Member Handbook

MCP logo goes here

What you need to know about your benefits

[MCP] Combined Evidence of Coverage (EOC) and Disclosure Form

[Benefit Year]

[Region]

[MCP may change the cover layout.]

[MCP may edit the terms “member services” and “nurse triage line” to match MCP’s terms throughout EOC]

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. Call [member services telephone number] (TTY [member services TTY number] or 711). The call is toll free. [MCP should edit “member services” as appropriate throughout to match the name MCP uses. MCP may also add additional contact information and information on resources available to the member, such as a member portal.] 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 [member services telephone number] (TTY [member services TTY number] or 711). The call is toll free.

Interpreter services

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

[English tagline]

[Arabic tagline]

[Armenian tagline]

[Chinese tagline][Eastern Punjabi tagline]

[Hindi tagline]

[Hmong tagline]

[Japanese tagline]

[Korean tagline]

[Laotian tagline]

[Mien Tagline]

[Mon-Khmer, Cambodian tagline]

[Persian (Farsi) tagline]

[Russian tagline]

[Spanish tagline]

[Tagalog tagline]

[Thai tagline]

[Ukrainian tagline]

[Vietnamese tagline]

Welcome to [MCP]!

Thank you for joining [MCP]. [MCP] is a health plan for people who have Medi-Cal. [MCP] works with the State of California to help you get the health care you need. [MCP can explain the relationship between MCP and Plan Partners and Individual Practice Association here. MCP may edit or add language throughout handbook sections where relationship distinctions, i.e., plan partners, medical groups, or independent practice associations, need to be made.]

Member Handbook

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

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. It is a summary of [MCP] rules and policies and based on the contract between [MCP] and Department of Health Care Services (DHCS). If you would like more information, call [MCP] at [member services telephone number] (TTY [member services TTY number] or 711).

Call [member services telephone number] (TTY [member services TTY number] or 711) to ask for a copy of the contract between [MCP] and DHCS. You may also ask for another copy of the Member Handbook at no cost to you or visit the [MCP] website at [MCP URL] to view the Member Handbook. You may also request, at no cost to you, a copy of the [MCP] non-proprietary clinical and administrative policies and procedures, or how to access this information on the [MCP] website.

Contact us

[MCP] is here to help. If you have questions, call [member services telephone number] (TTY [member services TTY number] or 711). [MCP] is here [days and hours of

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

operation]. The call is toll free.

You can also visit online at any time at [MCP URL].

Thank you,
[MCP]
[MCP address]

Table of contents

[MCPs may add heading levels in the Table of Contents to improve accessibility]

1. Getting started as a member

How to get help

[MCP] wants you to be happy with your health care. If you have any questions or concerns about your care, [MCP] wants to hear from you!

Member services

[MCP] member services is here to help you. [MCP] can:

- Answer questions about your health plan and 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
- [MCP may list other services offered.]

If you need help, call [member services telephone number] (TTY [member services TTY number] or 711). [MCP] is here [days and hours of operation]. The call is toll free. [MCP] must make sure that you wait less than 10 minutes when calling.

You can also visit online at any time at [MCP URL].

Who can become a member

You qualify for [MCP] because you qualify for Medi-Cal and live in [insert county in which the member lives or insert “one of these counties” plus counties]. [MCP should include applicable county contact information.] You may also qualify for Medi-Cal through Social Security because you are receiving SSI/SSP.

[COHS plans may remove this sentence and other references to Health Care Options

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

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

Transitional Medi-Cal

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

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

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

[MCPs may edit this section to align with how their county operates.]

Identification (ID) cards

As a member of [MCP], you will get a[n] [MCP] ID card. You must show your [MCP] ID card and your Medi-Cal Benefits Identification Card (BIC), that the State of California sent you, when you get any health care services or prescriptions. You should carry all health cards with you at all times. Here are sample BIC and [MCP] ID cards to show you what yours will look like:

[Insert picture of front and back of MCP ID card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).]

[MCP may add additional information about the MCP ID card.]

If you do not get your [MCP] ID card within a few weeks after your enrollment date, or if your card is damaged, lost or stolen, call member services right away. [MCP] will send you a new card at no cost to you. Call [member services telephone number] (TTY [member services TTY number] or 711).

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

2. About your health plan

Health plan overview

[MCP] is [a/the] health plan for people who have Medi-Cal in these counties: [list counties]. [MCP] works with the State of California to help you get the health care you need. [If MCP has excluded/carved out zip codes, MCP may replace with the following language – MCP covers most zip codes in [service areas] county/counties except [excluded zip codes].

[COHS MCPs may add language about how the member was enrolled into the plan automatically based on Medi-Cal eligibility in the COHS County.]

You may talk with one of the [MCP] member services representatives to learn more about the health plan and how to make it work for you. Call [member services telephone number] (TTY [member services TTY number] or 711).

When your coverage starts and ends

[MCP may edit this paragraph.] When you enroll in [MCP], we will send you an ID card within two weeks of your enrollment date. You must show your [MCP] ID card and your Medi-Cal Benefits Identification Card (BIC) when you get any health care services or prescriptions.

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

[MCP may insert other details for starting coverage.]

You may ask to end your [MCP] coverage and choose another health plan at any time.

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]).
[MCP] is here [days and hours of operation]. The call is toll free.
Or call the California Relay Line at 711. Visit online at [MCP URL].

For help choosing a new plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711). Or visit www.healthcareoptions.dhcs.ca.gov. You can also ask to end your Medi-Cal. [COHS plans may remove these sentences and other references to Health Care Options (HCO).]

[MCP] is [a/the] health plan for Medi-Cal members in [county]. Find your local office at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

[MCP] eligibility may end if any of the following is true:

- You move out of [list county or contract service area(s) applicable]
- You are in jail or prison
- You no longer have Medi-Cal
- [Non COHS and CCI plans remove this bullet] You are in a long-term care facility after the month of admission plus the next month
- [COHS plans must remove the next sentence about waiver programs.] If you become eligible for a waiver program that requires you to be enrolled in FFS Medi-Cal.

If you lose your [MCP] Medi-Cal coverage, you may still be eligible for Fee-for-Service (FFS) Medi-Cal coverage. If you are not sure if you are still covered by [MCP], please call [member services telephone number] (TTY [member services TTY number] or 711).

Special considerations for American Indians in managed care

[COHS plans in non-CCI counties should remove this paragraph.]

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

[COHS plans may adjust this language to fit model type.]

If you are an American Indian, you have the right to get health care services at Indian Health Care Provider (IHCP). You may also stay with or disenroll from [MCP] while getting health care services from these locations. For information on enrollment and disenrollment call [member services telephone number] (TTY [member services TTY number] or 711).

How your plan works

[MCP may adjust this language to fit model type.]

[MCP] is a managed care health plan contracted with DHCS. [MCP] works with doctors, hospitals, and other health care providers in the [MCP] service area to give health care to you, the member. While you are a member of [MCP], you may be eligible to get some additional services provided through FFS Medi-Cal. These include outpatient prescriptions, non-prescription drugs and some medical supplies through FFS Medi-Cal Rx.

[Member services] will tell you how [MCP] works, how to get the care you need, how to schedule provider appointments within standard access times, how to request no-cost interpreting services, and how to find out if you qualify for transportation services. [MCP should edit this list as appropriate.]

To learn more, call [member services telephone number] (TTY [member services TTY number] or 711). You can also find member service information online at [MCP URL].

Changing health plans

[COHS plans should remove this section.]

You may leave [MCP] and join another health plan in your county of residence at any time. Call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711) to choose a new plan. You can call between 8:00 a.m. and 6:00 p.m. Monday through Friday. Or visit https://www.healthcareoptions.dhcs.ca.gov/.

It takes up to 30 days to process your request to leave [MCP] and enroll in another plan in your county if there are no issues with the request. 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 [MCP] sooner, you may ask Health Care Options for an expedited (fast) disenrollment. If the reason for your request meets the rules for expedited disenrollment, you will get a letter to tell you that you are disenrolled.

Members who can request expedited disenrollment include, but are not limited to, children receiving 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.

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

You may ask to leave [MCP] in person at your local county health and human services office. Find your local office at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx. Or call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711). [MCP should insert other details for changing health plans.]

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

If you move to a new county in California to attend college, [MCP] will cover emergency room and urgent care services in your new county. Emergency services and urgent care are available to all Medi-Cal enrollees statewide regardless of county of residence. Routine and preventive care are covered only in your county of residence.

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

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

- Notify [MCP insert appropriate name of local county office] that you are temporarily moving to attend college and provide your address in the new county. The county will update the case records with your new address and county code in the State's database. Use this choice if you want to get routine or preventive care in your new county. You may have to change health plans if [MCP] does not operate in the county where you will attend college. [MCPs may add language about what counties they operating in.] For questions and to prevent any delay in enrolling in the new health plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

  OR

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

If you are leaving California temporarily to attend college in another state and you want

to keep your Medi-Cal coverage, contact your eligibility worker at [MCP insert appropriate name of local county office]. As long as you are eligible, Medi-Cal will cover emergency services and urgent care in another state. We will also cover emergency care that result in hospitalization in Canada and Mexico if the service is approved and the doctor and hospital meet Medi-Cal rules. Routine and preventive care services, including prescription drugs, are not covered outside of California. If you want Medicaid in another state, you will need to apply in that state. You will not be eligible for Medi-Cal and [MCP] will not pay for your health care.

Continuity of care

As a member of [MCP], you will get your health care from providers in [MCP] network. In some cases, you may be able to go to providers who are not in the [MCP] network. This is called continuity of care. Call the [MCP] and tell us if you need to see a provider that is out of network. We will tell you if you have continuity of care. You are able to use continuity of care, for up to 12 months, or more in some cases, if all of the following are true:

- You have an ongoing relationship with the non-plan provider, prior to enrollment in [MCP]
- The non-plan provider is willing to work with [MCP] and agrees to [MCP's] requirements
- You were seen by the non-plan provider at least once during the twelve (12) months prior to your enrollment with [MCP] for a non-emergency visit
- You were seen by the non-plan provider at least once during the six (6) months prior to the transition of services from a Regional Center to [MCP]
- [MCP] does not have a documented quality of care concern with the non-plan provider

If your providers do not join the [MCP] network by the end of 12 months, do not agree to [MCP] payment rates or do not meet quality of care requirements, you will need to switch to providers in the [MCP] network or call member services at [MCP member services telephone number] (TTY [MCP TTY number] or 711) to discuss your options.

Providers who leave [MCP] or non-plan providers

If you are being treated by a provider for certain health conditions who is not a [MCP] provider or your provider stops working with [MCP], you may be able to keep getting services from that provider. This is another form of continuity of care. Services [MCP] provides for continuity of care include but are not limited to:

- Acute conditions (a medical issue that needs fast attention) – for as long as the condition lasts.
- Chronic physical and behavioral conditions (a medical issue you have for a long time) – for an amount of time required to finish the course of treatment and to arrange for a safe transfer to a new doctor in the [MCP] network.
- Pregnancy – during the pregnancy and the immediate postpartum period.
- Maternal mental health services
- Care of a newborn child between birth and age 36 months for up to 12 months from the start date of the coverage or the date the provider's contract ends with [MCP].
- Terminal illness (a life threatening medical issue) – for as long as the illness lasts. Completion of covered services may exceed twelve (12) months from the time the provider stops working with [MCP].
- Performance of a surgery or other medical procedure from a non-plan provider as long as it is covered, medically necessary and is authorized by [MCP] as part of a documented course of treatment and has been recommended and documented by the provider – surgery or other medical procedure to take place within 180 days of the provider's contract termination date or 180 days from the effective date of coverage of a new member.

For other conditions that may qualify, contact [MCP member services]

If the non-plan provider is not willing to continue to provide services, does not agree on payment or other terms for providing care, then you will not be able to receive continued care from the provider. Call member services at [MCP member services telephone number] (TTY [MCP TTY number] or 711) for help selecting a contracted provider to continue with your care or if you have any questions or problems in receiving covered services from a provider who is no longer part of [MCP].

[MCP] is not required to provide continuity of care for services not covered by Medi-Cal, durable medical equipment, transportation, other ancillary services and carved-out service providers. To learn more about continuity of care and eligibility qualifications,

and to hear about all available services, call [member services].

Costs

Member costs

[MCP may adjust this language to fit model type and the CCHIP county language if does not apply to MCP.]

[MCP] serves people who qualify for Medi-Cal. In most cases, [MCP] members do **not** have to pay for covered services, premiums or deductibles. Members enrolled in California Children's Health Insurance Program (CCHIP) in Santa Clara, San Francisco and San Mateo counties and members in the Medi-Cal for Families Program may have a monthly premium and copayments. Except for emergency care, urgent care or sensitive care, you must get pre-approval from [MCP] before you see a provider outside the [MCP] network. If you do not get pre-approval and you go to a provider outside of the network for care that is not emergency care, urgent care or sensitive care, you may have to pay for care from providers who are out of the network. For a list of covered services, go to "Benefits and services."

For members with long term care and a share of cost

You may have to pay a share of cost each month for your long-term care services. The amount of your share of cost depends on your income and resources. Each month you will pay your own medical bills, including but not limited to Managed Long Term Support Service (MLTSS) bills, until the amount that you have paid equals your share of cost. After that, your long-term care will be covered by [MCP] for that month. You will not be covered by [MCP] until you have paid your entire long-term care share of cost for the month.

How a provider gets paid

[MCP] pays providers in these ways:

- Capitation payments
  - [MCP] pays some providers a set amount of money every month for each [MCP] member. This is called a capitation payment. [MCP] and providers work together to decide on the payment amount.

- FFS payments
  - Some providers give care to [MCP] members and then send [MCP] a bill for the services they provided. This is called a FFS payment. [MCP] and providers work together to decide how much each service costs.
- [MCP should insert other ways they pay providers.]

To learn more about how [MCP] pays providers, call [member services telephone number] (TTY [member services TTY number] or 711).

[MCP should insert any provider incentive programs here.]

Asking [MCP] to pay a bill

Covered services are health care services that [MCP] is responsible to pay for. If you get a bill for support services fees, copays or registration fees for a covered service, do not pay the bill. Call member services right away at [member services telephone number] (TTY [member services TTY number] or 711).

Asking [MCP] to pay you back for expenses

If you paid for services you already received and you want [MCP] to reimburse you (pay you back), you must meet **all** of the following conditions:

- The service you received is a covered service that [MCP] is responsible to pay for. [MCP] will not reimburse you for a service that is not covered by either Medi-Cal or [MCP].
- You received the covered service after you became an eligible [MCP] member.
- You ask to be paid back within one year from the date you received the covered service.
- You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
- You received the covered service from a Medi-Cal enrolled provider in [MCP]'s network. You do not need to meet this condition if you received emergency services, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval.
- If the covered service normally requires pre-approval, you provide proof from the provider that shows a medical need for the covered service.

[MCP] will tell you of its decision to reimburse you in a letter called a Notice of Action. 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, [MCP] will pay you back for the full amount you paid. If the provider is enrolled in Medi-Cal, but is not in the [MCP] network and refuses to pay you back, [MCP] will pay you back, but only up to the amount that FFS Medi-Cal would pay. [MCP] 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. If you do not meet one of the above conditions, [MCP] will not pay you back.

[MCP] will not pay you back if:

- You asked for and received services that 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 asked to be paid back for co-pays for prescriptions covered by your Medicare Part D plan.

[MCP may add information in this section on the process for filing a claim.]

3. How to get care

Getting health care services

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

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

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

You may choose the same PCP or different PCPs for all family members in [MCP], as long as the PCP is available.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in the Provider Directory. It has a list of all PCPs in the [MCP] network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call [member services telephone number] (TTY [member services TTY number] or 711). You can also find the Provider Directory on the [MCP] website at [MCP URL].

If you cannot get the care you need from a participating provider in the [MCP] network, your PCP must ask [MCP] for approval to send you to an out-of-network provider. This is called a referral. You do not need approval to go to an out-of-network provider to get sensitive services that are described 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.

Pharmacy benefits are now administered through the Fee-For-Service (FFS) Medi-Cal Rx program. To learn more, read the "Other Medi-Cal programs and services" section in Chapter 4.

Primary care provider (PCP)

[MCP may edit this section to fit their policies, procedures and model type.]

You must choose a PCP within 30 days of enrolling in [MCP]. Depending on your age and sex, you may choose a general practitioner, OB/GYN, family practitioner, internist or pediatrician as your primary care provider (PCP). A nurse practitioner (NP), physician assistant (PA) or certified nurse midwife may also act as your PCP. If you choose an NP, PA or certified nurse midwife, you may be assigned a doctor to oversee your care. 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.

[MCP should edit this sentence as appropriate.] 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 may be able to choose one PCP for your entire family who are members of [MCP], as long as the PCP is available.

Note: American Indians may choose an IHCP as their PCP, even if the IHCP is not in the [MCP] network.

If you do not choose a PCP within 30 days of enrollment, [MCP] will assign you to a PCP. If you are assigned to a PCP and want to change, call [member services telephone number] (TTY [member services TTY number] or 711). The change happens the first day of the next month.

Your PCP will:

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

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

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

You can find the [MCP] Provider Directory online at [MCP URL]. Or you can request a Provider Directory to be mailed to you by calling [member services telephone number] (TTY [member services TTY number] 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 [MCP] 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 [member services telephone number] (TTY [member services TTY number] or 711) [MCPs may add other means for the member to change their PCP such as website/member portal].

[MCP] may ask you to change your PCP if the PCP is not taking new patients, has left the [MCP] network or does not give care to patients your age. [MCP] or your PCP may also ask you to change to a new PCP if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If [MCP] needs to change your PCP, [MCP] will tell you in writing.

If your PCP changes, you will get a new [MCP] 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. [MCP should edit this paragraph as appropriate.]

Some things to think about when picking a PCP [MCP may edit list]:

- 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 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 that I like?
- Does the PCP provide the services that I may need?
- Do the PCP's office hours fit my schedule?

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

Initial health assessment (IHA)

[MCP] recommends that, as a new member, you visit your new PCP within the first 120 days for an initial health assessment (IHA). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP may ask you some questions about your health history or may ask you to complete a questionnaire. Your PCP will also tell you about health education counseling and classes that may help you.

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

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

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

If you have questions about IHA, call [member services telephone number] (TTY [member services TTY number] 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 checkups and health education and counseling. Children are able to receive much needed early preventive services like hearing and vision screening, assessments of developmental process and many more services that are recommended by pediatricians' Bright Futures guidelines. In addition to preventive care, routine care also includes care when you are sick. [MCP] covers routine care from your PCP.

Your PCP will:

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

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

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]).
[MCP] is here [days and hours of operation]. The call is toll free.
Or call the California Relay Line at 711. Visit online at [MCP URL].

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

All [MCP] 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 [MCP] what you need.

Provider network

[MCP to insert information here related to the delegated model and associated usage restrictions if the MCP follows a delegated model.] The provider network is the group of doctors, hospitals and other providers that work with [MCP]. You will get most of your covered services through the [MCP] network.

Note: American Indians may choose an IHCP as their PCP, even if the IHCP is not in the [MCP] 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 [member services telephone number] (TTY [member services TTY number] or 711). For more about moral objections, read the “Moral objection” section later in this chapter.

If your provider has a moral objection, they can help you find another provider who will give you the services you need. [MCP] can also help you find a provider who will perform the service.

In network providers

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

To get a Provider Directory of network providers, call [member services telephone number] (TTY [member services TTY number] or 711). You can also find the Provider Directory online at [MCP URL]. To get a copy of the Contract Drug List, call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711). Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

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

Except for emergency care or sensitive care, you must get pre-approval from [MCP] before you see a provider outside the [MCP] network. If you do not get pre-approval and you go to a provider outside of the network for care that is not emergency care or sensitive care, you may have to pay for care from providers who are out-of-network.

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

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

[MCP] 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.

You must get pre-approval (prior authorization) before you go to an out-of-network provider inside the [MCP] service area except for emergency care and sensitive care. For urgent care inside the [MCP] service area, you must see a [MCP] network provider. You do not need pre-approval to get urgent care from a network provider. If you do not get pre-approval, you may have to pay for the urgent care you get from out-of-network provider inside the [MCP] service area. For more information on emergency care, urgent care and sensitive care services, go to those headings 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.

If you need help with out-of-network services, call [member services telephone number] (TTY [member services TTY number] or 711).

Outside the service area

If you are outside of the [MCP] service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call [member services telephone number] (TTY [member services TTY number] or 711). [MCP may add information here to define plan's service area.]

For emergency care, call **911** or go to the nearest emergency room. [MCP] covers out-of-network emergency care. If you travel to Canada or Mexico and need emergency services requiring hospitalization, [MCP] will cover your care. If you are traveling

internationally outside of Canada or Mexico and need emergency care, [MCP] will **not** cover your care.

If you pay for emergency services requiring hospitalization in Canada or Mexico, you can ask [MCP] to pay you back. [MCP] will review your request.

If you are in another State, including US territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the US Virgin Islands), you are covered for emergency care, but not all hospitals and doctors accept Medicaid (Medicaid is what Medi-Cal is called in other States). If you need emergency care outside of California, tell the hospital or emergency room doctor that you have Medi-Cal and are a [MCP] member as soon as possible. Ask the hospital to make copies of your [MCP] ID card. Tell the hospital and the doctors to bill [MCP]. If you get a bill for services you received in another State, call [MCP] immediately. We will work with the hospital and/or doctor to arrange for [MCP] to pay for your care.

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

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

[MCP should include the following paragraph if participating in the Whole Child Model program.]

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

If you have questions about out-of-network or out-of-service-area care, call [member services telephone number] (TTY [member services TTY number] or 711). If the office is closed and you want help from a representative, call [nurse line/triage services telephone number].

[Delegated Model MCPs]

[MCP to insert information here related to the delegated model and associated usage restrictions if the MCP follows a delegated model.]

Doctors

You will choose your doctor to be your primary care provider (PCP) from the [MCP] Provider Directory. The doctor you choose must be a network provider. To get a copy of the [MCP] Provider Directory, call [member services telephone number] (TTY [member services TTY number] or 711). Or find it online at [MCP URL].

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

If you had a doctor before you were a member of [MCP], and that doctor is not part of the [MCP] network, you may be able to keep that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call [member services telephone number] (TTY [member services TTY number] or 711).

If you need a specialist, your PCP will refer you to a specialist in the [MCP] network.

Remember, if you do not choose a PCP, [MCP] will choose one for you. 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.

If you want to change your PCP, you must choose a PCP from the [MCP] Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call [member services telephone number] (TTY [member services TTY number] or 711) [MCPs may add other means for members to change PCP such as website/member portal].

Hospitals

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

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

Women's health specialists

You may go to a women's health specialist within [MCP] network for covered care necessary to provide women's routine and preventive health care services. You do not need a referral from your PCP to get these services. For help finding a women's health specialist, you can call [member services telephone number] (TTY [member services TTY

number] or 711). You may also call the 24/7 [nurse line or triage services telephone number]. [MCP may add other resources or means of contacting the MCP here.]

Provider Directory

The [MCP] Provider Directory lists providers that participate in the [MCP] network. The network is the group of providers that work with [MCP].

The [MCP] Provider Directory lists hospitals, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, Federally Qualified Health Centers (FQHCs), outpatient mental health providers, managed long-term services and supports (MLTSS), Freestanding Birth Centers (FBCs), Indian Health Care Providers (IHCPs) and Rural Health Clinics (RHCs). [MCP should edit this list, as appropriate, to provide a comprehensive list of providers.]

The Provider Directory has [MCP] network provider names, specialties, addresses, phone numbers, business hours and languages spoken. It tells if the provider is taking new patients. It also gives the level of physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars. If you want information about a doctor's education, training, and board certification, please call [member services telephone number] (TTY [member services TTY number] or 711).

You can find the online Provider Directory at [MCP URL].

If you need a printed Provider Directory, call [member services telephone number] (TTY [member services TTY number] 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 800-977-2273 and press 5 or 711).Timely access to care

Your provider must offer you an appointment within the time frames listed below.

Sometimes waiting longer for care is not a problem. Your provider may give you a longer wait time if it would not be harmful to your health. If must be noted in your record that a longer wait time will not be harmful to your health.

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

Travel time or distance to care

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

If [MCP] is not able to provide care to you within these travel time or distance standards, DHCS may approve a different standard, called an alternative access standard. For [MCP]'s time or distance standards for where you live, visit [insert link to MCP's website]. Or call [member services telephone number] (TTY [member services TTY number] or 711).

If you need care from a provider and that provider is located far from where you live, call member services at [member services telephone number] (TTY [member services TTY number] or 711). They can help you find care with a provider located closer to you. If [MCP] cannot find care for you with a closer provider, you can ask [MCP] 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, please call Medi-Cal Rx at

800-977-2273 (TTY 800-977-2273 and press 5 or 711).

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

Appointments

When you need health care [MCPs may add to the list below]:

- Call your PCP
- Have your [MCP] ID number ready on the call
- Leave a message with your name and phone number if the office is closed
- Take your BIC and [MCP] ID card to your appointment
- Ask for transportation to your appointment, if needed
- Ask for language assistance or interpreting services, if needed
- Be on time for your appointment, arriving 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 in case you need them

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

Getting to your appointment

If you don't have a way to get to and from your health care services and appointments, we can help arrange transportation for you. Transportation help is available for services and appointments that are not related to emergency services and you may be able to get a free ride. This service, called medical transportation, is **not** for emergencies. If you are having an emergency, call **911**.

Go to the section "Transportation benefits" for more information.

Canceling and rescheduling

If you can't make your appointment, call your provider's office right away. Most doctors ask you to call 24 hours (1 business day) before your appointment if you have to cancel.

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

If you miss repeated appointments, your doctor may not want to see you as a patient anymore.

Payment

You do **not** have to pay for covered services. In most cases, you will not get a bill from a provider. You must show your [MCP] ID card and your Medi-Cal BIC when you get any health care services or prescriptions so your provider knows who to bill. You may get an Explanation of Benefits (EOB) or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call [member services telephone number] (TTY [member services TTY number] or 711). If you get a bill for prescriptions, call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711). Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/. Tell [MCP] the amount charged, the date of service and the reason for the bill. You are **not** responsible to pay a provider for any amount owed by [MCP] for any covered service. You must get pre-approval (prior authorization) before you go to an out-of-network provider, except for emergency care or sensitive care and urgent care (within the [MCP] service area).

If you do not get pre-approval, you may have to pay for care from providers who are not in the network. If you need covered health care services, you may be able to get them at an out-of-network provider at no cost to you, as long as they are medically necessary, not available in the network and pre-approved by [MCP]. For more information about emergency care, urgent care, and sensitive services, go to those headings in this chapter.

[If MCP does not use a claim form, MCP may adjust paragraph to explain how to submit a request to pay a bill/get reimbursed.] If you get a bill or are asked to pay a co-pay that you think you did not have to pay, call [member services telephone number] (TTY [member services TTY number] or 711). If you pay the bill, you can file a claim form with [MCP]. You will need to tell [MCP] in writing why you had to pay for the item or service. [MCP] will read your claim and decide if you can get money back. For questions or to ask for a claim form, call [member services telephone number] (TTY [member services TTY number] or 711). [MCP may add other resources or means of contacting the MCP here.]

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

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free.
Or call the California Relay Line at 711. Visit online at [MCP URL].

[MCP] will not pay you back if:

- You asked for and received services that 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 asked to be paid back for co-pays for prescriptions covered by your Medicare Part D plan.

Referrals

[MCP may add to this section to reflect its own policies and procedures.]

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

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

Your PCP may give you a form to take to the specialist. The specialist will fill out the form and send it back to your PCP. The specialist will treat you for as long as they think you need treatment. [MCP may edit this paragraph if referral processes are different.]

If you have a health problem that needs special medical care for a long time, you may need a standing referral. This means you can 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 [MCP] referral policy, call [member services telephone number] (TTY [member services TTY number] 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 Office of Family Planning Information and Referral Service at 1-800-942-1054)

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

- HIV testing and counseling (12 years or older)
- Sexually transmitted infection services (12 years or older)
- Chiropractic services (a referral may be required when provided by out-of-network FQHCs, RHCs and IHCPs)
- Initial mental health assessment
- [MCP should insert other services that do not require referral.]

Minors can also get certain outpatient mental health services, sensitive services and substance use disorder services without parent's consent. For more information read "Minor consent services" and "Substance use disorder treatment services" in this handbook.

Ready to quit smoking? Call English: 1-800-300-8086 or Spanish: 1-800-600-8191 to find out how. Or go to www.kickitca.org.

Pre-approval (prior authorization)

For some types of care, your PCP or specialist will need to ask [MCP] for permission before you get the care. This is called asking for prior authorization, prior approval, or pre-approval. It means that [MCP] must make sure that the care is medically necessary or 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 the age of 21, Medi-Cal services includes 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 [MCP] network:

- Hospitalization, if not an emergency
- Services out of the [MCP] service area, if not an emergency or urgent
- Outpatient surgery
- Long-term care at a nursing facility
- Specialized treatments
- Medical transportation services when it is not an emergency. Emergency

ambulance services do not require pre-approval.

- [Plans may insert additional services that may require prior authorization]

Under Health and Safety Code Section 1367.01(h)(1), [MCP] will decide routine pre-approvals (prior authorizations) within 5 working days of when [MCP] gets the information reasonably needed to decide.

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

Pre-approval (prior authorization) requests are reviewed by clinical or medical staff, such as doctors, nurses and pharmacists.

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

[MCP] will contact you if [MCP] needs more information or more time to review your request.

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

For questions about pre-approval (prior authorization), call [member services telephone number] (TTY [member services TTY number] 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 may want a second opinion if you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan and it has not worked.

If you want to get a second opinion, we will refer you to a qualified network provider who can give you a second opinion. For help choosing a provider, call [member services telephone number] (TTY [member services TTY number] or 711).

[MCP] will pay for a second opinion if you or your network provider asks for it and you get the second opinion from a network provider. You do not need permission from [MCP] to get a second opinion from a network provider. However, if you need a referral, your network provider can help you get a referral for a second opinion if you need one.

If there is no provider in the [MCP] network to give you a second opinion, [MCP] will pay for a second opinion from an out-of-network provider. [MCP] 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 face an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, [MCP] will tell you in writing within 72 hours.

If [MCP] denies your request for a second opinion, you may file a grievance. To learn more about grievances, go to the “Complaints” heading in the Chapter titled “Reporting and Solving Problems” in this handbook.

Sensitive care

Minor consent services

You may only get the following services without your parent or guardian’s permission if you are 12 years old or older:

- Outpatient mental health care for (minors age 12 or older):
  - Sexual assault (no lower age limit)
  - Incest
  - Physical assault
  - Child abuse
  - When you have thoughts of hurting yourself or others (minors age 12 or older)
- HIV/AIDS prevention/testing/treatment
- Sexually transmitted infections prevention/testing/treatment
- Substance use disorder treatment services (minors age 12 or older). For more information see “Substance use disorder treatment services” in this handbook.

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

- Pregnancy
- Family planning/birth control (including sterilization)
- Abortion services

For pregnancy testing, family planning services, birth control, or sexually transmitted infection services, the doctor or clinic does not have to be part of the [MCP] 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 not related to sensitive care may not be covered. For help finding a doctor or clinic giving these services, or for help getting to these services (including transportation), you can call [member services telephone number] (TTY [member services TTY number] or 711).

Minors can talk to a representative in private about their health concerns by calling the 24/7 [nurse line/triage services telephone number].

Adult sensitive services

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

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

The doctor or clinic does not have to be part of the [MCP] network. You can choose any provider and go to them without a referral or pre-approval (prior authorization) for these services. Services from an out-of-network provider not related to sensitive care may not be covered. For help finding a doctor or clinic giving these services, or for help getting to these services (including transportation), you can call [member services telephone number] (TTY [member services TTY number] or 711). You may also call the 24/7 [nurse line/triage services telephone number].

Moral objection

Some providers have a moral objection to some covered services. This means they have a right to **not** offer some covered services if they morally disagree with the services. If your provider has a moral objection, they will help you find another provider for the needed services. [MCP] can also work with you to find a provider.

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free.
Or call the California Relay Line at 711. Visit online at [MCP URL].

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

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

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call [MCP] **at [member services telephone number] (TTY [member services TTY number] or 711) to ensure that you can obtain the health care services that you need.**

These services are available and [MCP] must ensure you or your family member sees a provider or is admitted to a hospital that will perform the covered services. Call [MCP] at [member services telephone number] (TTY [member services TTY number] or 711) if you have questions or need help finding a provider.

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) and are available within 48 hours of your request for an appointment. If the urgent care services you need require a pre-approval, you will be offered an appointment within 96 hours of your request.

For urgent care, call your PCP. If you cannot reach your PCP, call [member services telephone number] (TTY [member services TTY number] or 711). Or you can call [nurse line/triage services telephone number], to learn the level of care that is best for you. [MCP may add information about the 24/7 nurse line/triage services here.]

If you need urgent care out of the area, go to the nearest urgent care facility. Urgent care needs could be a cold, sore throat, fever, ear pain, sprained muscle or maternity services. You do not need pre-approval (prior authorization). If you need mental health urgent care, call your county mental health plan or Member Services at [member services telephone number] (TTY [member services TTY number] or 711). You may call your county mental health plan or your [MCP] Behavioral Health Organization any time,

24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, visit http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Emergency care

For emergency care, call **911** or go to the nearest emergency room (ER). For emergency care, you do **not** need pre-approval (prior authorization) from [MCP]. You have the right to use any hospital or other setting for emergency care, including in Canada and Mexico. Emergency care and other care in other countries are not covered.

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, you would place your health (or your unborn baby's health) in serious danger, or you risk serious harm to your body functions, body organ or body part. 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. If you are not sure if your medical condition is an emergency, call your PCP. You may also call the 24/7 [nurse line/triage services] at [nurse line/triage services telephone number].

If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in the [MCP] network. If you go to an ER, ask them to call [MCP]. You or the hospital to which you were admitted should call [MCP] within 24 hours after you get emergency care. If you are traveling outside the U.S., other than to Canada or Mexico, and need emergency care, [MCP] will **not** cover your care.

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

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

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

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

> **[MCP] Nurse Advice Line gives you free medical information and advice 24 hours a day, every day of the year. Call [MCP advice line number] (TTY [Nurse advice TTY number] or 711).**

Nurse advice line [MCPs may edit term Nurse Advice Line to appropriate term used by MCP]

[MCP] Nurse advice line gives you free medical information and advice 24 hours a day, every day of the year. Call [MCP advice line number] (TTY [Nurse advice TTY number] or 711) to:

- Talk to a nurse who will answer medical questions, give care advice, and help you decide if you should see 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

[MCPs may edit this sentence if advice line is able to help with appointments and/or refills.] The Nurse advice line **cannot** help with clinic appointments or medication refills. Call your provider's office if you need help with these.

Advance directives

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

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free.
Or call the California Relay Line at 711. Visit online at [MCP URL].

You can get an advance directive form at pharmacies, hospitals, law offices and doctors' offices. You may 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. [MCP] will tell you about changes to the state law no longer than 90 days after the change.

You can call [MCP] at [member services telephone number] for more information.

Organ and tissue donation

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

4. Benefits and services

What your health plan covers

This chapter explains your covered services as a member of [MCP]. Your covered services are free as long as they are medically necessary and provided by an in-network provider. You must ask us for pre-approval (prior authorization) if the care is out-of-network except for sensitive services, emergencies and some urgent care services. Your health plan may cover medically necessary services from an out-of-network provider. But you must ask [MCP] 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 reduces 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 details on your covered services, call [member services telephone number] (TTY [member services TTY number] or 711).

Members under 21 years old get extra benefits and services. Read Chapter 5: Child and youth well care for more information.

Some of the basic health benefits [MCP] offers are listed below. Benefits with a star (*) may need pre-approval. [MCP may edit the bulleted list and prior authorization/pre-approval designation as appropriate.]

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

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

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

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

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

Medically necessary services do not include:

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

[MCP] will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not [MCP].

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; and
- Attain, maintain, and regain functional capacity.

For Members less than 21 years of age, medically necessary services include all covered services, identified above, and any other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions, as required by the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

EPSDT provides a broad range of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. The EPSDT benefit is more robust than the benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

[MCP] will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not [MCP].

Medi-Cal benefits covered by [MCP]

Outpatient (ambulatory) services

Adult immunizations

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

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

Allergy care

[MCP] covers allergy testing and treatment, including allergy desensitization, hypo-sensitization or immunotherapy.

Anesthesiologist services

[MCP] covers anesthesia services that are medically necessary when you get outpatient care. This may include anesthesia for dental procedures when provided by a medical anesthesiologist.

Chiropractic services

[MCP may edit language allowing for more than two services per month and/or not in combination with other services] [MCP] covers chiropractic services, limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to two services per month in combination with acupuncture, audiology, occupational therapy and speech therapy services (limits do not apply to children under age 21). [MCP] may pre-approve other services as medically necessary.

The following members are eligible for chiropractic services:

- Children under age 21
- Pregnant women through the end of the month that includes 60-days following the end of a pregnancy
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility
- All members when services are provided at county hospital outpatient departments, outpatient clinics, FQHCs or RHCs that are in the [MCP]'s network. Not all FQHCs, RHCs or county hospitals offer outpatient chiropractic services.

Dialysis and hemodialysis services

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

Outpatient surgery

[MCP] covers outpatient surgical procedures. Those needed for diagnostic purposes, procedures considered to be elective, and specified outpatient medical procedures must have pre-approval (prior authorization). [MCP may adjust language if outpatient surgery is not subject to prior authorizations.]

Physician services

[MCP] covers physician services that are medically necessary.

Podiatry (foot) services

[MCP] covers podiatry services as medically necessary for diagnosis and medical, surgical, mechanical, manipulative and electrical treatment of the human foot. This includes the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg controlling the functions of the foot.

Treatment therapies

[MCP] covers different treatment therapies, including:

- Chemotherapy
- Radiation therapy

Maternity and newborn care

[MCP] covers these maternity and newborn care services:

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

Telehealth services

Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider. Or telehealth may involve sharing information with your provider without a live conversation. You can receive many services through telehealth. However, telehealth may not be available for all covered services. You can contact your provider to learn which types of services may be available through telehealth. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. You have the right to in-person services and are not required to use telehealth even if your provider agrees that it is appropriate for you.

Mental health services

Outpatient mental health services

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

Your PCP or mental health provider may make a referral for additional mental health screening to a specialist within the [MCP] network to determine your level of impairment. If your mental health screening results determine you are in mild or moderate distress or have impairment of mental, emotional or behavioral functioning, [MCP] can provide mental health services for you. [MCP] covers mental health services such as:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purposes of monitoring medication therapy
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation
- Family Therapy

For help finding more information on mental health services provided by [MCP], call [member services telephone number] (TTY [member services TTY number] or 711).

If your mental health screening results determine you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider will refer you to the county mental health plan to get an assessment. To learn more, read “Other Medi-Cal programs and services” on page [MCP insert page number].

Emergency services

Inpatient and outpatient services needed to treat a medical emergency

[MCP] covers all services that are needed to treat a medical emergency that happens in the U.S. (including territories such as Puerto Rick, U.S. Virgin Islands, etc.) or requires you to be in a hospital in Canada or Mexico. A medical emergency is a medical

condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent layperson could expect it to result in:

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

If a hospital emergency room gives you up to a 72-hour supply of an outpatient prescription drug as part of your treatment, the prescription drug will be covered 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 be responsible for the coverage of that prescription.

If a pharmacist at an outpatient pharmacy gives you an emergency supply of a medication, that emergency supply will be covered by Medi-Cal Rx and not [MCP]. Have the pharmacy call Medi-Cal Rx at 800-977-2273 if they need help in giving you an emergency medication supply.

Emergency transportation services

[MCP] covers ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico. If you receive emergency ambulance services in Canada and Mexico and you are not hospitalized during that episode of care, your ambulance services will not be covered by [MCP].

Hospice and palliative care

[MCP] covers hospice care and palliative care for children and adults, which help reduce physical, emotional, social and spiritual discomforts. Adults age 21 years or older may not receive both hospice care and palliative care services at the same time.

Hospice care

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

Hospice care includes:

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

Palliative care

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

Palliative care includes:

- Advance care planning
- Palliative care assessment and consultation
- Plan of care including, but not limited to:
  - A doctor of medicine or osteopathy
  - A physician assistant
  - A registered nurse
  - A licensed vocational nurse or nurse practitioner
  - A social worker

    - A chaplain
- Care coordination
- Pain and symptom management
- Mental health and medical social services

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

Hospitalization

Anesthesiologist services

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

Inpatient hospital services

[MCP] covers medically necessary inpatient hospital care when you are admitted to the hospital.

Surgical services

[MCP] covers medically necessary surgeries performed in a hospital.

The Provisional Postpartum Care Extension Program

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

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

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

Rehabilitative and habilitative (therapy) services and devices

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

The plan covers:

Acupuncture

[MCP may edit language allowing for more than two services per month and/or not in combination with other services] [MCP] covers acupuncture services to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of needles) are limited to two services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services when provided by a physician, dentist, podiatrist or acupuncturist (limits do not apply to children under age 21). [MCP] may pre-approve (prior authorize additional services as medically necessary.

Audiology (hearing)

[MCP may edit language allowing for more than two services per month and/or not in combination with other services] [MCP] covers audiology services. Outpatient audiology is limited to two services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services (limits do not apply to children under age 21). [MCP] may pre-approve (prior authorize) additional services as medically necessary.

Behavioral health treatments

[MCP] covers behavioral health treatment (BHT) services for members under 21 years of age through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. BHT includes services and treatment programs, such as applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual 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 and are not experimental. Examples of BHT services include behavioral interventions, cognitive behavioral intervention packages, comprehensive behavioral treatment and applied behavioral analysis.

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

Cardiac rehabilitation

[MCP] covers inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment (DME)

[MCP] covers the purchase or rental of DME supplies, equipment and other services with a prescription from a doctor, physician assistants, nurse practitioners, and clinical nurse specialists. Prescribed DME items may be covered as medically necessary to preserve bodily functions essential to activities of daily living or to prevent major physical disability.

Generally, [MCP] does not cover the following:

- Comfort, convenience or luxury equipment, features and supplies, except for retail-grade breast pumps as described under “Breast pumps and supplies” under the heading “Maternity and newborn care in this chapter
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional 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 (however diabetes blood 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 primarily for health care

However, in some cases, these items may be approved with Prior Authorization (Pre-Approval) submitted by your doctor.

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 and parenteral nutrition products are covered through Medi-Cal Rx, when medically necessary.

Hearing aids

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

Hearing aids for Members under age 21

State law requires children who need hearing aid to be referred to the California Children's Services (CCS) program to determine if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for medically necessary hearing aids. If the child is not eligible for CCS, we will cover medically necessary hearing aids as part of Medi-Cal coverage.

Hearing aids for Members age 21 and older

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

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

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

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

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

- Replacement hearing aid batteries

Home health services

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

Home health services are limited to services that Medi-Cal covers such as:

- Part-time skilled nursing care
- Part-time home health aide
- Medical social services
- Medical supplies

Medical supplies, equipment and appliances

[MCP] covers medical supplies that are prescribed by doctor physician assistants, nurse practitioners, and clinical nurse specialists. Some medical supplies are covered through FFS Medi-Cal Rx and not [MCP].

Medi-Cal coverage does not include the following:

- 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 which are regularly and primarily used by persons who do not have a specific medical need for them.

Occupational therapy

[MCP may edit language allowing for more than two services per month and/or not in combination with other services] [MCP] covers occupational therapy services, including

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

Orthotics/prostheses

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

Ostomy and urological supplies

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

Physical therapy

[MCP] covers medically necessary physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services and application of topical medications.

Pulmonary rehabilitation

[MCP] covers pulmonary rehabilitation that is medically necessary and prescribed by a doctor.

Skilled nursing facility services

[MCP may need to adjust this information based on plan type.] [MCP] covers skilled nursing facility services as medically necessary if you are disabled and need a high level of care. These services include room and board in a licensed facility with skilled nursing care on a 24-hour per day basis.

Speech therapy

[MCP may edit language allowing for more than two services per month and/or not in combination with other services] [MCP] covers speech therapy that is medically

necessary. Speech therapy services are limited to two services per month, in combination with acupuncture, audiology, chiropractic and occupational therapy services (limits do not apply to children under age 21). [MCP] may pre-approve (prior authorize) additional services as medically necessary.

Transgender services

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

Clinical trials

[MCP] covers routine patient care costs for patients accepted into Phase I, Phase II, Phase III or Phase IV clinical trials if it is related to the prevention, detection or treatment of cancer or other life-threatening conditions and if the study is conducted by the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS). Studies must be approved by the National Institutes of Health, the FDA, the Department of Defense or the Veterans Administration. Medi-Cal Rx, a Medi-Cal FFS program, covers most outpatient prescription drugs. Read the “Outpatient prescription drugs” section later in this chapter for more information.

Laboratory and radiology services

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

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- American Academy of Pediatrics Bright Futures recommendations
- Preventive services for women recommended by the American College of Obstetricians and Gynecologists
- Help to quit smoking, also called smoking cessation services
- United States Preventive Services Task Force Grade A and B recommended

preventive services

Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the FDA. [MCP]'s PCP and OB/GYN specialists are available for family planning services.

For family planning services, you may also choose a Medi-Cal doctor or clinic not connected with [MCP] without having to get pre-approval (prior authorization) from [MCP]. Services from an out-of-network provider not related to family planning may not be covered. To learn more, call [member services telephone number] (TTY [member services TTY number] or 711).

Read Chapter 5: Child and youth well care for preventive care information for youth 20 years old and younger.

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program. It is designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The program lasts one year. It can last for a second year for members who qualify. The program-approved lifestyle supports and 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 program eligibility requirements to join DPP. Call [MCP] to learn more about the program and eligibility. [MCP may edit last sentence to change contact to the vendor if appropriate.]

Reconstructive services

[MCP] 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, disease, or breast reconstruction after a mastectomy. Some limitations and exceptions may apply.

Substance use disorder screening services

The plan covers [MCPs may add covered services to list]:

- Alcohol misuse screenings and illicit-drug screenings

See “Substance use disorder treatment services” later in this chapter for treatment coverage through the county.

Vision benefits

The plan covers [MCPs may add covered services to list]:

- Routine eye exam once every 24 months; Additional or more frequent eye exams are covered if medically necessary for members, such as those with diabetes.
- Eyeglasses (frames and lenses) once every 24 months; when you have a valid prescription.
- Replacement eyeglasses within 24 months if you have a change in prescription 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 for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine, or surgery that interferes with a person’s ability to perform everyday activities (i.e., age-related macular degeneration).
- Medically necessary Contact Lenses
  Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (i.e., missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keracotonus.

[MCPs may add language explaining what to do if Member loses/breaks glasses or prescription changes and coverage limits for eyeglasses/contact lenses.]

Transportation benefits for situations that are not emergencies

You are entitled to medical transportation if you have medical needs that don’t allow you

to use a car, bus or taxi to your appointments. Medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. [MCPs may change the remaining paragraph as needed to reflect MCP operational process.] If you need medical transportation, you can request this by speaking to your doctor. Your doctor will decide the correct type of transportation to meet your needs. If they find that you need medical transportation, they will prescribe it by completing a form and submit it to [MCP]. Once approved, the approval is good for one year depending on the medical need. Additionally, there are no limits for how many rides you can get. Your doctor will need to reassess your medical need for medical transportation and re-approve every 12 months.

Medical transportation is an ambulance, litter van, wheelchair van or air transport. [MCP] 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, [MCP] will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Medical transportation must be used when:

- It is physically or medically needed as determined with a written authorization by a doctor or other provider because you are not able to physically or medically able to use a bus, taxi, car or van to get to your appointment.

- You need help from the driver to and from your residence, vehicle or place of treatment due to a physical or mental disability.

[MCPs may adjust contact information as appropriate when member calls vendor instead of plan.] To ask for medical transportation that your doctor has prescribed for non-urgent (routine) appointments, please call [MCP] at [phone number] **or** [transportation provider phone number] at least [MCPs may adjust to align with their notification requirements] [number of hours or days advanced notice – e.g. business or calendar days] (Monday-Friday) before your appointment. For urgent appointments, please call as soon as possible. Please have your member ID card ready when you call.

Limits of medical transportation: [MCP] provides the lowest cost medical transportation that meets your medical needs to the closest provider from your home where an appointment is available. Medical transportation will not be provided if the service is not covered by Medi-Cal. If the appointment type is covered by Medi-Cal but not through the health plan, [MCP] will help you schedule your transportation. A list of

covered services is in this Member Handbook. Transportation is not covered outside of the network or service area unless pre-authorized by [MCP]. For more information or to ask for medical transportation, please call [MCP] at [phone number] or [transportation provider phone number].

Cost to member: There is no cost when transportation is arranged by [MCP].

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. You can get a ride, at no cost to you, when you are:

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

[MCP] allows you to use a car, taxi, bus or other public/private way of getting to your medical appointment for Medi-Cal-covered services. [MCP] will cover the lowest cost of non-medical transportation type that meets your needs. Sometimes, [MCP] can give reimbursement for rides in a private vehicle that you arrange. This must be approved by [MCP] before you get the ride, and you must tell us why you cannot get a ride other ways, like the bus. [MCPs may adjust contact information as appropriate.]You can tell us by calling us, by emailing, or in person. You cannot drive yourself and be reimbursed.

Mileage reimbursement requires all of the following:

- The driver's license of the driver
- The vehicle registration of the driver
- Proof of car insurance for the driver

[MCPs may adjust contact information as appropriate when member calls vendor instead of plan.] To request a ride for services that have been authorized, call [MCP] at [phone number] or [transportation provider phone number] at least [number of days advanced notice] business days (Monday-Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have your member ID card ready when you call.

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

Limits of non-medical transportation: [MCP] 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 more information, please call [MCP] at [phone number] or [transportation provider phone number].

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 assistance from the driver to and from the residence, vehicle or place of treatment due to a physical or medical condition.
- You are in a wheelchair and are unable to move in and out of the vehicle without help from the driver.
- The service is not covered by Medi-Cal.

Cost to member: There is no cost when non-medical transportation is arranged by [MCP].

Other [MCP] covered benefits and programs

Managed long-term services and supports (MLTSS)

[MCP] covers these MLTSS benefits for members who qualify:

- Long-term care facility services as approved by [MCP]

If you have questions about MLTSS, call [member services telephone number or case management direct line] (TTY [member services TTY number] or 711).

Care coordination

[MCP] offers Case Management services to help you coordinate your health care needs at no cost to you. [MCP] will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not [MCP].

If you have questions or concerns about your health or the health of your child, call [member services telephone number or case management direct line] (TTY [member services TTY number] or 711).

Coordinated Care Initiative (CCI) benefits

[Non-CCI counties should delete this CCI section including the Cal MediConnect and MLTSS language.]

[MCPs operating in both CCI and non-CCI counties may add language indicating county(ies) language applies to or submit separate EOC for each county.]

The California Coordinated Care Initiative (CCI) works to improve care coordination for dual eligibles (people who qualify for both Medi-Cal and Medicare). CCI has two main parts:

Cal MediConnect

The Cal MediConnect program aims to improve care coordination for beneficiaries dually eligible for Medicare and Medi-Cal. It lets them enroll in a single plan to manage all of their benefits, instead of having separate Medi-Cal and Medicare plans. It also aims for high-quality care that helps people stay healthy and in their homes for as long as possible.

If you are enrolled in [MCP CMC], the plan covers:

- A network of providers working together for you
- A personal care coordinator who will make sure you get the care and support you need
- A customized review of your health needs and care plan

Managed Long-Term Services and Supports (MLTSS)

Individuals dually eligible for Medicare and Medi-Cal or Seniors or Persons with Disabilities (SPD) enrolled in Medi-Cal only must join a Medi-Cal managed care plan to receive their Medi-Cal benefits, including MLTSS and Medicare wrap-around benefits. [Include SPDs if Plan is in a CCI county.]

Enhanced Care Management

[MCP] covers Enhanced Care Management (ECM) services for members with highly complex needs. ECM is a benefit that provides extra services to help you get the care you need to stay healthy. It coordinates the care you get from different doctors. ECM helps coordinate primary care, acute care, behavioral health, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

If you qualify, you may be contacted about ECM services. You can also call [MCP] to find out if and when you can receive ECM. Or talk to your health care provider who can find out if you qualify for ECM and when and how you can receive it.

Covered ECM services

If you qualify for ECM, you will have your own care team, including a care coordinator. This person will talk to you and your doctors, specialists, pharmacists, case managers, social services providers and others to make sure everyone works together to get you the care you need. A care coordinator 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 may be right for you, talk to your [MCP] representative or health care provider.

Cost to member

There is no cost to the member for ECM services.

Community Supports

[MCPs should remove Community Supports if it will not be offered] Community Supports may be available under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for Members to receive. If you qualify, these services may help you live more independently. They do not replace benefits that you already get under Medi-Cal. [Insert as applicable: Examples of Community Supports that MCP plans to offer: medically-supportive food/meals or medically-tailored meals, help for you or your caregiver, or shower grab bars and ramps.] If you need help or would like to find out what Community Supports may be available for you, call [member services telephone number or case

management direct line] (TTY [member services TTY number] or 711) or call your health care provider.

Major Organ Transplant

Transplants for children under age 21

State law requires children who need transplants to be referred to the California Children's Services (CCS) program to see if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for the transplant and related services. If the child is not eligible for CCS, then [MCP] will refer the child to a qualified transplant center for evaluation. If the transplant center confirms the transplant would be needed and safe, [MCP] will cover the transplant and related services.

Transplants for adults age 21 and older

If your doctor decides you may need a major organ transplant, [MCP] 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, [MCP] will cover the transplant and other related services.

The following major organ transplants covered by [MCP] include but are not limited to:

- Bone marrow
- Heart
- Heart/Lung
- Kidney
- Kidney/Pancreas
- Liver
- Liver/Small bowel
- Lung
- Pancreas
- Small bowel

Whole Child Model (WCM) Program

[Plans not participating in the Whole Child Model Program should delete this section.]

The WCM program incorporates California Children's Services (CCS) program covered services for Medi-Cal eligible CCS children and youth into [MCP]. 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 [MCP] or your PCP believes your child has a CCS condition, they will be referred to the CCS county program to be assessed for eligibility. If your child is determined eligible for WCM, they will get their CCS care through [MCP].

CCS does not cover all health conditions. CCS covers most health conditions that

physically disable or that need to be treated with medicines, surgery or rehabilitation (rehab). 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
- Seizures under certain circumstances
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

CCS county 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 [MCP] will treat the child for the CCS condition.

[MCP should insert other programs and services for people with Medi-Cal.]

Other Medi-Cal programs and services

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

Sometimes [MCP] does not cover services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. [MCP] will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not [MCP]. This section lists some of these services. To learn more, call [member services telephone number] (TTY [member services TTY number] or 711).

Outpatient prescription drugs

Prescription drugs covered by Medi-Cal Rx

Prescription drugs given by a pharmacy are covered by Medi-Cal Rx, a Medi-Cal FFS

program. Some drugs given by a provider in an office or clinic may be covered by [MCP]. Your provider can prescribe you drugs that are on the Medi-Cal Rx Contract Drugs List.

Sometimes, a drug is needed and is not on the Contract Drug List. These drugs will need to be approved before they can be filled at the pharmacy. Medi-Cal Rx will review and decide these requests within 24 hours.

- A pharmacist at your outpatient pharmacy or hospital emergency room may give you a 72-hour emergency supply if they think you need it. Medi-Cal Rx will pay for the emergency medication supply given by an outpatient pharmacy.
- Medi-Cal Rx may say no to a non-emergency request. If they say no, they will send you a letter to tell you why. They will tell you what your choices are. See the “Complaints” section in Chapter 6 Reporting and solving problems for more information.

To find out if a drug is on the Contract Drug List or to get a copy of the Contract Drug List, call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711), visit 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 800-977-2273 (TTY 800-977-2273 and press 5 or 711).

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

Members may also receive transportation services from [MCP] to get to pharmacies. To learn more about transportation services, read “Transportation benefits” in this handbook.

Specialty mental health services

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

Outpatient services:

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

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

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

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

Substance use disorder treatment services

The county provides substance use disorder services to Medi-Cal members who meet

medical necessity rules. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. To find all counties' telephone numbers online, visit https://dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

[MCP should insert information about any covered outpatient substance use disorder services, including residential treatment services.]

Dental services

[For Los Angeles and Sacramento counties, dental managed care services should be inserted in the "Medi-Cal Benefits" section above and this text removed from "Other services you can get through FFS Medi-Cal."]

[HPSM should move the dental section to the "Medi-Cal Benefits" section above and add additional or edit language appropriate for the demonstration project]

Medi-Cal (through the Medi-Cal Dental Program) covers some dental services, including:

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

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

[MCP should remove the California Children's Services language below if participating in the Whole Child Model program.]

California Children's Services (CCS)

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

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

[MCP] does not cover services provided by the CCS program. For CCS to cover these services, CCS must approve the provider, services and equipment.

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

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

Medi-Cal pays for CCS services. [WCM MCPs should use this CCS language in the "Covered benefits" section.] If your child is not eligible for CCS program services, they

will keep getting medically necessary care from [MCP].

To learn more about CCS, you can visit the CCS web page at https://www.dhcs.ca.gov/services/ccs. Or call [member services telephone number] (TTY [member services TTY number] or 711).

Institutional long-term care

[MCPs in CCI counties that cover institutional long-term care as an MLTSS benefit may move this language to MLTSS under the CCI section and edit as appropriate.]

[MCP] covers long-term care for the month you enter a facility and the month after that. [MCP] does **not** cover long-term care if you stay longer. [MCP may need to adjust this information based on plan type.]

FFS Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call [member services telephone number] (TTY [member services TTY number] or 711).

Services you cannot get through [MCP] or Medi-Cal

There are some services that neither [MCP] nor Medi-Cal will cover, including, but not limited to [MCPs may change the list below; however, bathroom lifts (mobility transfer devices are covered), medical ID bracelets (if they meet the criteria under W&I Code Section 14132.81) and wigs (are covered under certain conditions if medically necessary) should not be included]:

- Experimental services
- Fertility preservation
- In vitro fertilization (IVF)
- Home modifications
- Vehicle modifications
- Cosmetic surgery

[MCP] may cover a non-benefit if medical necessity is established. Your provider must submit a Prior Authorization to [MCP UM delegate or other contact] with the reasons why the non-benefit is medically needed.

To learn more call [member services telephone number] (TTY [member services TTY number] or 711).

[Evaluation of new and existing technologies

(Optional) Insert details about MCP evaluation process for new technology and new applications of existing technology to maintain compliance with federal and state regulatory bodies and accrediting agencies such as NCQA or URAC.]

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, mental health and developmental and specialty services. This chapter explains these services.

Pediatric services (Children under age 21)

Members under 21 years old are covered for needed care. The following list includes care that is medically necessary service to treat or ameliorate defects and physical, mental diagnosis. Covered services include [MCPs may add to the list below]:

- Well-child visits and teen check-ups (Important visits children need)
- Immunizations (shots)
- Mental health services (specialty mental health services are covered by the county)
- Lab tests, including blood lead poisoning testing
- Health and preventive education
- Vision services
- Dental services [HSPM must remove the reference to Medi-Cal Dental] (covered under Medi-Cal Dental)
- Hearing services (covered by CCS for children who qualify. [MCP] will cover services for children who do not qualify for CCS)

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

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 use (drug) disorders. [MCP] covers check-ups to screen for problems (including blood lead level assessment) any time there is a need for them, even if it is not during your or your child's regular check-up.

Preventive care also includes shots you or your child need. [MCP] must make sure that all enrolled children get needed shots at the time of any health care visit. Preventive care services and screenings are available at no cost and without pre-approval (prior authorization).

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 shots (California follows the American Academy of Pediatrics Bright Futures Periodicity schedule)
- Lab tests, including blood lead poisoning testing
- Health education
- Vision and hearing screening
- Oral health screening
- Behavioral health assessment

When a physical problem or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem. If the care is medically necessary and [MCP] is responsible for paying for the care, then [MCP] covers the care at no cost to you. These services include:

- Doctor, nurse practitioner and hospital care
- Shots to keep you healthy
- Physical, speech/language and occupational therapies

- Home health services, which could be medical equipment, supplies and appliances
- Treatment for vision problems, including eyeglasses
- Treatment for hearing problems, including hearing aids when they are not covered by CCS
- Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
- Case management and health education
- Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance

Blood lead poisoning testing

All children enrolled in [MCP] should get blood lead poisoning testing at 12 and 24 months or between the ages of 36 and 72 months if they were not tested earlier.

Help getting child and youth well care services

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

- Tell you about available services
- Help find 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 that are available through 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 [HSPM must move Dental check-ups to MCP covered area]

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

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

Babies ages 1 to 4

- Baby's first dental visit
- Baby's first dental exam
- Dental exams (every 6 months; every 3 months from birth to age 3)
- X-rays
- Teeth cleaning (every 6 months)
- Fluoride varnish (every 6 months)
- Fillings
- Tooth removal
- Emergency services
- Outpatient services
- Sedation (if medically necessary)

Kids ages 5-12

- Dental exams (every 6 months)
- X-rays
- Fluoride varnish (every 6 months)
- Teeth cleaning (every 6 months)
- Molar sealants
- Fillings
- Root canals
- Emergency services
- Outpatient services
- Sedation (if medically necessary)

Kids ages 13-17

- Dental exams (every 6 months)
- X-rays
- Fluoride varnish (every 6 months)
- Teeth cleaning (every 6 months)
- Orthodontics (braces) for those who qualify
- Fillings
- Crowns
- Root canals
- Tooth removal
- Emergency services
- Outpatient services
- Sedation (if medically necessary)

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

Additional preventive education referral services

If you are worried that your child is having a hard time taking part and learning at school, talk to your child's Primary Care Doctor, teachers or administrators at the school. In addition to your medical benefits covered by [MCP], there are services that the school must provide to help your child learn and not fall behind.

Examples of services that may 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

These services are provided by and paid for by the California Department of Education. Together with your child's doctors and teachers, you can make a custom plan that will best help your child.

6. Reporting and solving problems

There are two ways to report and solve problems:

- A **complaint** (or **grievance**) is when you have a problem with [MCP] or a provider, or with the health care or treatment you got from a provider
- An **appeal** is when you don't agree with [MCP]'s decision to change your services or to not cover them

You have the right to file grievances and appeals with [MCP] 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 complaining to us. Letting us know about your problem will help us improve care for all members.

You should always contact [MCP] first to let us know about your problem. Call us between [hours of operation] at [member services telephone number] (TTY [member services TTY number] or 711). Tell us about your problem. [MCP may add additional methods of filing a grievance such as in person or via fax if appropriate.]

[COHS plans that do not have a Knox-Keene license may remove this paragraph.] If your grievance or appeal is still not resolved after 30 days, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC) and ask them to review your complaint or conduct an Independent Medical Review. You can call the DMHC at 1-888-466-2219 (TTY 1-877-688-9891 or 711) or visit the DMHC website for more information: https://www.dmhc.ca.gov.

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can also help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609.

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call [member services telephone number] (TTY [member services TTY number] or 711).

To report incorrect information about your additional health insurance, please call Medi-Cal Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-800-541-5555.

Complaints

[COHS plans that do not have a Knox-Keene license may remove any IMR language here.]

A complaint (or grievance) is when you have a problem or are unhappy with the services you are receiving from [MCP] or a provider. There is no time limit to file a complaint. You can file a complaint with [MCP] at any time by phone, in writing or online.

- **By phone:** Call [MCP] at [member services telephone number] (TTY [member services TTY number] or 711) between [hours of operation]. Give your health plan ID number, your name and the reason for your complaint.
- **By mail:** Call [MCP] at [member services telephone number] (TTY [member services TTY number] 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:
  [complete mailing address]

  Your doctor's office will have complaint forms available.
- **Online:** Visit the [MCP] website. Go to [MCP URL].

If you need help filing your complaint, we can help you. We can give you free language services. Call [member services telephone number] (TTY [member services TTY number] or 711).

Within 5 calendar days of getting your complaint, we will send you a letter telling you we got it. Within 30 days, we will send you another letter that tells you how we resolved your problem. If you call [MCP] 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 want us to make a fast decision because the time it takes to resolve your complaint would put your life, health or ability to function in danger, you can ask for an

expedited (fast) review. To ask for an expedited review, call us at [member services telephone number] (TTY [member services TTY number] or 711). Within 72 hours of receiving your complaint, we will make a decision about how we will handle your complaint and whether we will expedite your complaint. If we determine that we will not expedite your complaint, we will let you know that we will resolve your complaint within 30 days.

[COHS plans that do not have a Knox-Keene license may remove the IMR language in this paragraph.] Complaints related to Medi-Cal Rx pharmacy benefits are not subject to the [MCP] grievance process or eligible for Independent Medical Review. Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling 800-977-2273 (TTY 800-977-2273 and press 5 or 711) or going to https://medi-calrx.dhcs.ca.gov/home/. However, complaints related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1-877-688-9891. You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: https://www.dmhc.ca.gov/.

Appeals

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

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

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

- **By phone:** Call [MCP] at [member services telephone number] (TTY [member services TTY number] or 711) between [hours of operation]. Give

your name, health plan ID number and the service you are appealing.

- **By mail:** Call [MCP] at [member services telephone number] (TTY [member services TTY number] 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:
[complete mailing address]

Your doctor's office will have appeal forms available.

- **Online:** Visit the [MCP] website. Go to [MCP URL].

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 [member services telephone number] (TTY [member services TTY number] or 711).

[COHS plans that do not have a Knox-Keene license may remove the IMR language here.] Within 5 days of getting your appeal, we will send you a letter telling you we got it. Within 30 days, we will tell you our appeal decision and send you a Notice of Appeal Resolution (NAR) letter. If we do not provide you with our appeal decision within 30 days, you can request a State Hearing and an IMR. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has final say.

If you or your doctor wants us to make a fast decision because the time it takes to decide your appeal would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call [member services telephone number] (TTY [member services TTY number] or 711). We will make a decision within 72 hours of receiving your appeal about.

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

[COHS plans that do not have a Knox-Keene license may remove the IMR language here.]

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:

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

- Ask for a **State Hearing** from the California Department of Social Services (CDSS), and a judge will review your case.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have [MCP]'s decision reviewed or ask for an **Independent Medical Review (IMR)** from the DMHC. During DMHC's IMR and an outside doctor who is not part of [MCP] will review your case. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1-877-688-9891. You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: https://www.dmhc.ca.gov.

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

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

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

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by [MCP]. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling 800-977-2273 (TTY 800-977-2273 and press 5 or 711). However, complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review.

If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing. Medi-Cal Rx pharmacy benefit decisions are not subject to the IMR process with the DMHC.

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

[COHS plans that do not have a Knox-Keene license may remove this section.]

An IMR is when an outside doctor who is not related to your health plan reviews your case. If you want an IMR, you must first file an appeal with [MCP]. If you do not hear from your health plan within 30 calendar days, or if you are unhappy with your health plan's decision, then you may request an IMR. You must ask for an IMR within 6 months from the date on the notice telling you of the appeal decision but you only have 120 days to request a State Hearing so if you want an IMR and a State hearing file your

complaint as soon as you can. Remember, if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say.

You may be able to get an IMR right away without filing an appeal first. This is in cases where your health problem is urgent.

If your complaint to DMHC does not qualify for an IMR, DMHC will still review your complaint to make sure [MCP] made the correct decision when you appealed its denial of services. [MCP] has to comply with DMHC's IMR and review decisions.

Here is how to ask for an IMR. The term "grievance" is for "complaints" and "appeals":

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

State Hearings

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

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]).
[MCP] is here [days and hours of operation]. The call is toll free.
Or call the California Relay Line at 711. Visit online at [MCP URL].

You must ask for a State Hearing within 120 days from the date on our NAR letter. However, 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 service(s) 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 [MCP] between [Hours of Operation] by calling [Telephone Number]. If you cannot hear or speak well, please call [TYY Number]. Your PCP 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, you can request a State Hearing without having to complete our appeal process, if we did not notify you correctly or on time about your service(s). This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- We did not make a NOA 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 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 by phone or mail.

- **By phone:** Call the CDSS Public Response Unit at 1-800-952-5253 (TTY 1-800-952-8349 or 711).
- **By mail**: Fill out the form provided with your appeals resolution notice. Send it to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, MS 09-17-37
  Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call [member services telephone number] (TTY [member services TTY number] or 711).

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

If you want the CDSS to make a fast decision because the time it takes to have a State

Hearing would put your life, health or ability to function fully in danger, you or your PCP can contact the CDSS and ask for an expedited (fast) State Hearing. CDSS must make a decision no later than 3 business days after it gets your complete case file from [MCP].

Fraud, waste and abuse

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

Provider fraud, waste and abuse includes:

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

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

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

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

dates of the events and a summary of exactly what happened.

Send your report to:

[Mailing address]
[Compliance hotline, if applicable]

7. Rights and responsibilities

As a member of [MCP], 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 [MCP].

Your rights

These are your rights as a member of [MCP]:

[MCP should insert member rights, including:]

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- To make recommendations about [MCP]'s member rights and responsibilities policy.
- To be able to choose a primary care provider within [MCP]'s network.
- To have timely access to network providers.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting 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 [MCP] and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including

Call member services at [1-XXX-XXX-XXXX] (TTY [1-XXX-XXX-XXX]). [MCP] is here [days and hours of operation]. The call is toll free. Or call the California Relay Line at 711. Visit online at [MCP URL].

information on the circumstances under which an expedited hearing is possible.

- [COHS plans may remove this sentence.] To disenroll from [MCP] and change to another health plan in the county upon request.
- To access minor consent services.
- To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions 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 §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by [MCP], your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside [MCP]'s network pursuant to the federal law.
- [MCP may add additional member rights to this list as well as change the bullets to a numbered list for easy to reference items in other member informing materials.]

Your responsibilities

[MCP] members have these responsibilities:

[MCP should insert written policy of member responsibilities, including providing accurate information to the professional staff, following instructions, and cooperating with the providers.]

Notice of non-discrimination

Discrimination is against the law. [MCP] follows State and Federal civil rights laws. [MCP] 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.

[MCP] 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 [MCP] between [hours of operation] by calling [telephone number]. Or, if you cannot hear or speak well, please call [TTY number] or 711 to use the California Relay Service.

How to file a grievance

If you believe that [MCP] has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with [MCP's Civil Rights Coordinator]. You can file a grievance in writing, in person, or electronically:

- **By phone**: Contact between [hours of operation] by calling [telephone number]. Or, if you cannot hear or speak well, please call [TTY number] or 711 to use the California Relay Service.
- **In writing:** Fill out a complaint form or write a letter and send it to: [Name of civil rights coordinator or department]

[Mailing address]

- **In person:** Visit your doctor's office or [MCP] and say you want to file a grievance.
- **Electronically:** Visit [MCP]'s website at [MCP web link].

Office of Civil Rights – California Department of Health Care Services

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

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

  Complaint forms are available at https://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- **Electronically:** Send an email to CivilRights@dhcs.ca.gov.

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

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

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

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

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

Ways to get involved as a member

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

[MCP name for member participation committee]

[MCP] has a group called [MCP name for member participation committee]. This group is made up of [member participation committee members]. You can join this group if you would like. The group talks about how to improve [MCP] policies and is responsible for:

- [member participation committee responsibilities]

If you would like to be a part of this group, call [member services telephone number] (TTY [member services TTY number] or 711). [MCP may also add contact and resource information, such as a member portal.]

[MCP should insert other ways for members to get involved.]

[MCP may edit the above section as appropriate.]

Notice of privacy practices

A statement describing [MCP] policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

[MCP should insert Notice of Privacy Practices, including details from https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf.]

Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The

main laws that apply to this handbook are state and federal laws about the Medi-Cal program. Other federal and state laws may apply too.

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

The Medi-Cal program complies with state and federal laws and regulations relating to the legal liability of third parties for health care services to members. [MCP] 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 and/or retain any available OHC when there is no cost to you.

Federal and state laws require Medi-Cal members to report OHC and any changes to OHC. If you do not report OHC promptly, you may have to repay DHCS for any benefits paid erroneously. Submit your OHC online at http://dhcs.ca.gov/OHC. If you do not have access to the internet, OHC can be reported to your health plan, or by calling 1-800-541-5555 (TTY 1-800-430-7077 or 711; inside California), or 1-916-636-1980 (outside California). DHCS has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. For example, if you are injured in a car accident or at work, auto or workers' compensation insurance may have to pay first, or reimburse Medi-Cal.

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

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

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

Notice about estate recovery

The Medi-Cal program must seek repayment for the estates of certain deceased Medi-Cal members from payments made, including managed care premiums for nursing facility services, home and community-based services, and related hospital and

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

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

Notice of Action

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

[MCP should insert other legal notices.]

8. Important numbers and words to know

Important phone numbers

- [MCP] member services [member services number] (TTY [member services TTY number] or 711)
- Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711)
- [MCP should insert other important telephone numbers.]

Words to know

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

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

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

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

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

California Children's Services (CCS): A Medi-Cal program that provides services for

children up to age 21 with certain diseases and health problems.

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

Case manager: Registered nurses or social workers who can help you understand major health problems and arrange care with your providers. [MCP may add LVNs or other licensed professionals if used as case managers.]

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

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

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

Clinic: 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 [MCP], a provider, or quality of services provided. A complaint is the same as a grievance.

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

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

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

[Non-COHS plan may remove this definition.] **County Organized Health System**

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

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

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

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

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

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

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

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

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

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

Emergency room care: An exam performed by a doctor (or staff under direction of a

doctor as allowed by law) to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.

Emergency medical transportation: Transportation in an ambulance or emergency vehicle to an emergency room to 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 seen that provider within a specified amount of time established by the Plan.

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

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

Family planning services: Services to prevent or delay pregnancy.

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

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

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

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

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

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

Grievance: A member's verbal or written expression of dissatisfaction about [MCP], a provider, or the services provided. A complaint is an example of a grievance.

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

Health Care Options (HCO): The program that can enroll or disenroll you from the health plan. [COHS plans may remove this definition.]

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

You usually need a referral from your PCP to go to a specialist. Your PCP must get pre-approval from [MCP] before you get care from the specialist. [MCP may edit or delete this sentence.]

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

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

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

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

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

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

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

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

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

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

Investigational treatment: A treatment drug, biological product or device that has successfully completed phase one of a clinical investigation approved by the FDA but

that has not been approved for general use by the FDA and remains under investigation in an FDA approved clinical investigation.

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

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

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

Medical home: A model of care that will provide better health care quality, improve self-management by members of their own care and reduce avoidable costs over time.

Medical transportation: Transportation when you cannot get to a covered medical appointment and/or to pick up prescriptions by car, bus, train or taxi. [MCP] pays for the lowest cost transportation for your medical needs when you need a ride to your appointment.

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

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

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

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

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

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

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

Non-covered service: A service that [MCP] does not cover.

Non-formulary drug: A drug not listed in the drug formulary.

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

Non-participating provider: A provider not in the [MCP] network.

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

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

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

Out-of-network provider: A provider who is not part of the [MCP] network.

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

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

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

Palliative care: Care to reduce physical, emotional, social and spiritual discomforts for a member with a serious illness. 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 [MCP] to provide

services to members at the time a member gets care. The covered services that some participating hospitals may offer to members are limited by [MCP]'s utilization review and quality assurance policies or [MCP]'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 [MCP] to offer covered services to members at the time a member gets care.

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

Plan: Go to "Managed care plan."

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition. Post-stabilization care services are covered and paid for. Out-of-network hospitals may need pre-approval.

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

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.

Primary care: Go to "Routine care."

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

- You have an emergency
- You need OB/GYN care
- You need sensitive services
- You need family planning services/birth control

Your PCP can be a:

- General practitioner

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

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

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

Provider Directory: A list of providers in the [MCP] network.

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

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

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

Reconstructive surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors or disease.

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

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

and physical skills.

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

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

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

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

Service area: The geographic area [MCP] serves. This includes the counties of [MCP to list counties served].

Skilled nursing care: Covered services provided by licensed nurses, technicians and/or therapists during a stay in a skilled nursing facility or in a member's home.

Skilled nursing facility: A place that gives 24-hour-a-day nursing care that only trained health professionals may give.

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

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

Terminal illness: A medical condition that cannot be reversed and will most likely cause death within one year or less if the disease follows its natural course.

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

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

[MCP may insert index, if needed.]