you need that must be approved by Partnership.

To ask for a list of covered Physician Administered Drugs, call Member Service at 1-800-863-4155. The list also shows if there are limits and requirements for how the drug is covered.

Physician Administered Drugs that are NOT a part of the medical drug benefit (no TAR exceptions) are those drugs used to treat erectile dysfunction, infertility, cosmetic purpose, and dietary supplements that are not approved by the Food and Drug Administration (FDA), like herbs, Coenzyme Q-10, probiotics, fish oil, glucosamine and others labeled as an over-the-counter supplement.

Physician services

Partnership covers physician services that are medically necessary.

Podiatry (foot) services

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

Treatment therapies

Partnership covers different treatment therapies, including:

- Chemotherapy
- Radiation therapy

Maternity and newborn care

Partnership covers these maternity and newborn care services:

- Birthing center services
- Breast pumps and supplies
- Breastfeeding education and aids

- Care coordination
- Certified Nurse Midwife (CNM)
- Counseling
- Delivery and postpartum care
- Diagnosis of fetal genetic disorders and counseling
- Doula Services
- Licensed Midwife (LM)
- Maternal mental health services
- Newborn care
- Nutrition education
- Pregnancy-related health education
- Prenatal care
- Social and mental health assessments and referrals
- Vitamin and mineral supplements

Telehealth services

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

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

Mental health services

Outpatient mental health services

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

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

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory, and problem solving
- Outpatient services for the purposes of monitoring medicine therapy
- Outpatient laboratory services
- Outpatient medicines that are not already covered under the Medi-Cal Rx Contract Drugs List (https://medi-calrx.dhcs.ca.gov/home/), supplies and supplements
- Psychiatric consultation
- Family therapy which involves at least 2 family members. Examples of family therapy include, but are not limited to:
  - Child-parent psychotherapy (ages 0 through 5)
  - Parent child interactive therapy (ages 2 through 12)
  - Cognitive-behavioral couple therapy (adults)

To provide these outpatient mild to moderate health care services, Partnership has partnered with Carelon Behavioral Health. For help finding more information on mental health services provided by Carelon, you can call 1-855-765-9703 (TTY 1-800-735-2929), 24 hours a day, 7 days a week. You can also call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711), Monday – Friday, 8 a.m. – 5 p.m.

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

If your mental health screening shows that you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider can refer you to the county mental health plan to get the care you need. Partnership will help you coordinate your first appointment with a county mental health plan provider to choose the right care for you. To learn more, read Chapter 4, “Other Medi-Cal programs and services” under Specialty mental health services in this handbook.

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

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

well as, opiate and other medication assisted treatment, and recovery services.

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

The W&R program's purpose is to provide substance use disorder treatment services for people who struggle with alcohol and/or drug addictions. If you think you need substance use disorder treatment services, you can request an assessment from your PCP or by calling Carelon at 1-855-765-9703.

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

- Butte
  1-800-334-6622
- Colusa
  1-530-458-0520
- Del Norte

  1-707-464-4813
- Glenn
  1-530-865-6459
- Lake
  1-707-274-9101 (North Lake area)

  1-707-994-6494 (South Lake area)
- Marin
  1-888-818-1115
- Napa
  1-707-253-4412 Adults
  1-707-255-1855 Teens
- Nevada
  1-530-265-1437
- Placer
  1-530-889-7240
- Plumas

1-530-283-6307

- Sierra
  1-530-993-6746
- Sonoma
  1-707-565-7450
- Sutter
  1-530-822-7200
- Tehama
  1-800-240-3208
- Trinity
  1-530-623-1362
- Yolo
  1-916-403-2970
- Yuba
  1-530-822-7200

See “Substance use disorder treatment services” in this chapter for more information about services offered by the county.

Emergency care services

Inpatient and outpatient services needed to treat a medical emergency

Partnership covers all services needed to treat a medical emergency that happens in the United States (including territories such as Puerto Rico, United States Virgin Islands, etc.). Partnership also covers emergency care that requires hospitalization in Canada or Mexico.

A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent (reasonable) layperson (not a health care professional) could expect it to result in any of the following:

- Serious risk to your health
- Serious harm to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious risk in cases of a pregnant person in active labor, meaning labor at a time

when either of the following would occur:

- There is not enough time to safely transfer you to another hospital before delivery
- The transfer might pose a threat to your health or safety or to that of your unborn child

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

If you need an emergency supply of a medication from an outpatient pharmacy while traveling, Medi-Cal Rx will be responsible for covering the medication, and not Partnership. If the pharmacy needs help giving you an emergency medication supply, have them call Medi-Cal Rx at 1-800-977-2273.

Emergency transportation services

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

Hospice and palliative care

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

Hospice care

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

Hospice care includes:

- Nursing services
- Physical, occupational, or speech services

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

Partnership may require that you get hospice care from an in-network provider unless medically necessary services are not available in-network.

Palliative care

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

Palliative care includes:

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

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

Hospitalization

Anesthesiologist services

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

Inpatient hospital services

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

Rapid Whole Genome Sequencing

Rapid Whole Genome Sequencing (RWGS) is a covered benefit for any Medi-Cal member who is 1 year of age or younger and is getting inpatient hospital services in an intensive care unit. It includes individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing.

RWGS is a new way to diagnose conditions in time to affect Intensive Care Unit (ICU) care of children 1 year of age or younger.

Surgical services

Partnership covers medically necessary surgeries performed in a hospital.

Extended postpartum coverage

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

Rehabilitative and habilitative (therapy) services and devices

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

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

- The services are medically necessary
- The services are to address a health condition

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

Partnership covers these rehabilitative/habilitative services:

Acupuncture

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

Audiology (hearing)

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

Behavioral health treatments

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

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

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

Cardiac rehabilitation

Partnership covers inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment (DME)

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

Generally, Partnership does not cover:

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

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

Enteral and parenteral nutrition

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

Hearing aids

Partnership covers hearing aids if you are tested for hearing loss, the hearing aids are medically necessary, and you have a prescription from your doctor. Coverage is limited to the lowest cost hearing aid that meets your medical needs. Partnership will cover one

hearing aid unless a hearing aid for each ear is needed for better results than what you can get with one hearing aid.

Hearing aids for members under age 21:

Partnership covers CCS-eligible medical services, including hearing aids. Partnership will cover the medically necessary hearing aids as part of Medi-Cal coverage.

Hearing aids for members ages 21 and older.

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

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

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

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

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

- Replacement hearing aid batteries

Home health services

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

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

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

Medical supplies, equipment, and appliances

Partnership covers medical supplies prescribed by doctors, physician assistants, nurse practitioners, and clinical nurse specialists. Some medical supplies are covered through

Medi-Cal Rx, part of Fee-for-Service (FFS) Medi-Cal, and not by Partnership. When Medi-Cal Rx covers supplies, the provider will bill Medi-Cal.

Medi-Cal does **not** cover:

- Common household items including, but not limited to:
  - Adhesive tape (all types)
  - Rubbing alcohol
  - Cosmetics
  - Cotton balls and swabs
  - Dusting powders
  - Tissue wipes
  - Witch hazel
- Common household remedies including, but not limited to:
  - White petrolatum
  - Dry skin oils and lotions
  - Talc and talc combination products
  - Oxidizing agents such as hydrogen peroxide
  - Carbamide peroxide and sodium perborate
- Non-prescription shampoos
- Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid, and zinc oxide paste
- Other items not generally used primarily for health care, and that are regularly and primarily used by persons who do not have a specific medical need for them

Occupational therapy

Partnership covers occupational therapy services including occupational therapy evaluation, treatment planning, treatment, instruction, and consultative services. Occupational therapy services are limited to 2 services per month in combination with acupuncture, audiology, chiropractic, and speech therapy services (limits do not apply to children under age 21). Partnership may pre-approve (prior authorize) more services as medically necessary.

Orthotics/prostheses

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

Ostomy and urological supplies

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

Physical therapy

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

Pulmonary rehabilitation

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

Skilled nursing facility services

Partnership covers skilled nursing facility services as medically necessary if you are disabled and need a high level of care. These services include room and board in a licensed facility with 24-hour per day skilled nursing care.

Speech therapy

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

Transgender services

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

Clinical trials

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

Laboratory and radiology services

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

Preventive and wellness services and chronic disease management

Partnership covers:

- Advisory Committee for Immunization Practices (ACIP) recommended vaccines
- Family planning services
- American Academy of Pediatrics Bright Futures recommendations (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Adverse childhood experiences (ACE) screening
- Asthma prevention services
- Preventive services for women recommended by the American College of Obstetricians and Gynecologists
- Help to quit smoking, also called smoking cessation services
- United States Preventive Services Task Force Grade A and B recommended preventive services

Family planning services

Family planning services are provided to members of childbearing age to allow them to choose the number and spacing of children. These services include all methods of birth control approved by the Food and Drug Administration (FDA). Partnership ’s PCP and OB/GYN specialists are available for family planning services.

For family planning services, you may choose any Medi-Cal doctor or clinic not in-network with Partnership without having to get pre-approval (prior authorization) from Partnership. If you get services not related to family planning from an out-of-network provider, those services might not be covered. To learn more, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Chronic disease management

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

- Diabetes
- Cardiovascular disease
- Asthma

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

Diabetes Prevention Program

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

- Providing a peer coach
- Teaching self-monitoring and problem solving
- Providing encouragement and feedback
- Providing informational materials to support goals
- Tracking routine weigh-ins to help accomplish goals

Members must meet certain rules to join DPP. Call Partnership to learn if you qualify for the program.

Reconstructive services

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

Substance use disorder screening services

Partnership covers substance use disorder services:

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

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

Vision benefits

Partnership covers:

- A routine eye exam once every 24 months; more frequent eye exams are covered if

medically necessary for members, such as those with diabetes
- Eyeglasses (frames and lenses) once every 24 months with a valid prescription
- Replacement eyeglasses within 24 months if your prescription changes or your eyeglasses are lost, stolen, or broken and cannot be fixed, and it was not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken.
- Low vision devices if you have vision impairment that impacts your ability to perform everyday activities (such as age-related macular degeneration) and standard glasses, contact lenses, medicine, or surgery cannot correct your visual impairment.
- Medically necessary contact lenses. Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (such as missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus.

Transportation benefits for situations that are not emergencies

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

If they find that you need medical transportation, they will prescribe it by filling out a form and submitting it to Partnership. Once approved, the approval is good for up to 12 months, depending on the medical need. Once approved, you can get as many rides as you need. Your doctor will need to re-assess your medical need for medical transportation and, if appropriate, re-approve your prescription for medical transportation when it expires, if you still qualify. Your doctor may re-approve the medical transportation for up to 12 months or less.

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

You will get medical transportation if:

- It is physically or medically needed, with a written authorization by a doctor or other

provider because you are not able to physically or medically able to use a car, bus, train, or taxi to get to your appointment
- You need help from the driver to and from your home, vehicle, or place of treatment due to a physical or mental disability

To ask for medical transportation that your doctor has prescribed for non-urgent (routine) appointments, call Partnership at 1-866-828-2303 at least 5 business days (Monday-Friday) before your appointment. For urgent appointments, call as soon as possible. Have your Partnership member ID card ready when you call.

Limits of medical transportation

Partnership provides the lowest cost medical transportation that meets your medical needs to the closest provider from your home where an appointment is available. You cannot get medical transportation if Medi-Cal does not cover the service you are getting, or it is not a Medi-Cal-covered pharmacy appointment. The list of covered services is in the "Benefits and services" section in Chapter 4 of this handbook.

If Medi-Cal covers the appointment type but not through the health plan, Partnership will not cover the medical transportation but can help you schedule your transportation with Medi-Cal. Transportation is not covered outside of the Partnership network or service area unless pre-authorized by Partnership. To learn more or to ask for medical transportation, call Partnership at 1-866-828-2303.

Cost to member

There is no cost when Partnership arranges transportation.

How to get non-medical transportation

Your benefits include getting a ride to your appointments when the appointment is for a Medi-Cal covered service and you do not have any access to transportation. You can get a ride, for free, when you have tried all other ways to get transportation and are:

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

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

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

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

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

To request a ride for services that have been authorized, call Partnership at 1-866-828-2303 at least one business day (Monday - Friday) before your appointment, or as soon as you can when you have an urgent appointment. Have your Partnership member ID card ready when you call.

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

Limits of non-medical transportation

Partnership provides the lowest cost non-medical transportation that meets your needs to the closest provider from your home where an appointment is available. Members cannot drive themselves or be reimbursed directly for non-medical transportation. To learn more, call Partnership at 1-866-828-2303.

Non-medical transportation does not apply if:

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

Cost to member

There is no cost when Partnership arranges non-medical transportation.

Travel expenses

In some cases, if you have to travel for doctor's appointments that are not available near your home, Partnership can cover travel expenses such as meals, hotel stays, and other related expenses such as parking, tolls, etc. These travel expenses may also be

covered for someone who is traveling with you to help you with your appointment or someone who is donating an organ to you for an organ transplant. You need to request pre-approval (prior authorization) for these services by contacting Partnership at 1-866-828-2303.

Other Partnership covered benefits and programs

Long-term care services and supports

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

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

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

If you have questions about long-term care services, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Basic care management

Getting care from many different providers or in different health systems is challenging. Partnership wants to make sure members get all medically necessary services, prescription medicines, and behavioral health services. Partnership can help coordinate and manage your health needs for free. This help is available even when another program covers the services.

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

- If you have trouble getting a follow-up appointment or medicines after you are discharged from the hospital, Partnership can help you.

- If you need help getting to an in-person appointment, Partnership can help you get free transportation.

If you have questions or concerns about your health or the health of your child, call Care Coordination at 1-800-809-1350 (TTY 1-800-735-2929 or 711).

Complex Care Management (CCM)

Members with more complex health needs may qualify for extra services focused on care coordination. Partnership offers Complex Care Management (CCM).

If you are enrolled in CCM or Enhanced Care Management, (read below) Partnership will make sure you have an assigned care manager who can help with basic care management described above and with other transitional care supports available if you are discharged from a hospital, skilled nursing facility, psychiatric hospital, or residential treatment.

Enhanced Care Management (ECM)

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

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

Covered ECM services

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

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care

- Member and family support services
- Coordination and referral to community and social supports

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

Cost to member

There is no cost to the member for ECM services.

Community Supports

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

If you need help or want to find out what Community Supports might be available for you, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). Or call your health care provider.

Major organ transplant

Transplants for children under age 21

Partnership must refer CCS-eligible children to a CCS-approved facility for an evaluation within 72 hours of when the child's doctor or specialist identifies the child as a potential candidate for transplant. If the CCS-approved facility confirms that the transplant would be needed and safe, Partnership will cover the transplant and related services.

Transplants for adults ages 21 and older

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

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

- Bone marrow
- Heart
- Heart/lung
- Kidney

- Kidney/pancreas
- Liver
- Liver/small bowel
- Lung
- Small bowel

Street medicine programs

Members experiencing homelessness may receive covered services from street medicine providers within Partnership's provider network. Members experiencing homelessness may be able to select a Partnership street medicine provider to be their primary care provider (PCP), if the street medicine provider meets PCP eligibility rules and agrees to be the member's PCP. To learn more about Partnership's street medicine program, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Other Medi-Cal programs and services

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

Partnership does not cover some services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. Partnership will coordinate with other programs to make sure you get all medically necessary services, including those covered by another program and not Partnership. This section lists some of these services. To learn more, call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Outpatient prescription drugs

Prescription drugs covered by Medi-Cal Rx

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

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

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

and decide these requests within 24 hours.

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

To find out if a drug is on the Contract Drugs List or to get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Pharmacies

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

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

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

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

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

Specialty mental health services (SMHS)

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

Outpatient services:

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

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

- Psychiatric inpatient hospital services
- Psychiatric health facility services

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

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

Substance use disorder treatment services

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

To learn more about treatment options for substance use disorders, call us at 1-800-863-4155.

Partnership members can have an assessment to match them to the services that best fit their health needs and preferences. When medically necessary, available services include outpatient treatment, residential treatment, and medicines for substance use disorders (also called Medications for Addiction Treatment or MAT) such as

buprenorphine, methadone, and naltrexone.

The county provides substance use disorder services to Medi-Cal members who qualify for these services. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. For a list of all counties' telephone numbers go to https://dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

Partnership will provide or arrange for MAT to be given in primary care, inpatient hospital, emergency department, and other medical settings. For members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties, see "Drug Medi-Cal Organized Delivery System (DMC-ODS)/ Wellness and Recovery (W&R) Program" in this chapter.

Dental services

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

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

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

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

Whole Child Model (WCM) program

The WCM program provides medically necessary services and equipment for California Children's Services (CCS) and non-CCS medical conditions. WCM provides case management and care coordination for primary specialty and behavioral health services for CCS and non-CCS conditions. WCM operates in certain counties. 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 Partnership or your PCP believes you or your child has a CCS condition, they will refer you to the county CCS program to be assessed for eligibility. County CCS program staff will decide if your child qualifies for CCS services. If your child qualifies to get this type of care, CCS providers working with Partnership will assign a personal care coordinator to help coordinate treatment for the CCS eligible condition using a care team and care plan.

CCS does not cover all health conditions. However, WCM will cover medically necessary services.

Examples of CCS-eligible conditions include, but are not limited to:

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

To learn more about WCM, go to https://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx or call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Transportation and travel expenses for CCS

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

If your transportation or travel expenses that you paid for yourself are found necessary and Partnership verifies that you tried to get transportation through Partnership, you can get paid back from Partnership. We must pay your back within 60 calendar days of the date you submit the required receipts and proof of transportation expenses.

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

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

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

California's 6 Medi-Cal 1915(c) waivers allow the state to provide services to persons who would otherwise need care in a nursing facility or hospital in the community-based setting of their choice. Medi-Cal has an agreement with the Federal Government that allows waiver services to be offered in a private home or in a homelike community setting. The services offered under the waivers must not cost more than the alternative institutional level of care. HCBS Waiver recipients must qualify for full-scope Medi-Cal. Some 1915(c) waivers have limited availability across the State of California and/or may have a waitlist. The 6 Medi-Cal 1915(c) waivers are:

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

To learn more about the Medi-Cal Waivers, go to https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx. Or call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

In-Home Supportive Services (IHSS)

The In-Home Supportive Services (IHSS) program provides in-home personal care assistance as an alternative to out-of-home care to qualified Medi-Cal-eligible persons, including those who are aged, blind, and/or disabled. IHSS allows recipients to stay safely in their own homes. Your health care provider must agree that you need in-home personal care assistance and that you would be at risk of placement in out-of-home care if you did not get IHSS services. The IHSS program will also perform a needs assessment.

To learn more about IHSS available in your county, go to https://www.cdss.ca.gov/inforesources/ihss. Or call your local county social services agency.

Services you cannot get through Partnership or Medi-Cal

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

- Services that are excluded from Medi-Cal under state and federal law
- Experimental and investigational services except in certain circumstances and always requires pre-approval from Partnership.
- Infertility, including reversing sterilization
- Same day surgery or hospital admission solely for the purpose of circumcision
- Substance Use Disorder Treatment Services sometimes called Drug Medi-Cal Organized Delivery (DMC-ODS) in Del Norte, Lake, Napa, Marin, Sonoma, Trinity, and Yolo counties
- 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
- In vitro fertilization (IVF) including, but not limited to infertility studies or procedures to diagnose or treat infertility
- Fertility preservation
- Experimental services
- Vehicle modifications
- Cosmetic surgery

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

To learn more call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Evaluation of new technologies

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

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

5. Child and youth well care

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

Medi-Cal for Kids and Teens

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

- Well-child visits and teen check-ups (important visits children need)
- Immunizations (shots)
- Behavioral health assessment and treatment
- Mental health evaluation and treatment, including individual, group, and family psychotherapy (specialty mental health services (SMHS) are covered by the county)
- Adverse childhood experiences (ACE) screening
- Enhanced Care Management (ECM) for Children and Youth Populations of Focus (POFs) (a Medi-Cal managed care plan (MCP) benefit)
- Lab tests, including blood lead poisoning screening
- Health and preventive education
- Vision services
- Dental services (covered under Medi-Cal Dental)
- Hearing services (covered by California Children's Services (CCS) for children who qualify. Partnership will cover services for children who do not qualify for CCS)
- Home Health Services, such as private duty nursing (PDN), occupational therapy, physical therapy, and medical equipment and supplies

These services are called Medi-Cal for Kids and Teens (also known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)) services. Additional information for members regarding Medi-Cal for Kids and Teens can be found here,

https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Member-Information.aspx. Medi-Cal for Kids and Teens services that are recommended by pediatricians' Bright Futures guidelines to help you, or your child, stay healthy are covered for free. To read the Bright Futures guidelines, go to https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

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

- Children and Youth Experiencing Homelessness
- Children and Youth at Risk for Avoidable Hospital or Emergency Department (ED) Utilization
- Children and Youth With Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) With Additional Needs Beyond the CCS Condition
- Children and Youth Involved in Child Welfare

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

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

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

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

Some of the services available through Medi-Cal for Kids and Teens, such as PDN, are

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

Well-child health check-ups and preventive care

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

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

Your child should get check-ups at these ages:

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

Well-child health check-ups include:

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

- Oral health screening
- Behavioral health assessment

If the doctor finds a problem with your or your child's physical or mental health during a check-up or screening, you or your child might need to get further medical care. Partnership will cover that care for free, including:

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

Blood lead poisoning screening

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

Help getting child and youth well care services

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

- Tell you about available services
- Help find in-network providers or out-of-network providers, when needed
- Help make appointments
- Arrange medical transportation so children can get to their appointments
- Help coordinate care for services available through Fee-for-Service (FFS) Medi-Cal, such as:

- Treatment and rehabilitative services for mental health and substance use disorders
- Treatment for dental issues, including orthodontics

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

Dental check-ups

Keep your baby's gums clean by gently wiping the gums with a washcloth every day. At about 4 to 6 months, "teething" will begin as the baby teeth start to come in. You should make an appointment for your child's first dental visit as soon as their first tooth comes in or by their first birthday, whichever comes first.

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

Babies ages 0-3

- Baby's first dental visit
- Baby's first dental exam
- Dental exams (every 6 months, and sometimes more)
- X-rays
- Teeth cleaning (every 6 months, and sometimes more)
- Fluoride varnish (every 6 months, and sometimes more)
- Fillings
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Kids ages 4-12

- Dental exams (every 6 months, and sometimes more)
- X-rays
- Fluoride varnish (every 6 months, and sometimes more)
- Teeth cleaning (every 6 months, and sometimes more)
- Molar sealants
- Fillings
- Root canals
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary

Youth ages 13-20

- Dental exams (every 6 months, and sometimes more)
- X-rays
- Fluoride varnish (every 6 months, and sometimes more)
- Teeth cleaning (every 6 months, and sometimes more)
- Orthodontics (braces) for those who qualify
- Fillings

- Crowns
- Root canals
- Partial and full dentures
- Scaling and root planing
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

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

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

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

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

Additional preventive education referral services

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

- Speech and language services
- Psychological services
- Physical therapy
- Occupational therapy
- Assistive technology
- Social Work services
- Counseling services
- School nurse services
- Transportation to and from school

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

6. Reporting and solving problems

There are two ways to report and solve problems:

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

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

You may contact Partnership first to let us know about your problem. Call us Monday through Friday, 8 a.m. to 5 p.m. at 1-800-863-4155 (TTY 1-800-735-2929 or 711). Tell us about your problem. A friend or family member can also file a grievance or appeal on your behalf. They must have permission from you first. You can contact member services to get permission for someone to speak on your behalf.

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

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call 1-800-863-1455 (TTY 1-800-735-2929 or 711).

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

Complaints

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

- **By phone:** Call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711) between Monday through 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 Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the reason for your complaint. Tell us what happened and how we can help you.

  Mail the form to:

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

  Your doctor's office will have complaint forms.
- **Online:** Go to the Partnership website at www.partnershipHP.org.

If you need help filing your complaint, we can help you. We can give you free language services. Call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

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

If you have an urgent matter involving a serious health concern, we will start an expedited (fast) review. We will give you a decision within 72 hours. To ask for an expedited review, call us at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Within 72 hours of getting your complaint, we will decide how we will handle your

complaint and whether we will expedite it. If we find that we will not expedite your complaint, we will tell you that we will resolve your complaint within 30 days. You may contact DMHC directly for any reason, including if you believe your concern qualifies for expedited review, Partnership does not respond to you within the 72-hour period, or if you are unhappy with Partnership's decision.

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

Appeals

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

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

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

- **By phone:** Call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711) between Monday through Friday, 8 a.m. to 5 p.m. Give your name, health plan ID number, and the service you are appealing.
- **By mail:** Call Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the service you are appealing.

  Mail the form to:

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

Your doctor's office will have appeal forms available.

- **Online:** Visit the Partnership website. Go to www.partnershipHP.org.

If you need help asking for an appeal or with Aid Paid Pending, we can help you. We can give you free language services. Call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Within 5 days of getting your appeal, Partnership will send you a letter telling you we got it. Within 30 days, we will tell you our appeal decision and send you a Notice of Appeal Resolution (NAR) letter. If we do not give you our appeal decision within 30 days, you can request a State Hearing from the California Department of Social Services.

If you or your doctor wants us to make a fast decision because the time it takes to decide your appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call 1-800-863-4155 (TTY 1-800-735-2929 or 711). We will decide within 72 hours of receiving your appeal.

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

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

- Ask for a **State Hearing** from the California Department of Social Services (CDSS) and a judge will review your case. CDSS' toll-free telephone number is 1-800-743-8525 (TTY1-800-952-8349). You can also ask for a State Hearing online at https://www.cdss.ca.gov. More ways of asking for a State Hearing can be found in "State hearings" later in this chapter.

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by Partnership. To submit complaints and appeals about Medi-Cal Rx pharmacy benefits, call 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711.

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

State Hearings

A State Hearing is a meeting with Partnership and a judge from the California Department of Social Services (CDSS). The judge will help to resolve your problem and decide whether Partnership made the correct decision or not. You have the right to ask for a State Hearing if you already asked for an appeal with Partnership and you are still not happy with our decision, or if you did not get a decision on your appeal after 30 days.

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

If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, contact Partnership between Monday – Friday, 8 a.m. – 5 p.m. by calling 1-800-863-4155. If you cannot hear or speak well, call 1-800-735-2929. Your authorized representative or provider can ask for a State Hearing for you with your written permission.

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

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

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

You can ask for a State Hearing in these ways:

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

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-433
Sacramento, CA 94244-2430

- **Online:** Request a hearing online at www.cdss.ca.gov
- **By email:** Fill out the form that came with your appeals resolution notice and email it to Scopeofbenefits@dss.ca.gov
  - Note: If you send it by email, there is a risk that someone other than the State Hearings Division could intercept your email. Consider using a more secure method to send your request.
- **By Fax:** Fill out the form that came with your appeals resolution notice and fax it to the State Hearings Division at 916-309-3487 or toll free at 1-833-281-0903

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call 1-800-863-4155 (TTY 1-800-735-2929 or 711).

At the hearing, you will tell the judge why you disagree with Partnership's decision. Partnership will tell the judge how we made our decision. It could take up to 90 days for the judge to decide your case. Partnership must follow what the judge decides.

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

Fraud, waste, and abuse

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

Provider fraud, waste, and abuse includes:

- Falsifying medical records
- Prescribing more medicine than is medically necessary
- Giving more health care services than is medically necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service

- Offering free or discounted items and services to members to influence which provider is selected by the member
- Changing member's primary care provider without the knowledge of the member

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

- Lending, selling, or giving a health plan ID card or Medi-Cal Benefits Identification Card (BIC) to someone else
- Getting similar or the same treatments or medicines from more than one provider
- Going to an emergency room when it is not an emergency
- Using someone else's Social Security number or health plan ID number
- Taking medical and non-medical transportation rides for non-healthcare related services, for services not covered by Medi-Cal, or when there is no medical appointment or prescriptions to pick up

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

Send your report to:

Mail:

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

Phone:

Call Partnership's Compliance Hotline at 1-800-601-2146, 24 hours a day, 7 days a week.

7. Rights and responsibilities

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

Your rights

These are your rights as a member of Partnership:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health
- To be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities
- To get fully translated written member information in your preferred language, including all grievance and appeals notices
- To make recommendations about Partnership's member rights and responsibilities policy
- To be able to choose a primary care provider within Partnership's network
- To have timely access to network providers
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care you got
- To ask for an expedited grievance in instances that would put your life, health or ability to function fully, in danger.
- To get help from patient advocate, provider, ombudsperson or any other person you choose.
- To know the medical reason for Partnership's decision to deny, delay, terminate (end), or change a request for medical care
- To get care coordination

- To ask for an appeal within 60 days from when Partnership or someone acting on Partnership's behalf, notifies you of a decision to deny, delay or modify a requested service
- To get free interpreting and translation services for your language
- To get free legal help at your local legal aid office or other groups
- To formulate advance directives
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Partnership and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible
- To disenroll (drop) from Partnership and change to another health plan in the county upon request
- To access minor consent services
- To get free written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how you are treated by Partnership, your providers, or the State
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside Partnership's network pursuant to federal law

Your responsibilities

Partnership members have these responsibilities:

- You are responsible for treating your provider(s) and their staff in a respectful and courteous way.
- You are responsible for showing up to your appointments on time. If you are

unable to make an appointment, you must call your provider at least 24 hours before the appointment, to cancel or reschedule.

- You are responsible for treating Partnership staff in a respectful and courteous way.
- You are responsible for making requests, such as for transportation, in advance, and calling Partnership to cancel any transportation if you have to cancel or reschedule your medical appointment.
- Play an active part in your care. You are responsible to provide, to the extent possible, information that Partnership and its medical providers need in order to care for you. You are responsible for talking to your medical provider about things you can do to improve your overall health.
- Understanding treatment options. You are responsible to understand treatment options and participate in developing mutually agreed upon treatment goals to the degree possible.
- Calling your provider. You are responsible for calling your provider for appointments when you need medical care, including routine checkups.
- Listen and cooperate with your provider. You are responsible for telling your medical provider about your medical condition and any medications you are taking. You are also responsible for following instructions for the care you have received from your medical provider.
- Use the emergency room (ER) only in an emergency. You are responsible for using the emergency room in cases of an emergency or as directed by your provider or our Advice Nurse.
- You are responsible for reporting fraud or wrongdoing to Partnership. You can do this without giving your name by calling Partnership's hotline at 1-800-601-2146, 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 1-800-822-6222.

Notice of non-discrimination

Discrimination is against the law. Partnership follows state and federal civil rights laws.

Partnership does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Partnership provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Partnership between Monday – Friday, 8 a.m. – 5 p.m. by calling 1-800-863-4155. Or, if you cannot hear or speak well, call 1-800-735-2929 or 711 to use the California Relay Service.

How to file a grievance

If you believe that Partnership has failed to provide these services or unlawfully discriminated in another way based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with a Partnership Civil Rights Coordinator. You can file a grievance by phone, by mail, in person, or online:

- **By phone**: Contact Partnership between Monday – Friday, 8 a.m. – 5 p.m by calling 1-800-863-4155. Or, if you cannot hear or speak well, call 1-800-735-2929 or 711 to use the California Relay Service.
- **By mail:** Fill out a complaint form or write a letter and mail it to:

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

- **In person:** Visit your doctor's office or Partnership and say you want to file a grievance.
- **Online:** Visit Partnership's website at www.partnershipHP.org.

Office of Civil Rights – California Department of Health Care Services

You can also file a civil rights complaint with the California Department of Health Care Services (DHCS), Office of Civil Rights by phone, by mail, or online:

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

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

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

Office of Civil Rights – United States Department of Health and Human Services

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

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

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

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

Ways to get involved as a member

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

Consumer Advisory Committee

Partnership has a group called Consumer Advisory Committee (CAC). This group is made up of our members and community advocates who live in our counties. You can join this group if you would like. The group talks about how to improve Partnership 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 Partnership at 1-800-863-4155 (TTY 1-800-735-2929 or 711).

Notice of privacy practices

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

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

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

Partnership will honor your requests to get confidential communications in the form and format you asked for. Or we will make sure your communications are easy to put in the

form and format you asked for. We will send them to another location of your choice. Your request for confidential communications lasts until you cancel it or submit a new request for confidential communications.

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

Effective Date of this Notice

This notice has been updated and is effective October 28, 2024.

Why am I receiving this Notice?

Partnership HealthPlan of California ("Partnership") is required by law to maintain the privacy and confidentiality of your medical information and protected health information ("PHI"), provide you with adequate written notice of our legal duties and privacy practices, and to notify you following a breach of your unsecured PHI. Any disclosure of PHI beyond the provisions of the law is prohibited.

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

What is PHI?

PHI is individually identifiable health information, such as your name, Social Security number, birthdate, medical condition or diagnosis, prescriptions, lab tests, and payment history. PHI also includes race/ethnicity, language, gender identity, sexual orientation, and pronoun data. Your disclosure of this type of information does not negatively affect how we make decisions about your Medi-Cal benefits or impact your access to covered services. PHI may be in oral, written or electronic form.

Partnership collects this information from you, your health care provider or other health care providers on your behalf, and the State of California; and protects this information consistent with privacy laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the California Confidentiality of Medical Information Act ("CMIA"). For example, to ensure the confidentiality of your PHI, Partnership staff complete HIPAA and CMIA trainings, utilize password protections, and access your information only at a level necessary to do their job.

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

Partnership 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.** Partnership 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, Partnership maintains your health information in electronic form, and allows pharmacies to have on-line access to it to provide appropriate prescriptions for you.
- **Payment.** Partnership 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.** Partnership 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 we are prohibited from using or disclosing genetic information for these purposes.
- **Business associates**. Partnership 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 provider or to provide appointment reminders.
- **Health Information Exchange (HIE)**. Partnership participates in multiple Health Information Exchanges (HIEs), which allow providers to coordinate care and provide faster access to our members. HIEs 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, Partnership 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 Partnership. 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 substance use disorder, and STD; birth control; or HIV test results are all considered 'Protected Records' and require your direct authorization to be shared. Any identifiable information about abortion or abortion-related services will not be shared on an HIE or to an out-of-state individual, agency or department, unless you provide written authorization or a legal exception exists.)

When working to process payment, provide care to our members, or within our daily operations, Partnership 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. Partnership works to ensure that our contractors have as minimal contact with your health information as possible.

- **Communication and Marketing:** Partnership will not use your health information for marketing purposes for which we receive payment without your prior written authorization. Partnership may use your health information for case management or care coordination purposes and related functions without your authorization. Partnership 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. Partnership 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: For fundraising for Partnership, you can tell us your choices about what we share. If you have a preference for how we share your information or contact you for fundraising purposes, talk to us. Tell us what you want us to do, and we will follow your instructions. You have both the right and choice to tell us not to contact you for

fundraising purposes.

Can my health information ever be released without my permission?

Yes, Partnership 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 substance use disorder treatment. We comply with these restrictions in our use of your health information.

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

- **When legally required:** Partnership 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:** Partnership 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: Partnership 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:** Partnership 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 Partnership makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information. Partnership may also use and disclose PHI to the extent permitted by law without your authorization to defend a lawsuit or arbitration. Any substance use disorder treatment records will not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you give written consent, or unless a

court orders the disclosure after giving you notice and an opportunity to object and the order is accompanied by a subpoena or other legal requirement compelling disclosure.

- **For law enforcement purposes:**
  - As required by law pursuant to a search warrant lawfully issued to a governmental law enforcement agency
  - 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 Partnership has a suspicion that your death was the result of criminal conduct including criminal conduct at Partnership
  - In an emergency in order to report a crime
- **To coroners and medical examiners:** Partnership 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:** Partnership 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, Partnership may disclose your health information prior to, and in reasonable anticipation of, your death.
- **For organ, eye, or tissue donation:** Partnership 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:** Partnership may, consistent with applicable law and ethical standards of conduct, disclose your health information if Partnership, 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:** Partnership may make disclosure to authorized federal officials in national security activities or for the provision of protective services to officials.
- **For workers compensation:** Partnership 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, Partnership 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:** Partnership 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:** Partnership may use or disclose protected health information for research purposes.

Can others involved in my care receive information about me?

Yes, Partnership 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, PARTNERSHIP WILL NOT DISCLOSE YOUR HEALTH INFORMATION OTHER THAN WITH YOUR WRITTEN AUTHORIZATION. IF YOU OR YOUR REPRESENTATIVE AUTHORIZES PARTNERSHIP 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. Please note that it is possible that information that Partnership has properly disclosed pursuant to this Notice will be redisclosed by the recipient and, if so, it is no longer protected by the policies in this Notice. 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.

Furthermore, your health information cannot be used or disclosed to conduct any criminal, civil, or administrative investigation or impose any liability on you or anyone else, or identify you or anyone else in connection with either of those purposes, for seeking, obtaining, providing, or facilitating reproductive health care, provided that the reproductive health care is lawful under Federal law and the law of the state in which the reproductive health care is provided. For example, if you live in one state and travel to California to receive lawful reproductive health care, such as an abortion, we are not allowed to and will not share that information if someone tries to investigate you for obtaining that care. However, if Partnership receives a lawful attestation from the person requesting it, we may disclose your protected health information potentially related to reproductive health care (such as an abortion) for the following purposes:

- Health oversight activities
- Judicial or administrative proceedings
- Law enforcement
- Coroner or medical examinations.

Pursuant to the requirements of CMIA, we will not cooperate with any inquiry or investigation by or provide medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would disclose identifiable abortion or abortion-related services that are lawful under the laws of California, unless the individual provides written authorization or disclosure is required by law.

We will not knowingly disclose, transmit, transfer, share, or grant access to medical information in an electronic health records system or through a health information exchange identifiable abortion or abortion-related services that is lawful under the laws of California to any individual from another state, unless the individual provides written authorization or disclosure is required by law.

YOUR INDIVIDUAL RIGHTS

What rights do I have as a Partnership member?

As a Partnership 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 for the purpose of carrying out treatment, payment, or health care operations, or if the disclosure is to a family member, relative, or close personal friend and is related to the person's involvement with your health care or payment for your health care or for notification purposes. Partnership 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 Partnership, has paid for the service(s) out of pocket.
- To receive confidential communications from Partnership 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 Partnership maintains on you, including billing records, we must receive your request in writing. We will respond to your request within 30 days. Partnership may charge a fee to cover the cost of copying, assembling and mailing your records, as applicable. You may also request Partnership 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, Partnership 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, Partnership 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. Partnership 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 Partnership; 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, Partnership 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 called Health Information Restriction Request, which you can obtain from our Internet website at https://www.partnershiphp.org/Members/Medi-Cal/Documents/HealthInformationRestriction.pdf 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 Partnership 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/

Partnership encourages you to contact us with any concerns you have regarding the privacy of your information. Partnership 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 Partnership member.

Contact us at:

Mailing address:

Partnership HealthPlan of California

Attn: Privacy Officer

4665 Business Center Drive

Fairfield, CA 94534

Phone: **1-800-863-4155** or

TTY/TDD: **1-800-735-2929** or call **711**

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

Partnership's Complaint Hotline is 1-800-601-2146 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: 1-916-445-4646 or

TTY: 1-877-735-2929

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: 1-877-696-6775

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, other health coverage, and tort recovery

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

Medi-Cal members may have other health coverage (OHC), also referred to as private health insurance. As a condition of Medi-Cal eligibility, you must apply for or retain any available OHC when it is free.

Federal and state laws require Medi-Cal members to report OHC and any changes to an existing OHC. You may have to repay DHCS for any benefits paid by mistake if you

do not report OHC quickly. Submit your OHC online at http://dhcs.ca.gov/OHC.

If you do not have access to the internet, you can report OHC to Partnership by calling 1-800-863-4155 (TTY 1-800-735-2929 or 711) . Or you can call DHCS's OHC Processing Center at 1-800-541-5555 (TTY 1-800-430-7077 or 711) or 1-916-636-1980.

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

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

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

To learn more, visit the DHCS Third Party Liability and Recovery Division website at https://dhcs.ca.gov/tplrd or call 1-916-445-9891.

Notice about estate recovery

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-for-Service (FFS) and managed care premiums or capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the DHCS Estate Recovery Program website at https://dhcs.ca.gov/er or call 1-916-650-0590.

Notice of Action

Partnership will send you a Notice of Action (NOA) letter any time Partnership denies, delays, terminates, or modifies a request for health care services. If you disagree with

Partnership's decision, you can always file an appeal with Partnership. Go to the "Appeals" section in Chapter 6 of this handbook for important information on filing your appeal. When Partnership sends you a NOA it will tell you all the rights you have if you disagree with a decision we made.

Contents in notices

If Partnership bases denials, delays, modifications, terminations, suspensions, or reductions to your services in whole or in part on medical necessity, your NOA must contain the following:

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

Translations

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

The fully translated notice must include the medical reason for Partnership's decision to deny, delay, modify, terminate, suspend, or reduce a request for health care services.

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

About legal assistance

You may be able to get free legal help. California Department of Consumer Affairs at 1-800-952-5210, or (TTY 1-800-326-2297). You may also call the local Legal Aid Society in your county at 1-888-804-3536.

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.

8. Important numbers and words to know

Important phone numbers

Partnership's Member Services The toll-free number to call Partnership's Member Services Department	1-800-863-4155 8 a.m. to 5 p.m., Monday – Friday
Partnership's 24 hour Advice Nurse Line The toll-free number to speak to a nurse about your health if you're unsure about going to the ER	1-866-778-8873 24 hours a day, 7 days a week
Partnership's Compliance Hotline The toll-free number to report fraud, privacy concerns and other compliance issues	1-800-601-2146 24 hours a day, 7 days a week
Vision Services Partnership's vision services are covered through Vision Services Plan (VSP).	1-800-877-7195 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
Mental Health Services Partnership covers the treatment of mild to moderate mental health conditions and are covered through Carelon Behavioral Health.	1-855-765-9703 24 hours a day, 7 days a week
Disability Services	
California Relay Service (CRS) – TTY/TDD/TDD	1-800-735-2929 or 711

The toll-free number for the hearing impaired	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	1-888-452-8609 8 a.m. to 5 p.m., Monday – Friday
Health Care Options The program that can enroll or disenroll a member from a health plan in counties that offer more than one Medi-Cal plan	1-800-430-4264 8 a.m. to 6 p.m., Monday – Friday
Dental Services Call Medi-Cal Dental to learn more about covered dental services	1-800-322-6384 8 a.m. to 5 p.m., Monday – Friday
Department of Social Services (State Hearings) The State office that helps you file a State Hearing	1-800-952-5253
Medi-Cal Fraud and Elder Abuse Hotline The State office that helps you with concerns about fraud in the Medi-Cal program	1-800-722-0432
Medi-Cal Rx The state program that provides you with pharmacy services	1-800-977-2273 (TTY 1-800-977-2273 and press 7 or 711)
U.S. Office for Civil Rights (Privacy Complaints) The federal office that helps you with privacy questions and concerns	1-866-627-7748

Words to know

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

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

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

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

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

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

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

Case manager: Registered nurses or social workers who can help a member understand major health problems and arrange care with the member's providers.

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

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

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

Clinic: A facility that members can select as a primary care provider (PCP). It can be

either a Federally Qualified Health Center (FQHC), community clinic, Rural Health Clinic (RHC), Indian Health Care Provider (IHCP), or other primary care facility.

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

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

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

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

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

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

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

Covered Services: Medi-Cal services for which Partnership is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form).

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

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

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

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

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

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

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

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

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

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

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

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

Family planning services: Services to prevent or delay pregnancy. Services are provided to members of childbearing age to enable them to determine the number and spacing of children.

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

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

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

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

Freestanding Birth Centers (FBCs): Health facilities where childbirth is planned to occur away from the pregnant member's residence and that are licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan. These facilities are not hospitals.

Grievance: A member's verbal or written expression of dissatisfaction about a service covered by Medi-Cal, Partnership, a county mental health plan, or a Medi-Cal provider. A complaint filed with Partnership about a network provider is an example of a grievance.

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

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

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

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

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

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

Hospital: A place where a member gets inpatient and outpatient care from doctors and nurses.

Hospital outpatient care: Medical or surgical care performed at a hospital without

admission as an inpatient.

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

Indian Health Care Providers (IHCP): A health care program operated by the Indian Health Service (IHS), an Indian Tribe, Tribal Health Program, Tribal Organization or Urban Indian Organization (UIO) as those terms are defined in Section 4 of the Indiane Health Care Improvement Act (25 U.S.C. section 1603).

Inpatient care: When a member has to stay the night in a hospital or other place for medical care that is needed.

Intermediate care facility or home: Care provided in a long-term care facility or home that provides 24-hour residential services. Types of intermediate care facilities or homes include intermediate care facility/developmentally disabled (ICF/DD), intermediate care facility/developmentally disabled-habilitative (ICF/DD-H), and intermediate care facility/developmentally disabled-nursing (ICF/DD-N).

Investigational treatment: A treatment drug, biological product, or device that has successfully completed phase one of a clinical investigation approved by the Federal Drug Administration (FDA), but that has not been approved for general use by the FDA and remains under investigation in an FDA-approved clinical investigation.

Long-term care: Care in a facility for longer than the month of admission plus 1 month.

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

Medi-Cal for Kids and Teens: A benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early. They must get treatment to take care of or help the conditions that might be found in the check-ups. This benefit is also known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit under federal law.

Medi-Cal Rx: A pharmacy benefit service that is part of FFS Medi-Cal and known as “Medi-Cal Rx” that provides pharmacy benefits and services, including prescription drugs and some medical supplies to all Medi-Cal beneficiaries.

Medical home: A model of care that provides the main functions of primary health care. This includes comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Medically necessary (or medical necessity): Medically necessary services are important services that are reasonable and protect life. The care is needed to keep patients from getting seriously ill or disabled. This care reduces severe pain by diagnosing or treating the disease, illness, or injury. For members under the age of 21, Medi-Cal medically necessary services include care that is needed to fix or help a physical or mental illness or condition, including substance use disorders.

Medical transportation: Transportation that a provider prescribes for a member when the member is not physically or medically able to use a car, bus, train, or taxi to get to a covered medical appointment or to pick up prescriptions. Partnership pays for the lowest cost transportation for your medical needs when you need a ride to your appointment.

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

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

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

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

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

Network provider (or in-network provider): Go to “Participating provider.”

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

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

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

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

(Part D), or Medicare supplemental plans (Medigap).

Orthotic device: A device used as a support or brace attached outside the body to support or correct a badly injured or diseased body part that is medically necessary for the medical recovery of the member.

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

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

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

Outpatient mental health services: Outpatient services for members with mild to moderate mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory, supplies, and supplements

Palliative care: Care to reduce physical, emotional, social, and spiritual discomforts for a member with a serious illness. Palliative care does not require the member to have a life expectancy of 6 months or less.

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

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

Plan: Go to "Managed care plan."

Post-stabilization services: Covered services related to an emergency medical

condition that are provided after a member is stabilized to keep the member stabilized. Post-stabilization care services are covered and paid for. Out-of-network hospitals might need pre-approval (prior authorization).

Pre-approval (prior authorization): The process by which a member or their provider must request approval from Partnership for certain services to make sure Partnership will cover them. A referral is not an approval. A pre-approval is the same as prior authorization.

Prescription drug coverage: Coverage for medications prescribed by a provider.

Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed, unlike over-the-counter ("OTC") drugs that do not require a prescription.

Primary care: Go to "Routine care."

Primary care provider (PCP): The licensed provider a member has for most of their health care. The PCP helps the member get the care they need.

A PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- OB/GYN
- Indian Health Care Provider (IHCP)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (pre-approval): The process by which a member or their provider must request approval from Partnership for certain services to ensure Partnership will cover them. A referral is not an approval. A prior authorization is the same as pre-approval.

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

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

Psychiatric emergency medical condition: A mental disorder in which the symptoms are serious or severe enough to cause an immediate danger to the member or others or

the member is immediately unable to provide for or use food, shelter, or clothing due to the mental disorder.

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

Qualified provider: A doctor qualified in the area of practice appropriate to treat a member's condition.

Reconstructive surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors, or disease.

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

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

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

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

Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

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

Service area: The geographic area Partnership serves. This includes the counties of Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba counties.

Skilled nursing care: Covered services provided by licensed nurses, technicians, or therapists during a stay in a skilled nursing facility or in a member's home.

Skilled nursing facility: A place that gives 24-hour-a-day nursing care that only trained health professionals can give.

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

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

Subacute care facility (adult or pediatric): A long-term care facility that provides comprehensive care for medically fragile members who need special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.

Terminal illness: A medical condition that cannot be reversed and will most likely cause death within 1 year or less if the disease follows its natural course.

Tort recovery: When benefits are provided or will be provided to a Medi-Cal member because of an injury for which another party is liable, DHCS recovers the reasonable value of benefits provided to the member for that injury.

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

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

Partnership HealthPlan of California

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