Member Handbook

What you need to know about your benefits

Health Net Community Solutions (“Health Net”) Combined Evidence of Coverage (EOC) and Disclosure Form

2024

Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne, and Tulare counties

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. Health Net provides written translations from qualified translators. Call 1-800-675-6110 (TTY 711). The call is free. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

Other formats

You can get this information in other formats, such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call 1-800-675-6110 (TTY 711). The call is free.

Interpreter services

Health Net provides 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 1-800-675-6110 (TTY 711). The call is free.

ATTENTION: If you need help in your language, call 1-800-675-6110 (TTY 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-675-6110 (TTY 711). These services are free.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like accessible PDF and large print documents, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل الملفات المنقولة (PDF) التي يمكن الوصول إليها والمستندات المطبوعة الكبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711)։ Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ մատչելի PDF և մեծ տպագրությամբ փաստաթղթեր։ Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាទម្រង់ PDF សម្រាប់អ្នកពិការ និងឯកសារព្រីនជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese: 如果您或者您正在帮助的人需要语言服务，请致电1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如无障碍 PDF 和大字版文档。这些服务免费为您提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با چاپ درشت و PDF دسترس‌پذیر نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे सुलभ PDF और बड़े प्रिंट वाले दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv PDF uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、
1-800-675-6110 (TTY: 711)までお問い合わせください。
障がいをお持ちの方のために、アクセシブルなPDFや大きな文字で書かれたドキュメントなどの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711)번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 액세스 가능한 PDF 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດຫນຶ່ງທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສໍາລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານ PDF ທີ່ສາມາດເຂົ້າເຖິງໄດ້ສະດວກ ແລະ ເອກະສານພິມຂະຫນາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດ ໆ.

Mien: Da’faanh Meih, Fai Heuc Meih Haih Tengx, Oix Janx-kaeqv waac gong, Heuc 1-800-675-6110 (TTY: 711). JomcCaux gong Bun Yangh mienh Caux mv fungc, Oix dongh eix PDF Caux Bunh Fiev dimc, Haih yaac kungx nyei. Deix gong Haih buatc Yietc liuz maiv jaax-zinh Bieqc Meih.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਪਹੁੰਚਯੋਗ PDF ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਾਲੇ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы в специальном формате PDF или напечатанные крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1 800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en letra grande y en archivos PDF accesibles. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng naa-access na PDF at mga dokumentong malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: **หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา**
โทร 1-800-675-6110 (TTY: 711)
นอกจากนี้ยังมีความช่วยเหลือและบริก
ารสำหรับผู้ทุพพลภาพ เช่น PDF
ที่เข้าถึงได้และเอกสารที่พิมพ์ขนาดใหญ่
บริการเหล่านี้ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи в спеціальному форматі PDF або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu dạng bản in khổ lớn và PDF có thể tiếp cận được. Quý vị được nhận các dịch vụ này miễn phí.

Welcome to Health Net!

Thank you for joining Health Net. Health Net is a health plan for people who have Medi-Cal. Health Net works with the State of California to help you get the health care you need.

Member Handbook

This Member Handbook tells you about your coverage under Health Net. Please read it carefully and completely. It will help you understand your benefits, the services available to you, and how to get the care you need. It also explains your rights and responsibilities as a member of Health Net. 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 Health Net's rules and policies and is based on the contract between Health Net and the Department of Health Care Services (DHCS). If you would like more information, call Health Net at 1-800-675-6110 (TTY 711).

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

To ask for a copy of the contract between Health Net and DHCS call 1-800-675-6110 (TTY 711). You may ask for another copy of the Member Handbook at no cost to you. You can also find the Member Handbook on the Health Net website at www.healthnet.com. You can also ask for a free copy of the Health Net non-proprietary clinical and administrative policies and procedures. They are also on the Health Net website.

Contact us

Health Net is here to help. If you have questions, call 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free.

You can also visit online at any time at www.healthnet.com.

Thank you,
Health Net
21281 Burbank Blvd.
Woodland Hills, CA 91367

Table of contents

1. Getting started as a member

How to get help

Health Net wants you to be happy with your health care. If you have questions or concerns about your care, Health Net wants to hear from you!

Member services

Health Net member services is here to help you. Health Net can:

- Answer questions about your health plan and Health Net 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

If you need help, call 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Health Net must make sure you wait less than 10 minutes when calling.

You can also visit Member Services online at any time at www.healthnet.com.

Who can become a member

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

You qualify for Health Net because you qualify for Medi-Cal and live in one of these counties: Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne, and Tulare. You might also qualify for Medi-Cal through Social Security because you are getting SSI or SSP.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

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

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

Transitional Medi-Cal

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, or
- Your family started getting 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).

Identification (ID) cards

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

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Your Health Net ID card has important information on it, including:

- Your Primary Care Provider's (PCP) name (or the name of your clinic or medical group). This information does not appear on ID cards for members who have both Medicare (Part A and Part B) and Medi-Cal coverage. The PCP information will say "See Your Medicare Doctor." This information also does not appear on ID cards for newborns who have been assigned a Client Index Number (CIN) by DHCS. The PCP information will say "No Primary MD."
- Your PCP's address and phone number. This information does not appear on ID cards for members who have both Medicare (Part A and Part B) and Medi-Cal coverage. The PCP information will say "See Your Medicare Doctor." This information also does not appear on ID cards for newborns who have been assigned a CIN by DHCS. The PCP information will say "Please Call Member Services."
- If your PCP and/or medical group information is wrong or if you have changed your PCP and/or medical group since your last ID card was issued, call member services at 1-800-675-6110 (TTY 711) to get a new card with the correct PCP information.
- If you have any questions regarding your ID card, please call member services at 1-800-675-6110 (TTY 711).

Here's what to do with your Health Net ID card:

- Check to make sure the information on your ID card is correct. If anything on your ID card is wrong, call member services at 1-800-675-6110 (TTY 711)

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

right away. If your name is not spelled right or is incorrect, we will connect you to your county office to get it fixed.

Show your Health Net ID card whenever you:

- have a doctor's appointment,
- go to the hospital, or
- need urgent care/emergency services.

If you do not get your Health Net ID card within a few weeks after your enrollment date, or if your card is damaged, lost or stolen, call member services right away. Health Net will send you a new card at no cost to you. Call 1-800-675-6110 (TTY 711).

2. About your health plan

Health plan overview

Health Net is a health plan for people who have Medi-Cal in these counties: Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne and Tulare. Health Net works with the State of California to help you get the health care you need.

Talk with one of the Health Net member services representatives to learn more about the health plan and how to make it work for you. Call 1-800-675-6110 (TTY 711).

When your coverage starts and ends

When you enroll in Health Net, we will send your Health Net Identification (ID) card within two weeks of your enrollment date. You must show both your Health Net ID card and your Medi-Cal BIC when you get health care services or prescriptions.

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

Your care through Health Net starts when your enrollment in Health Net is complete. You can start using your Medi-Cal benefits through Health Net on your effective date of coverage. Your effective date of coverage is the 1st day of the month following completion of enrollment in Health Net. Check the Health Net member ID card mailed to you for the effective date of coverage.

You can end your Health Net coverage and choose another health plan at any time. For help choosing a new plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077 or 711). Or go to www.healthcareoptions.dhcs.ca.gov. You can also ask to end your Medi-Cal.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Health Net is a health plan for Medi-Cal members in Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne and Tulare counties. Find your local office at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Health Net eligibility may end if any of the following is true:

- You move out of Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne and Tulare counties
- You no longer have Medi-Cal
- You become eligible for a waiver program that requires you to be enrolled in Fee-for-Service (FFS) Medi-Cal
- You are in jail or prison

If you lose your Health Net Medi-Cal coverage, you may still qualify for FFS Medi-Cal coverage. If you are not sure if you are still covered by Health Net, call 1-800-675-6110 (TTY 711).

Special considerations for American Indians in managed care

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

If you are an American Indian, you have the right to get health care services at an Indian Health Care Provider (IHCP). You can also stay with or disenroll (drop) from Health Net while getting health care services from these locations. To learn more about enrollment and disenrollment call 1-800-675-6110 (TTY 711).

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

How your plan works

Health Net is a managed care health plan contracted with DHCS. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. Health Net works with doctors, hospitals, and other health care providers in the Health Net service area to provide health care to our members. As a

member of Health Net, you may qualify for some services provided through FFS Medi-Cal. These include outpatient prescriptions, non-prescription drugs, and some medical supplies through Medi-Cal Rx.

Member services will tell you how Health Net works, how to get the care you need, how to schedule provider appointments during office hours, how to request no-cost interpreting and translation services or written information in alternative formats.

To learn more, call 1-800-675-6110 (TTY 711). You can also find member service information online at www.healthnet.com.

Changing health plans

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

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

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

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

You can ask to leave Health Net by contacting 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).

Students who move to a new county or out of California

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

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

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

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

  OR

- If Health Net does not serve the new county where you attend college, and you do not change your health plan to one that serves that county, you will only get emergency room and urgent care services for some conditions in the new county. To learn more, read Chapter 3, “How to get care.” For routine or preventive health care, you would need to use the Health Net network of providers located in the head of household’s county of residence.

If you are leaving California temporarily to be a student in another state and you want to keep your Medi-Cal coverage, contact your eligibility worker at your local county social services office. As long as you qualify, Medi-Cal will cover emergency services and urgent care in another state. If Health Net approves the service and the doctor and hospital meet Medi-Cal rules, Medi-Cal will also cover emergency care that requires hospitalization in Canada and Mexico.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

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

Continuity of care

Continuity of Care for an out-of-network provider

As a member of Health Net, you will get your health care from providers in Health Net's network. To find out if a health care provider is in the Health Net's network, read the Provider Directory. It has a list of all providers in the Health Net network. The Provider Directory has other information to help you choose a provider. If you need a Provider Directory, call 1-800-675-6110 (TTY 711). You can also find the Provider Directory on the Health Net website at www.healthnet.com. Providers not listed in the directory may not be in the Health Net's network.

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

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

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

- The out-of-network provider is enrolled and participating in the Medi-Cal program

To learn more, call member services at 1-800-675-6110 (TTY 711).

If your providers do not join the Health Net network by the end of 12 months, do not agree to Health Net payment rates, or do not meet quality of care requirements, you will need to change to providers in the Health Net network. To discuss your choices, call member services at 1-800-675-6110 (TTY 711).

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

To learn more about continuity of care and if you qualify, call 1-800-675-6110.

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

As a member of Health Net, you will get covered services from providers in Health Net's network.

If you are being treated for certain health conditions at the time you enrolled with Health Net or at the time your provider left Health Net's network, you might also still be able to get Medi-Cal services from an out-of-network provider.

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

Health condition	Time period
Acute conditions (a medical issue that needs fast attention)	For as long as your acute condition lasts
Serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time)	For an amount of time required to finish your course of treatment and to safely move you to a new doctor in the Health Net network
Pregnancy and postpartum (after birth) care	During your pregnancy and up to 12 months after the end of pregnancy
Maternal mental health services	For up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later

Care of a newborn child between birth and 36 months old	For up to 12 months from the start date of the coverage or the date the provider's contract ends with Health Net
Terminal illness (a life-threatening medical issue)	For as long as your illness lasts. You may still get services for more than 12 months from the date you enrolled with Health Net or the time the provider stops working with Health Net
Performance of a surgery or other medical procedure from an out-of-network provider as long as it is covered, medically necessary, and authorized by Health Net as part of a documented course of treatment and recommended and documented by the provider	The surgery or other medical procedure must take place within 180 days of the provider's contract termination date or 180 days from the effective date of your enrollment with Health Net

For other conditions that might qualify, call 1-800-675-6110.

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

For help choosing a contracted provider to continue with your care or if you have questions or problems getting covered services from a provider who is no longer in Health Net's network, call member services at 1-800-675-6110 (TTY 711).

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

Costs

Member costs

Health Net serves people who qualify for Medi-Cal. In most cases, Health Net members do not have to pay for covered services, premiums, or deductibles. If you are an American Indian, you do not have to pay enrollment fees, premiums, deductibles, co-

pays, cost sharing, or other similar charges. Managed care plans must not charge any American Indian member who gets an item or service directly from an IHCP or through a referral to an IHCP or reduce payments due to an IHCP by the amount of any enrollment fee, premium, deductible, copayment, cost sharing, or similar charge.

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

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

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

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

How a provider gets paid

Health Net pays providers in these ways:

- Capitation payments
  - Health Net pays some providers a set amount of money every month for each Health Net member. This is called a capitation payment. Health Net and providers work together to decide on the payment amount.
- FFS payments
  - Some providers give care to Health Net members and send Health Net a bill for the services they provided. This is called an FFS payment. Health Net and providers work together to decide how much each service costs.

- Incentive Payment
  - Health Net also pays providers for meeting certain quality benchmarks.

To learn more about how Health Net pays providers, call 1-800-675-6110 (TTY 711).

If you get a bill from a health care provider

Covered services are health care services that Health Net must pay. If you get a bill for support services fees, copayments, or registration fees for a covered service, do not pay the bill. Call member services right away at 1-800-675-6110 (TTY 711).

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

Asking Health Net to pay you back for expenses

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

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

Health Net will tell you if they will reimburse you in a letter called a Notice of Action (NOA). If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, Health Net will pay you back for the full amount you paid. We must reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal but is not

in the Health Net network and refuses to pay you back, Health Net will pay you back, but only up to the amount that FFS Medi-Cal would pay. Health Net will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval (prior authorization). If you do not meet one of the above conditions, Health Net will not pay you back.

Health Net will not pay you back if:

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

3.How to get care

Getting health care services

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

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

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

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

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

If you have a doctor you want to keep, or you want to find a new PCP, go to the Provider Directory for a list of all PCPs and other providers in the Health Net network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call 1-800-675-6110 (TTY or 711). You can also find the Provider Directory on the Health Net website at www.healthnet.com.

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

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

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

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

Primary care provider (PCP)

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

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

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

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

If you do not choose a PCP within 30 days of enrollment, Health Net will assign you to a PCP. If you are assigned to a PCP and want to change, call 1-800-675-6110 (TTY 711). The change happens the first day of the next month.

Your PCP will:

- Get to know your health history and needs
- Keep your health records
- Give you the preventive and routine health care you need
- Refer (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 Health Net network. The Provider Directory has a list of IHCPs, FQHCs and RHCs that work with Health Net.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

You can find the Health Net Provider Directory online at www.healthnet.com. Or you can request a Provider Directory to be mailed to you by calling 1-800-675-6110 (TTY 711). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

You know your health care needs best, so it is best if you choose your PCP.

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

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

To change your PCP, call 1-800-675-6110 (TTY 711).

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

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

Some things to think about when picking a PCP:

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

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Initial Health Appointment (IHA)

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

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

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

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

If you have questions about IHA, call 1-800-675-6110 (TTY 711).

Routine care

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

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

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

Your PCP will:

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

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

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

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

Provider network

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

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

Each Medical Group and PCP makes referrals to certain plan specialists and uses certain hospitals within their network. If there is a particular plan specialist or hospital that you want to use, check first to be sure that the specialists and hospitals are in the Medical Group and PCP’s network. The name and office telephone number of your PCP is printed on your Member ID card.

Some Medical Groups have formal referral circles, which mean that their providers will only refer patients to other providers belonging to the same medical group.

You may also have to use providers within your Primary Care Provider’s (PCP) Medical Group/IPA. If you would like to see a provider who is not within your PCP’s Medical Group/IPA, you may have to change your PCP. In addition, you may be limited to

providers within your Primary Care Provider's (PCP's) and/or Medical Group's network. This means that the PCP and/or Medical Group that you choose may determine the specialists and hospitals you can use. An IPA is an association of physicians, including PCPs and specialists, and other health care providers, including hospitals, which is contracted with the plan to provide services to members.

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

If your PCP, hospital or other provider has a moral objection to providing you with a covered service, such as family planning or abortion, call 1-800-675-6110 (TTY 711). For more about moral objections, read "Moral objection" later in this chapter.

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

In-network providers

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

To get a Provider Directory of in-network providers, call 1-800-675-6110 (TTY 711). You can also find the Provider Directory online at www.healthnet.com. To get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

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

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

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

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

Out-of-network providers are health care providers that do not have an agreement to work with Health Net. Except for emergency care, you might have to pay for any care you get from out-of-network providers. If you need medically necessary health care services that are not available in the network, you might be able to get them from an out-of-network provider at no cost to you.

Health Net may approve a referral to an out-of-network provider if the services you need are not available in-network or are located very far from your home. If we give you a referral to an out-of-network provider, we will pay for your care.

For urgent care inside the Health Net service area, you must go to a Health Net in-network urgent care provider. You do not need pre-approval (prior authorization) to get urgent care from an in-network provider. You do need to get pre-approval (prior authorization) to get urgent care from an out-of-network provider inside the Health Net service area. If you get urgent care from an out-of-network provider inside Health Net service area, you might have to pay for that care. You can read more about emergency care, urgent care, and sensitive care services in this chapter.

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

If you need help with out-of-network services, call 1-800-675-6110 (TTY 711).

Outside the service area

If you are outside of the Health Net service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call 1-800-675-6110 (TTY 711).

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

If you paid for emergency care requiring hospitalization in Canada or Mexico, you can ask Health Net to pay you back. Health Net will review your request.

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

Ask the hospital to make copies of your Health Net ID card. Tell the hospital and the doctors to bill Health Net. If you get a bill for services you got in another state, call Health Net right away. We will work with the hospital and/or doctor to arrange for Health Net to pay for your care.

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

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

If you have questions about out-of-network or out-of-service-area care, call 1-800-675-6110 (TTY 711). If the office is closed and you want help from a representative, call the nurse advice line at 1-800-675-6110 (TTY 711). Choose the 24-hour nurse advice line option in the menu.

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

How managed care works

Health Net is a managed care plan. Health Net provides care to members who live or work in Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne, and Tulare counties. In managed care, your PCP, specialists, clinic, hospital, and other providers work together to care for you.

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

When you join Health Net, you choose or are assigned to a PCP. Your PCP is part of a medical group. Your PCP and medical group direct the care for all of your medical needs. Your PCP may refer you to specialists or order lab tests and X-rays. If you need services that require pre-approval (prior authorization), Health Net or your medical group will review the pre-approval (prior authorization) and decide whether to approve the service.

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

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

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

Members who have both Medicare and Medi-Cal

Members with Medicare and Medi-Cal should access Medicare providers for Medicare covered benefits and Medi-Cal plan providers for Medi-Cal covered benefits.

- If you have a Medicare Advantage Plan including a Dual Special Needs Plan (D-SNP), please reference your Medicare plan's Evidence of Coverage (EOC)
- If you have Medicare Fee for Service (FFS), please reference the "Medicare & You" handbook provided by Medicare. It can also be found on Medicare's website: https://www.medicare.gov/medicare-and-you

Doctors

You will choose a doctor from the Health Net Provider Directory as your PCP. The doctor you choose must be an in-network provider. To get a copy of the Health Net Provider Directory, call 1-800-675-6110 (TTY 711). Or find it online at www.healthnet.com.

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

If you had a doctor before you were a member of Health Net, and that doctor is not part of the Health Net network, you might be able to keep that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call 1-800-675-6110 (TTY 711).

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

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

If you want to change your PCP, you must choose a PCP from the Health Net Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call 1-800-675-6110 (TTY 711). You are able to make a PCP change by mail, fax, and/or through the 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 Health Net provider network. The Provider Directory lists the hospitals in the Health Net network.

Women's health specialists

You can go to a women's health specialist in Health Net's network for covered care necessary to provide women's routine care services. You do not need a referral or authorization from your PCP to get these services. For help finding a women's health specialist, you can call 1-800-675-6110 (TTY 711). You can also call the 24/7 nurse advice line by calling the member services phone number at 1-800-675-6110 (TTY 711).

Provider Directory

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

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

The Provider Directory has Health Net in-network provider names, specialties, addresses, phone numbers, business hours and languages spoken. It tells you if the provider is taking new patients. It also gives the physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars. To learn more about a doctor's education, training, and board certification, call 1-800-675-6110 (TTY 711).

You can find the online Provider Directory at www.healthnet.com.

If you need a printed Provider Directory, call 1-800-675-6110 (TTY 711).

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

Timely access to care

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

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

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

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

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

Sometimes waiting longer for an appointment is not a problem. Your provider might give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health. Also, if you prefer to wait for a later appointment that will better fit your schedule or go to another provider of your choice, your provider or your Managed Care Plan will respect your wish.

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

Tell us if you need interpreter services when you call Health Net or when you get covered services. Interpreter services, including sign language, are available at no cost to you. We highly discourage the use of minors or family members as interpreters. To learn more about interpreter services we offer, call 1-800-675-6110.

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

Travel time or distance to care

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

If Health Net is not able to provide care to you within these travel time or distance standards, DHCS may allow a different standard, called an alternative access standard. For Health Net's time or distance standards for where you live, visit www.healthnet.com. Or call 1-800-675-6110 (TTY 711).

If you need care from a provider located far from where you live, call member services at 1-800-675-6110 (TTY 711). They can help you find care with a provider located closer to you. If Health Net cannot find care for you from a closer provider, you can ask Health Net to arrange transportation for you to go to your provider, even if that provider is located far from where you live.

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

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

Appointments

When you need health care:

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

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

If you have an emergency, call **911** or go to the nearest emergency room. If you need help deciding how urgently you need care and your PCP is not available to speak with you, call the nurse advice line.

Getting to your appointment

If you don't have a way to get to and from your appointments for covered services, Health Net can help arrange transportation for you. Depending on your situation, you may qualify for either Medical Transportation or for Non-Medical Transportation. These transportation services are not for emergencies and may be available at no cost to you.

If you are having an emergency, call **911**. Transportation is available for services and appointments not related to emergency care. They may be available at no cost to you.

To learn more, read, "Transportation benefits for situations that are not emergencies" below.

Canceling and rescheduling

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

Payment

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

If you do get a bill, call 1-800-675-6110 (TTY 711). If you get a bill for prescriptions, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/. Tell Health Net the amount you are being charged, the date of service, and the reason for the bill. You do

not need to pay providers for any amount owed by Health Net for any covered service. You must get pre-approval (prior authorization) from Health Net before you visit an out-of-network provider except when:

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

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

If you get a bill or are asked to pay a co-pay you don't think you have to pay, call 1-800-675-6110 (TTY 711).

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

Health Net will not pay you back if:

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

Referrals

If you need a specialist for your care, your PCP or another specialist will give you a referral to one. A specialist is a provider who focuses on one type of health care service.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

The doctor who refers you will work with you to choose a specialist. To help make sure you can go to a specialist in a timely way, DHCS sets time frames for members to get appointments. These time frames are listed in “Timely access to care” in this handbook. Your PCP’s office can help you set up an appointment with a specialist.

Other services that might need a referral include in-office procedures, X-rays, lab work and some services from a specialist.

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

Your PCP will start the referral process. Your PCP will know whether you need an authorization or whether you can make the appointment directly. If you have any questions about whether care from a specialist or from a hospital needs approval, you can call member services at 1-800-675-6110 (TTY 711). Routine referrals take up to 5 working days to process (“working days” are Monday through Friday) but may take up to 28 calendar days (14 days from the date of the original request plus an additional 14 days if an extension is requested) if more information is needed from your PCP. In some cases, your PCP may ask to rush your referral. Expedited (rush) referrals may not take more than 72 hours. Please call our plan if you do not get a response by these times.

If you have a health problem that needs special medical care for a long time, you might 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 Health Net referral policy, call 1-800-675-6110 (TTY 711).

You do not need a referral for:

- PCP visits
- Obstetrics/Gynecology (OB/GYN) visits
- Urgent or emergency care visits
- Adult sensitive services, such as sexual assault care
- Family planning services (to learn more, call the Office of Family Planning Information and Referral Service at 1-800-942-1054)
- HIV testing and counseling (12 years or older)
- Sexually transmitted infection services (12 years or older)
- Chiropractic services (a referral may be required when provided by out-of-network FQHCs, RHCs, and IHCPs)

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

- Initial mental health assessment
- Acupuncture (the first two services per month; additional appointments will need a referral)
- Podiatry services
- Eligible dental services
- Routine perinatal care from a doctor that works with Health Net
- Certified nurse midwife services

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

California Cancer Equity Act referrals

Effective treatment of complex cancers depends on many factors. These include getting the right diagnosis and getting timely treatment from cancer experts.

If you are diagnosed with a complex cancer, the new California Cancer Care Equity Act allows you to ask for a referral from your doctor to get cancer treatment from an in-network National Cancer Institute (NCI)-designated cancer center, NCI Community Oncology Research Program (NCORP)-affiliated site, or a qualifying academic cancer center.

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

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

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

To learn more, go to www.kickitca.org.

Pre-approval (prior authorization)

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

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

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

- Hospitalization, if not an emergency
- Services out of the Health Net service area, if not an emergency or urgent care
- Outpatient surgery
- Long-term care or skilled nursing services at a nursing facility
- Specialized treatments, imaging, testing, and procedures
- Medical transportation services when it is not an emergency.

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

Under Health and Safety Code Section 1367.01(h)(1), Health Net has 5 business days from when Health Net gets the information reasonably needed to decide (approve or deny) pre-approval (prior authorization) requests. For requests a provider made or when Health Net finds that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, Health Net will make an expedited (fast) pre-approval (prior authorization) decision. Health Net will give you notice as quickly as your health condition requires and no later than 72 hours after getting the request for services.

Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

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

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

For questions about pre-approval (prior authorization), call 1-800-675-6110 (TTY 711).

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you might want a second opinion if you want to make sure your diagnosis is correct, you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan and it has not worked.

If you want to get a second opinion, we will refer you to a qualified in-network provider who can give you a second opinion. For help choosing a provider, call 1-800-675-6110 (TTY 711).

Health Net will pay for a second opinion if you or your in-network provider asks for it, and you get the second opinion from an in-network provider. You do not need pre-approval (prior authorization) from Health Net to get a second opinion from an in-network provider. Your in-network provider can help you get a referral for a second opinion if you need one.

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

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

Sensitive care

Minor consent services

If you are under age 18, you can get some services without a parent's or guardian's permission. These services are called minor consent services.

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

- Sexual assault services, including outpatient mental health care
- Pregnancy
- Family planning and birth control
- Abortion services

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

- Outpatient mental health care for:
  - Sexual assault
  - Incest
  - Physical assault
  - Child abuse
  - When you have thoughts of hurting yourself or others
- HIV/AIDS prevention, testing, and treatment
- Sexually transmitted infections prevention, testing, and treatment
- Substance use disorder treatment
  - To learn more, read "Substance use disorder treatment services" in Chapter 4 of this handbook.

For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be in the Health Net network. You can choose any Medi-Cal provider and go to them for these services without a referral or pre-approval (prior authorization). For minor consent services that are not specialty mental health services, you can go to an in-network provider without a referral and without pre-approval (prior authorization). Your PCP does not have to refer you and you do not need to get pre-approval (prior authorization) from Health Net to get covered minor consent services.

Minor consent services that are specialty mental health services are not covered. Specialty mental health services are covered by the county mental health plan for the county where you live.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Minors can talk to a representative in private about their health concerns by calling the 24/7 nurse advice line. Call the member services phone number at 1-800-675-6110 (TTY 711) and choose the 24-hour nurse advice line option in the menu.

Health Net will not send information about getting sensitive services to parents or guardians. To learn more about how to ask for confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7 of this handbook.

Adult sensitive care services

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

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

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

If you need help finding a doctor or clinic for these services, or help getting to these services (including transportation), call 1-800-675-6110 (TTY 711). Or call the 24/7 nurse advice line by calling the member services phone number at 1-800-675-6110 (TTY 711). Choose the 24-hour nurse advice line option in the menu.

Health Net will not disclose medical information related to sensitive services to any other member without written authorization from you, the member receiving care. To learn more about how to ask for confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7.

Moral objection

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

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

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

To make sure you choose a provider who can give you the care you and your family needs, call the doctor, medical group, independent practice association, or clinic you want. Or call Health Net at 1-800-675-6110 (TTY 711). Ask if the provider can and will provide the services you need.

These services are available to you. Health Net will make sure you and your family members can use providers (doctors, hospitals, clinics) who will give you the care you need. If you have questions or need help finding a provider, call Health Net at 1-800-675-6110 (TTY 711).

Urgent care

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

For urgent care, call your PCP. If you cannot reach your PCP, call 1-800-675-6110 (TTY 711). Or you can call the nurse advice line by calling the member services phone number at 1-800-675-6110 (TTY 711). Choose the 24-hour nurse advice line option in the menu, to learn the level of care that is best for you.

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

Urgent care needs could be:

- Cold
- Sore throat
- Fever

- Ear pain
- Sprained muscle
- Maternity services

You must get urgent care services from an in-network provider when you are inside Health Net's service area. You do not need pre-approval (prior authorization) for urgent care from in-network providers inside Health Net's service area. If you are outside the Health Net service area, but inside the United States, you do not need pre-approval (prior authorization) to get urgent care. Go to the nearest urgent care facility. Medi-Cal does not cover urgent care services outside the United States. If you are traveling outside the United States and need urgent care, we will not cover your care.

If you need mental health urgent care, call your county mental health plan or member services at 1-800-675-6110 (TTY 711). Call your county mental health plan or your Health Net Behavioral Health Organization any time, 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, go to: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

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

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 Health Net.

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

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

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, you would place your health (or your unborn baby's health) in serious danger.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

This includes risking serious harm to your bodily functions, body organs or body parts. Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain
- Trouble breathing
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts (this may be covered by county mental health plans)

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 can also call the 24/7 nurse advice line by calling the member services phone number at 1-800-675-6110 (TTY 711). Choose the 24-hour nurse advice line option in the menu.

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

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

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.

Health Net's nurse advice line gives you free medical information and advice 24 hours a day, every day of the year. Call 1-800-675-6110 (TTY 711).

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Nurse Advice Line

Health Net's nurse advice line can give you free medical information and advice 24 hours a day, every day of the year. Call the 24/7 nurse advice line by calling the member services phone number at 1-800-675-6110 (TTY 711). Choose the 24-hour nurse advice line option in the menu to:

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

The nurse advice line **cannot** help with clinic appointments or medicine refills. Call your provider's office if you need help with these.

Advance directives

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

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

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

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

To learn more, you can call Health Net at 1-800-675-6110.

Organ and tissue donation

You can help save lives by becoming an organ or tissue donor. If you are between 15 and 18 years old, you can become a donor with the written consent of your parent or guardian. You can change your mind about being an organ donor at any time. If you

want to learn more about organ or tissue donation, talk to your PCP. You can also visit the United States Department of Health and Human Services website at www.organdonor.gov.

4. Benefits and services

What your health plan covers

This chapter explains your covered services as a member of Health Net. 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 certain sensitive services and emergency care. Your health plan might cover medically necessary services from an out-of-network provider, but you must ask Health Net for pre-approval (prior authorization) for this. Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under the age of 21, Medi-Cal services include care that is medically necessary to fix or help relieve a physical or mental illness or condition. For more on your covered services, call 1-800-675-6110 (TTY 711).

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

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

- Acupuncture*
- Acute (short-term treatment) home health therapies and services
- Adult immunizations (shots)
- Allergy testing and injections
- Ambulance services for an emergency
- Anesthesiologist services
- Asthma prevention
- Audiology*
- Behavioral health treatments*
- Biomarker testing*
- Cardiac rehabilitation
- Chiropractic services*
- Chemotherapy & Radiation therapy*
- Circumcision of newborn (birth through 30 days)
- Cognitive health assessment
- Community health worker services
- Dental services – limited (performed by medical professional/primary care provider (PCP) in a medical office)*
- Dialysis/hemodialysis services
- Doula services
- Durable medical equipment (DME)*
- Dyadic services
- Emergency room visits
- Enteral and parenteral nutrition*
- Family planning 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
- Rapid Whole Genome Sequencing
- 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 are 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**

Health Net 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 Health Net.

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

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

For members younger than 21 years old, medically necessary services include all covered services listed above plus any other necessary health care, diagnostic services, treatment, and other measures to correct or improve defects and physical and mental illnesses and conditions, the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires.

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

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

Medi-Cal benefits covered by Health Net

Outpatient (ambulatory) services

Adult immunizations

You can get adult immunizations (shots) from an in-network provider without pre-approval (prior authorization). Health Net covers 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 Medi-Cal Rx, read “Other Medi-Cal programs and services” in this chapter.

Allergy care

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

Anesthesiologist services

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

Chiropractic services

Health Net covers chiropractic services, limited to the treatment of the spine by manual manipulation Chiropractic services are limited to a maximum of 2 services per month, or combination of 2 services per month from the following services: acupuncture, audiology, occupational therapy, and speech therapy. Limits do not apply to children under age 21. Health Net may pre-approve other services as medically necessary.

These members qualify for chiropractic services:

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

Cognitive health assessments

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

Community health worker services

Health Net covers community health worker (CHW) services for individuals when recommended by a doctor or other licensed practitioner to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Services may include:

- Health education and training, including control and prevention of chronic or infectious diseases; behavioral, perinatal, and oral health conditions; and injury prevention
- Health promotion and coaching, including goal setting and creating action plans to address disease prevention and management

Dialysis and hemodialysis services

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

Medi-Cal coverage does not include:

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

Doula services

Health Net covers doula services for members who are pregnant or were pregnant in the past year when recommended by a physician or licensed practitioner. Medi-Cal does not cover all doula services. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.

Dyadic services

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

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

Outpatient surgery

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

Physician services

Health Net covers physician services that are medically necessary.

Podiatry (foot) services

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

Treatment therapies

Health Net covers different treatment therapies, including:

- Chemotherapy
- Radiation therapy

Maternity and newborn care

Health Net covers these maternity and newborn care services:

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

Telehealth services

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

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

Mental health services

Outpatient mental health services

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

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

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purposes of monitoring medicine therapy
- Outpatient laboratory services
- Outpatient medicines that are not already covered under the Medi-Cal Rx Contract Drugs List (https://medi-calrx.dhcs.ca.gov/home/), supplies and supplements
- Psychiatric consultation

- Family therapy which involves at least 2 family members. Examples of family therapy include, but are not limited to:
  - Child-parent psychotherapy (ages 0 through 5)
  - Parent child interactive therapy (ages 2 through 12)
  - Cognitive-behavioral couple therapy (adults)

For help finding more information on mental health services provided by Health Net, call 1-800-675-6110 (TTY 711).

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

If your mental health screening shows that you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider can refer you to the county mental health plan to get the care you need.

To learn more, read “Other Medi-Cal programs and services” on page 74 under “Specialty mental health services.”

Emergency care

Inpatient and outpatient services needed to treat a medical emergency

Health Net covers all services needed to treat a medical emergency that happens in the U.S. (including territories such as Puerto Rico, U.S. Virgin Islands, etc.). Health Net also covers emergency care that requires hospitalization in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent (reasonable) layperson (not a health care professional) could expect it to result in:

- Serious risk to your health,
- Serious harm to bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Serious risk in cases of a pregnant person in active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer you to another hospital before delivery.

- The transfer might pose a threat to your health or safety or to that of your unborn child.

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

If 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 Health Net. If the pharmacy needs help giving you an emergency medication supply, have them call Medi-Cal Rx at 1-800-977-2273.

Emergency transportation services

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

Hospice and palliative care

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

Hospice care

Hospice care is a benefit for terminally ill members. Hospice care requires the member to have a life expectancy of 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 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 all authorized palliative and curative care
- Plan of care team including, but not limited to:
    - Doctor of medicine or osteopathy
    - Physician assistant
    - Registered nurse
    - Licensed vocational nurse or nurse practitioner
    - Social worker
    - Chaplain
- Care coordination
- Pain and symptom management
- Mental health and medical social services

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

Hospitalization

Anesthesiologist services

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

Inpatient hospital services

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

Rapid Whole Genome Sequencing

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

RWGS is a new way to diagnose conditions in time to affect Intensive Care Unit (ICU) care of children one year of age or younger. If your child qualifies for California Children's Services (CCS), CCS may cover the hospital stay and the RWGS.

Surgical services

Health Net covers medically necessary surgeries performed in a hospital.

The Postpartum Care Extension (PPCE) program

Health Net covers post-partum care for up to 12 months after the end of the pregnancy regardless of income, citizenship, or immigration status. No other action is needed.

Rehabilitative and habilitative (therapy) services and devices

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

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

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

Health Net covers these rehabilitative/habilitative services:

Acupuncture

Health Net covers acupuncture services to prevent, change, or relieve the perception of severe, ongoing chronic pain resulting from a generally recognized medical condition.

Outpatient acupuncture services, with or without electric stimulation of needles, are limited to 2 services per month in combination with audiology, chiropractic, occupational therapy, and speech therapy services when provided by a doctor, dentist, podiatrist, or acupuncturist. Limits do not apply to children under age 21. Health Net may pre-approve (prior authorize) more services as medically necessary.

Audiology (hearing)

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

Behavioral health treatments

Health Net covers behavioral health treatment (BHT) services for members under 21 years old through the 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 a person under 21 years old.

BHT services teach skills using behavioral observation and reinforcement, or through prompting to teach each step of a targeted behavior. BHT services are based on

reliable evidence. They are not experimental. Examples of BHT services include behavioral interventions, cognitive behavioral intervention packages, comprehensive behavioral treatment and applied behavioral analysis.

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

Cardiac rehabilitation

Health Net covers inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment (DME)

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

Generally, Health Net does not cover:

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

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

Enteral and parenteral nutrition

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

Hearing aids

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

Hearing aids for members under age 21

In Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne, and Tulare counties, state law requires children who need hearing aid to be referred to the California Children's Services (CCS) program to decide if the child qualifies for CCS. If the child qualifies for CCS, CCS will cover the costs for medically necessary hearing aids. If the child does not qualify for CCS, we will cover medically necessary hearing aids as part of Medi-Cal coverage.

Hearing aids for members ages 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 ages 21 and older, Medi-Cal does not include:

- Replacement hearing aid batteries

Home health services

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

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

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

Medical supplies, equipment, and appliances

Health Net covers medical supplies prescribed by doctors, physician assistants, nurse practitioners, and clinical nurse specialists. Some medical supplies are covered through Fee-for-Service (FFS) Medi-Cal Rx and not by Health Net. When FFS covers supplies, the provider will bill Medi-Cal.

Medi-Cal does **not** cover:

- Common household items including, but not limited to:
  - Adhesive tape (all types)
  - Rubbing alcohol
  - Cosmetics
  - Cotton balls and swabs
  - Dusting powders
  - Tissue wipes
  - Witch hazel
- Common household remedies including, but not limited to:
  - White petrolatum
  - Dry skin oils and lotions

    - Talc and talc combination products
    - Oxidizing agents such as hydrogen peroxide
    - Carbamide peroxide and sodium perborate
- Non-prescription shampoos
- Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid, and zinc oxide paste
- Other items not generally used primarily for health care, and that are regularly and primarily used by persons who do not have a specific medical need for them.

Occupational therapy

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

Orthotics/prostheses

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

Ostomy and urological supplies

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

Physical therapy

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

Pulmonary rehabilitation

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

Skilled nursing facility services

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

Speech therapy

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

Transgender services

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

Clinical trials

Health Net covers routine patient care costs for patients accepted into clinical trials, including clinical trials for cancer, listed for the United States at https://clinicaltrials.gov.

Medi-Cal Rx, a Medi-Cal FFS program, covers most outpatient prescription drugs. To learn more, read “Outpatient prescription drugs” in this chapter.

Laboratory and radiology services

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

Preventive and wellness services and chronic disease management

The plan covers:

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

Family planning services are provided to members of childbearing age to allow them to choose the number and spacing of children. These services include all methods of birth control approved by the FDA. Health Net'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 Health Net without having to get pre-approval (prior authorization) from Health Net. Services from an out-of-network provider not related to family planning might not be covered. To learn more, call 1-800-675-6110 (TTY 711).

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

- Diabetes
- Cardiovascular disease
- Asthma
- Depression

For preventive care information for youth 20 years old and younger, read Chapter 5, "Child and youth well care."

Diabetes Prevention Program

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

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

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

Reconstructive services

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

Substance use disorder screening services

Health Net covers:

- Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)
- Services for adults (age 18 and older) who have alcohol or other substance use disorder conditions are offered to you at no cost. The covered services for alcohol misuse are:
  - One expanded screening for risky alcohol use per year (a screening tool that asks you for more information about your alcohol use)
  - Three 15-minute intervention sessions per year to talk about risky alcohol use

- The plan also covers inpatient treatment for acute drug or alcohol overdose when medically necessary.

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

Vision benefits

Health Net covers:

- Routine eye exam once every 24 months; more frequent eye exams are covered if medically necessary for members, such as those with diabetes.
- Eyeglasses (frames and lenses) once every 24 months with a valid prescription.
- Replacement eyeglasses within 24 months if your prescription changes or your eyeglasses are lost, stolen, or broken and cannot be fixed, and it was not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken.
- Low vision devices 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 (such as 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 (such as missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus.

Transportation benefits for situations that are not emergencies

You can get medical transportation if you have medical needs that do not allow you to use a car, bus, or taxi to your appointments. You can get medical transportation for covered services and Medi-Cal covered pharmacy appointments. You can request medical transportation by asking your participating physician group (PPG), independent practice association (IPA), primary care physician (PCP), MD, LVN, RN, PA, NP, mental health provider, substance use disorder provider, certified midwife, or discharge planner for it. Your provider will decide the correct type of transportation to meet your needs.

If they find that you need medical transportation, they will prescribe it by filling out a Physician Certification Statement form at https://providerlibrary.healthnetcalifornia.com/content/dam/centene/healthnet/pdfs/provi

derlibrary/5000_Medi-Cal_PCS_Form.pdf and submitting it to Health Net. Once approved, the approval is good for up to 12 months, depending on the medical need. Once approved, you can get as many rides as you need. Your doctor will need to reassess your medical need for medical transportation and re-approve it every 12 months.

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

You will get medical transportation if:

- It is physically or medically needed, with a written authorization by a doctor or other provider because you are not able to physically or medically able to use a bus, taxi, car, or van to get to your appointment
- You need help from the driver to and from your home, vehicle, or place of treatment due to a physical or mental disability

To ask for medical transportation that your doctor has prescribed for non-urgent (routine) appointments, call Health Net at 1-800-675-6110 at least 48 hours (Monday-Friday) before your appointment. For urgent appointments, call as soon as possible. Have your member ID card ready when you call.

Limits of medical transportation

Health Net provides the lowest cost medical transportation that meets your medical needs to the closest provider from your home where an appointment is available. You cannot get medical transportation if Medi-Cal does not cover the service you are getting, or it is not a Medi-Cal-covered pharmacy appointment. There is a list of covered services in this Member Handbook.

If Medi-Cal covers the appointment type but not through the health plan, Health Net will not cover the medical transportation but can help you schedule your transportation with Medi-Cal. Transportation is not covered outside of the network or service area unless pre-authorized by Health Net. To learn more or to ask for medical transportation, call Health Net at 1-800-675-6110 (TTY 711).

Cost to member

There is no cost when Health Net arranges transportation.

How to get non-medical transportation

Your benefits include getting a ride to your appointments when the appointment is for a Medi-Cal covered service and you do not have any access to transportation. You can get a ride, at no cost to you, when you have tried all other ways to get transportation and are:

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

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

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

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

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

To request a ride for services that have been authorized, call Health Net at 1-800-675-6110 (TTY 711) at least 24 hours (Monday-Friday) before your appointment. Or call as soon as you can when you have an urgent appointment. Have your member ID card ready when you call.

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

Limits of non-medical transportation

Health Net provides the lowest cost non-medical transportation that meets your needs to the closest provider from your home where an appointment is available. Members cannot drive themselves or be reimbursed directly for non-medical transportation. To learn more, call Health Net at 1-800-675-6110 (TTY 711).

Non-medical transportation does not apply if:

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

Cost to member

There is no cost when Health Net arranges non-medical transportation.

Travel expenses

In some cases, if you have to travel for doctor's appointments that are not available near your home, Health Net can cover travel expenses such as meals, hotel stays, and other related expenses such as parking, tolls, etc. They may also be covered for someone who is traveling with you to help you with your appointment or someone who is donating an organ to you for an organ transplant. You need to request pre-approval (prior authorization) for these services by contacting Health Net at 1-800-675-6110 (TTY 711).

Dental services

If you live in Los Angeles County, Medi-Cal uses managed care plans to provide your dental services. You can stay in Fee-for-Service Dental or you can choose the Dental Managed Care. To choose or change your dental plan, call Health Care Options at 1-800-430-4263. You may not be enrolled in a PACE or SCAN plan and a Dental Managed Care plan at the same time.

If you live in Sacramento County, Medi-Cal uses managed care plans to provide your dental services. You must enroll in Dental Managed Care. To learn more, go to Health Care Options at http://dhcs.ca.gov/mymedi-cal.

Medi-Cal covers dental services, including:

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

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

If you have questions or and live in Los Angeles or Sacramento counties or want to learn more about dental services and are enrolled in a Dental Managed Care plan, call your assigned Dental Managed Care plan.

For members in other counties, see “Other services you can get through FFS Medi-Cal or other programs” for information about dental benefits.

Other Health Net covered benefits and programs

Long-term care services and supports

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

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

- Intermediate care facility/developmentally disabled-habilitative (ICF/DD-H), and
- Intermediate care facility/developmentally disabled-nursing (ICF/DD-N)

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

If you have questions about long-term care services, call 1-800-675-6110 (TTY 711).

Basic care management

Getting care from many different providers or in different health systems is challenging. Health Net wants to make sure members get all medically necessary services, prescription medicines, and behavioral health services. Health Net can help coordinate and manage your health needs, at no cost to you. This help is available even when another program covers the services.

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

- If you have trouble getting a follow-up appointment or medicines after you are discharged from the hospital, Health Net can help you.
- If you need help getting to an in-person appointment, Health Net can help you get free transportation.

If you have questions or concerns about your health or the health of your child, call 1-800-675-6110 (TTY 711).

Complex Care Management (CCM)

Members with more complex health needs may qualify for extra services focused on care coordination. Health Net offers Complex Care Management (CCM) services to members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Complex Care Management is also for members who need additional support to avoid adverse outcomes, and/or those who have experienced a critical event

or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care.

Members who are enrolled in CCM and Enhanced Care Management (read below) have an Assigned Care Manager at Health Net who can help not only basic care management described above, but also an expanded set of transitional care supports that are available if you are discharged from a hospital, skilled nursing facility, psychiatric hospital, or residential treatment.

Enhanced Care Management (ECM)

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

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

Covered ECM services

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

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

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

Cost to member

There is no cost to the member for ECM services.

Community Supports

You may get supports 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. If you qualify, these services might help you with your health, well-being and live more independently. They do not replace benefits you already get under Medi-Cal.

Community Supports (CS) is a California Advancing and Innovating Medi-Cal (CalAIM), put in place by the Department of Health Care Services (DHCS). It is one of many programs to help improve the health of Medi-Cal members across the state.

Health Net has partnered with CS providers who are community-based organizations with experience working directly in the community who understands the needs of members. The key goal is to allow members to receive care in locations where they feel most comfortable and keep them in their home or community. There are 14 types of services that can help members, as described in the tables below.

To learn more about CS or to access these services, you may call Health Net at 1-800-675-6110 (TTY 711), 24 hours a day, 7 days a week, or talk to your provider for a referral.

You may also ask your doctor or clinic about the services.

Services to Address Homelessness and Housing:

Community Supports	**What you can get**
Housing Transition Navigation Services	**Help with getting housing.** This may include help with: • Looking for a place to live or housing. • How to apply for housing. • Making a housing support plan. Services are available in all counties **You may be able to get services if you:** • Are listed for housing help through the local homeless Coordinated Entry System or similar system.

	• Are experiencing homelessness. • Are at-risk of becoming homeless.
Housing Tenancy and Sustaining Services	Help with **keeping your housing once you've moved in**. This may include support with budgeting, timely rent payments, and understanding your lease agreement rights and responsibilities. Services are available in all counties. **You may be able to get services if you:** • Receive Housing Transition/Navigation Services. • Are listed for housing help through the local homeless Coordinated Entry System or a system like it. • Are currently experiencing homelessness. • Are at-risk of homelessness.
Housing Deposits	**Help with getting housing**. This includes: • Security deposits to get a lease. • First month's coverage of utilities. • First and last month's rent if required before move-in. Services are available in all counties **You may be able to get services if you:** • Receive Housing Transition/Navigation services. • Are listed for housing help through the local homeless Coordinated Entry System or a system like it. • Are experiencing homelessness.

Recuperative Services:

Community Supports	**What you can get**
Recuperative Care (medical respite)	**Short-term housing care for those who no longer need to be in a hospital but still need to heal** from injury or illness. Services are available in select counties. **You may be able to get services if you:** • At-risk of hospitalization or are post-hospitalization. • Live alone with no formal support.

	• Face housing insecurity or have housing that would jeopardize their health and safety without modification.
Respite	**Short-term relief given to caregivers of those who need care** or support on a short-term basis. Services are available in all counties **You may be able to get services if you:** • Live in a place that limits your daily activity. • Are needing a caregiver to provide most of your support. • Need caregiver relief to avoid being placed in a nursing home or someplace like it.
Short-Term Post Hospitalization Housing	**A place where you can keep getting care** for mental, or substance use disorder needs as soon as you leave a hospital. Services are available in select counties **You may be able to get services if you:** • Are leaving healing care. • Are leaving an inpatient hospital. • Meet the HUD meaning of homeless.
Sobering Centers	**A place where you can get help with alcohol or problems with drinking** rather than being taken to an emergency department or jail instead. Services are available in select counties. **You may be able to get services if you:** • Aged 18 and older and are drunk. • Taken to an emergency department or a jail. • Send to an emergency department and are a good fit for a Sobering Center.

Services for Long-Term Well-Being in Home-Like Settings:

Community Supports	**Description**
Asthma Remediation	**Changes** to a home to get rid of harmful asthma triggers. Services are available in all counties **You may be able to get services if you:** • Have had poorly controlled asthma in the past 12 months as defined by: ○ An emergency department visit.

	○ Being admitted into a hospital. ○ Two sick or urgent care visits. • Have a score of 19 or lower on the asthma control test.
Day Habilitation	**Programs given to help you learn the skills needed to live in home-like settings.** They can include training on use of public transportation or how to prepare meals. Services available in all counties. **You may be able to get services if you:** • Are experiencing homelessness. • Are no longer homeless and have entered housing in the last 24 months. • Are at-risk of being homeless. Or, home-like setting could be improved.
Environmental Accessibility Adaptation	**Changed to home for your health and safety.** Also, changes that allow you to function freely in the home. These may include ramps and grab bars. Services are available in all counties. **You may be able to get services if you:** • Are at-risk for being placed into a nursing home.
Meals/Medically Tailored Meals	**Meals that are delivered to your home that are prepared and cooked based on your health and diet needs.** This includes meals needed after you are released from the hospital. Services are available in all counties. **You may be able to get services if you:** • Have chronic conditions. • Are released from the hospital or skilled nursing home. • Are high risk of being admitted to the hospital or nursing home placement. • Have major care management needs. • Are assessed by register Dietitian or licensed Nutrition Professional.
Nursing Facility Transition/Diversion to ALF	**Services given to help you move out of a nursing home to community settings, like an assisted living facility.** This can also be services to keep you from being placed in a nursing home. Services available in all counties

	You may be able to get services if you: Nursing Home Transition • Have lived 60+ days in a nursing home. • Are willing to live in an assisted living facility (a place to help you with your daily medical needs) as an option to a nursing home. • Can live safely in an assisted living facility with support. Nursing Home Diversion • Want to stay in the community. • Are willing and able to live safely in an assisted living facility with support. • Are now getting nursing home services or meet the lowest standard to get nursing home services.
Community Transition Services/Nursing Facility Transition to Home	**Services given to help you if you're moving from a nursing home to a home setting** where you have to pay for living costs. Services available in all counties **You may be able to get services if you:** • Are now getting a medically needed nursing home level of care. • Have lived 60+ days in a nursing home and/or Medical Res pite setting. • Want to move back to the community. • Can live safely in the community with support services.
Personal Care and Homemaker Services	**Services provided to help you with your daily living needs**, such as bathing, dressing, housecleaning, and grocery shopping. Services available in all counties. **You may be able to get services if you:** • At-risk for being admitted to a hospital or placed in a nursing home. • A person that needs day-to-day help and have no other support system. • Approved for In-Home Supportive Services.

If you need help or want to find out what Community Supports might be available for you, call 1-800-675-6110 (TTY 711). Or, call your health care provider.

Major organ transplant

Transplants for children under age 21

In Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne, and Tulare counties, state law requires children who need transplants to be referred to the California Children's Services (CCS) program to decide if the child qualifies for CCS. If the child qualifies for CCS, CCS will cover the costs for the transplant and related services. If the child does not qualify for CCS, Health Net will refer the child to a qualified transplant center for evaluation. If the transplant center confirms that the transplant would be needed and safe, Health Net will cover the transplant and related services.

Transplants for adults ages 21 and older

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

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

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

Street medicine programs

Members experiencing homelessness may receive covered services from Street Medicine Providers within Health Net's provider network. A Street Medicine Provider is a licensed primary care physician or primary care non-physician in the Health Net network. For more information on Health Net's street medicine program, call 1-800-675-6110 (TTY 711).

Tobacco Cessation Program

The Kick It California tobacco cessation program is available to Health Net members. The program offers free telephone counseling, self-help materials and online help in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese).

Specialized services are available to teens, pregnant members, and tobacco chewers to help members quit smoking or vaping and stay tobacco-free. Texting programs, mobile apps and a live chat feature are also available. Health Net members can enroll in the telephonic tobacco cessation program, without prior authorization for members of any age regardless if they opt to use tobacco cessation medications, by calling Kick It California at 1-800-300-8086, or online at www.kickitca.org. Telephonic coaching is available Monday through Friday from 7:00 a.m. to 9:00 p.m., and Saturday from 9:00 a.m. to 5:00 p.m. Health Net will cover tobacco cessation counseling for at least two separate quit attempts per year, without prior authorization, and with no mandatory break between quit attempts. Members may request a referral to group counseling by calling the Health Education Department at 1-800-804-6074.

Non-pregnant adult members are eligible for a 90-day regimen of any FDA approved tobacco cessation medication. This includes over-the-counter medications with a prescription from the provider. At least one FDA-approved medication will be made available without prior authorization.

Health education interventions and resources are available to Health Net members at no cost through self-referral or a referral from their primary care physician (PCP). Members may request educational resources on health topics such as, but not limited to, nutrition, HIV/STD prevention, family planning, exercise, perinatal, asthma, substance abuse and much more. Members may obtain more information by contacting Health Net's toll-free Health Education Information Line at 1-800-804-6074.

Early Start/Early Intervention

- The Early Start Program is for infants and toddlers from birth to 3 years who need early intervention services and have problems that may result in developmental delays, or who show signs of developmental delay. Some risk conditions are:
  - Asphyxia
  - Central nervous system infection
  - Prematurity
- For more information about Early Start/Early Intervention or a referral to the Regional Center for Early Start/Early Intervention, talk to your doctor or to our plan.

Local Education Agency (LEA) assessment services

- The LEA provides certain health care assessment services through school programs. The LEA is your local public school. Children age 3 through 21 may get services without a referral from their PCP. The PCP should coordinate needed medical services with the LEA. LEA services may include:
  - Physical and Mental Health evaluations
  - Education and psychosocial assessments
  - Health and nutrition education
  - Developmental assessments
  - Physical and Occupational Therapy
  - Speech Therapy and audiology (hearing tests)
  - Counseling
  - Nursing services
  - School health aide services
  - Medical transportation

Members with developmental disabilities

REGIONAL CENTERS

- Regional Centers were created to meet the needs of people who are developmentally disabled. Disabling conditions include: intellectual disability, epilepsy, autism, cerebral palsy, Down's Syndrome, speech, and language delays. Regional Centers help their clients and families to find housing, day programs for adults, transportation, health care and social activities. Most of their services are free to eligible clients. If you have a family member who was diagnosed with a disabling condition before the age of 18, your PCP will connect you with the local Regional Center.

Other Medi-Cal programs and services

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

Health Net does not cover some services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. Health Net will coordinate with other programs to make sure you get all medically necessary services, including those covered by another program and not Health Net. This section lists some of these services. To learn more, call 1-800-675-6110 (TTY 711).

Outpatient prescription drugs

Prescription drugs covered by Medi-Cal Rx

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

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

Sometimes, you need a drug not on the Contract Drugs List. These drugs need approval before you can fill the prescription at the pharmacy. Medi-Cal Rx will review and decide these requests within 24 hours.

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

To find out if a drug is on the Contract Drugs List or to get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711.

Or go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Pharmacies

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

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

Once you choose a pharmacy, take your prescription to the pharmacy. Your provider can 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 medicines you are taking and any allergies you have. If you have any questions about your prescription, ask the pharmacist.

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

Specialty mental health services

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

Outpatient services:

- Mental health services
- Medication support services
- Day treatment intensive services
- Day rehabilitation services
- Crisis intervention services
- Crisis stabilization services
- Targeted case management
- Therapeutic behavioral services covered for members under 21 years old
- Intensive care coordination (ICC) covered for members under 21 years old
- Intensive home-based services (IHBS) covered for members under 21 years old

- Therapeutic foster care (TFC) covered for members under 21 years old
- Peer Support Services (PSS) (optional)

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

- Psychiatric inpatient hospital services
- Psychiatric health facility services

To learn more about 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, go to dhcs.ca.gov/individuals/Pages/MHPContactList.aspx. If Health Net finds you will need services from the county mental health plan, Health Net will help you connect with the county mental health plan services.

Substance use disorder treatment services

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

To learn more about treatment options for substance use disorders, call 1-800-675-6110.

Health Net members can have an assessment to match them to the services that best fit their health needs and preferences. When medically necessary, available services include outpatient treatment, residential treatment, and medicines for substance use disorders (also called Medication Assisted Treatment (MAT)) such as buprenorphine, methadone, and naltrexone.

The county provides substance use disorder services to Medi-Cal members who qualify for these services. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. For a list of all counties'

telephone numbers go to https://dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

Health Net will provide or arrange for MAT to be given in primary care, inpatient hospital, emergency department, and other medical settings.

Except as shown under the "Medi-Cal benefits covered by Health Net" subsection, all other alcohol and substance use disorder treatment services and outpatient heroin detoxification services are not covered by Health Net. Members requiring these services will be referred to a Voluntary Inpatient Detox (VID) provider or their county alcohol and substance use disorder treatment program for treatment. Health Net will continue to work with your PCP to cover primary care and other services unrelated to the alcohol and substance abuse treatment and will coordinate services with the treatment program(s), as necessary.

Dental services

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

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

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

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

California Children's Services (CCS)

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

County CCS program staff will decide if your child qualifies for CCS services. Health Net 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-eligible condition. Health Net 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.

Health Net does not cover services that the CCS program covers. 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 need treatment 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
- Seizures under certain circumstances
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain, or spinal cord injuries
- Severe burns
- Severely crooked teeth

Medi-Cal pays for CCS services. If your child does not qualify for CCS program services, they will keep getting medically necessary care from Health Net.

To learn more about CCS, go to https://www.dhcs.ca.gov/services/ccs. Or call 1-800-675-6110 (TTY 711).

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

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

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

To learn more about the Medi-Cal Waivers, go to https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx. Or call 1-800-675-6110 (TTY 711).

In-Home Supportive Services (IHSS)

The In-Home Supportive Services (IHSS) program provides in-home personal care assistance to qualified aged, blind, and disabled persons as an alternative to out-of-home care. It enables recipients to stay safely in their own homes.

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

Services you cannot get through Health Net or Medi-Cal

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

- In vitro fertilization (IVF), including but not limited to infertility studies or procedures to diagnose or treat infertility
- Fertility preservation
- Experimental services
- Home modifications
- Vehicle modifications
- Cosmetic surgery
- California Children's Services (CCS)
- All services excluded from Medi-Cal under state and/or federal law
- Circumcision for members age 31 days and older, unless medically necessary
- Mental Health services or counseling for couples or families for relationship problems
- Custodial Care
- Infertility
- Vaccines not recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)
- Personal comfort items (such as phones, television, and guest tray) when in the hospital
- Treatment for major alcohol problems. If you need services for major alcohol problems, you may be referred to the county alcohol and drug program.
- Vision Services:
  - Eyeglasses used for protective, cosmetic, or job-related purposes
  - Eyeglasses prescribed for other than the correction of refractive errors or binocular vision problems
  - Progressive lenses
  - Multifocal contact lenses
  - Vision therapy or visual training
- Prescription eyeglasses for a person who has and is able to wear contact lenses

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

To learn more call 1-800-675-6110 (TTY 711).

Evaluation of new and existing technologies

New technologies include procedures, drugs, biological product, or devices that have been newly developed to treat specific illnesses or conditions or are new ways of using current technologies.

Health Net keeps up with the change in technologies and treatments. To help decide if a new treatment or care should be added to your benefit plan, we review:

- The latest medical and scientific writings
- Recommendations by practicing doctors or nationally recognized medical associations
- Reports and publications of government agencies.

This work is done to be sure you have access to safe and effective care.

5. Child and youth well care

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

Pediatric services (Children under age 21)

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

- Well-child visits and teen check-ups (important visits children need)
- Immunizations (shots)
- Behavioral health assessment and treatment
- Mental health evaluation and treatment, including individual, group and family psychotherapy (specialty mental health services are covered by the county)
- Adverse childhood experiences (ACE) screening
- Lab tests, including blood lead poisoning screening
- Health and preventive education
- Vision services
- Dental services (covered under Medi-Cal Dental)
- Hearing services (covered by California Children's Services (CCS) for children who qualify. Health Net 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.

To read these guidelines, go to https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Well-child health check-ups and preventive care

Preventive care includes regular health check-ups, screenings to help your doctor find problems early, and counseling services to detect illnesses, diseases, or medical conditions before they cause problems. Regular check-ups help you or your child's doctor look for any problems. Problems can include medical, dental, vision, hearing, mental health, and any substance (alcohol or drug) use disorders. Health Net 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. Health Net must make sure all enrolled children are up to date with all the shots they need when they have their visits with their doctor. 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 schedule: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Lab tests, including blood lead poisoning screening
- Health education
- Vision and hearing screening
- Oral health screening
- Behavioral health assessment

If the doctor finds a problem with your or your child's physical or mental health during a check-up or screening, you or your child might need to get medical care. Health Net will cover that care at no cost to you, including:

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

Blood lead poisoning screening

All children enrolled in Health Net should get blood lead poisoning screening at 12 and 24 months of age or between 36 and 72 months of age if they were not tested earlier. Children should also be screened whenever the doctor believes a life change has put the child at risk.

Help getting child and youth well care services

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

- Tell you about available services
- Help find in-network providers or out-of-network providers, when needed
- Help make appointments
- Arrange medical transportation so children can get to their appointments

- Help coordinate care for services available through Fee-for-Service (FFS) Medi-Cal, such as:
  - Treatment and rehabilitative services for mental health and substance use disorders
  - Treatment for dental issues, including orthodontics

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

Dental check-ups

Keep your baby's gums clean by gently wiping the gums with a washcloth every day. At about 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.

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

Babies aged 1 to 4

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

Kids aged 5-12

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

Youth aged 13-20

- Dental exams (every 6 months, and sometimes more)
- X-rays
- Fluoride varnish (every 6 months, and sometimes more)
- Teeth cleaning (every 6 months, and sometimes more)
- Filings
- Orthodontics (braces) for those who qualify
- Crowns
- Root canals
- Extractions (tooth removal)
- Emergency dental services
- Sedation (if medically necessary)

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

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

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

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

Additional preventive education referral services

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

Services that can be provided to help your child learn include:

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

The California Department of Education provides and pays for these services. Together with your child's doctors and teachers, you 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:

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

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

You may contact Health Net first to let us know about your problem. Call 24 hours a day, 7 days a week at 1-800-675-6110 (TTY 711). Tell us about your problem.

If your grievance or appeal is still not resolved after 30 days, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC). Ask them to review your complaint or conduct an Independent Medical Review (IMR). If your matter is urgent, such as those involving a serious threat to your health, you may call DMHC right away without first filing a grievance or appeal with Health Net. You can call DMHC for free at 1-888-466-2219 (TTY 1-877-688-9891 or 711). Or go to: https://www.dmhc.ca.gov.

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

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call 1-800-675-6110 (TTY 711).

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

Complaints

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

- **By phone:** Call Health Net at 1-800-675-6110 (TTY 711) 24 hours a day, 7 days a week. Give your health plan ID number, your name and the reason for your complaint.
- **By mail:** Call Health Net at 1-800-675-6110 (TTY 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the reason for your complaint. Tell us what happened and how we can help you.

  Mail the form to:
  Health Net Appeals & Grievances
  P.O. Box 10348
  Van Nuys, CA 91410-0348

  Your doctor's office will have complaint forms.
- **Online:** Go to the Health Net website at www.healthnet.com.

If you need help filing your complaint, we can help you. We can give you no-cost language services. Call 1-800-675-6110 (TTY 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 Health Net about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and your grievance is resolved by the end of the next business day, you may not get a letter.

If you have an urgent matter involving a serious health concern, we will start an expedited (fast) review. We will give you a decision within 72 hours. To ask for an expedited review, call us at 1-800-675-6110 (TTY 711). Within 72 hours of getting your

complaint, we will decide how we will handle your complaint and whether we will expedite it. If we find that we will not expedite your complaint, we will tell you that we will resolve your complaint within 30 days. You may contact DMHC directly for any reason, including if you believe your concern qualifies for expedited review, or Health Net does not respond to you within the 72-hour period.

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

Complaints related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. DMHC's toll-free telephone number is 1-888-466-2219(TTY 1-877-688-9891). You can find the Independent Medical Review/Complaint form and instructions online at 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 services. If we sent you a Notice of Action (NOA) letter telling you that we are denying, delaying, changing, or ending a service, and you do not agree with our decision, you can ask us for an appeal. Your authorized representative or provider can also ask us for an appeal for you with your written permission.

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

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

- **By phone:** Call Health Net at 1-800-675-6110 (TTY 711) 24 hours a day, 7 days a week. Give your name, health plan ID number and the service you are appealing.
- **By mail:** Call Health Net at 1-800-675-6110 (TTY 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the service you are appealing.

  Mail the form to:
  Health Net Appeals & Grievances
  P.O. Box 10348
  Van Nuys, CA 91410-0348

  Your doctor's office will have appeal forms available.
- **Online:** Visit the Health Net website. Go to www.healthnet.com.

If you need help asking for an appeal or with Aid Paid Pending, we can help you. We can give you no-cost language services. Call 1-800-675-6110 (TTY 711).

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 give you our appeal decision within 30 days, you can request a State Hearing from the California Department of Social Services (CDSS) and an Independent Medical Review (IMR) with DMHC. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR with DMHC. 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 1-800-675-6110 (TTY 711). We will decide within 72 hours of receiving your appeal.

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

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

- Ask for a **State Hearing** from the California Department of Social Services (CDSS), and a judge will review your case. CDSS' toll-free telephone number is 1-800-743-8525(TTY1-800-952-8349). You can also ask for a State Hearing online at https://www.cdss.ca.gov.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have Health Net's decision reviewed. Or ask for an **Independent Medical Review (IMR)** from DMHC. If your complaint qualifies for DMHC's Independent Medical Review (IMR) process, an outside doctor who is not part of Health Net will review your case and make a decision that Health Net must follow.

  DMHC's toll-free telephone number is 1-888-466-2219 (TTY 1-877-688-9891). You can find the Independent Medical Review/Complaint form and instructions online at 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 Health Net. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711. Complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review (IMR).

If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing. **You cannot ask DMHC for an IMR for Medi-Cal Rx pharmacy benefit decisions.**

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

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 Health Net. 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 first filing an appeal with Health Net. This is in cases where your health concern is urgent, such as those involving a serious threat to your health.

If your complaint to DMHC does not qualify for an IMR, DMHC will still review your complaint to make sure Health Net made the correct decision when you appealed its denial of services.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-675-6110 (TTY 711)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with Health Net and a judge from the CDSS. The 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 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.

You must ask for a State Hearing within 120 days from the date on our NAR letter. If we gave you Aid Paid Pending during your appeal and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 days of our NAR letter, or before the date we said your services will stop, whichever is later. If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, contact Health Net 24 hours a day, 7 days a week by calling 1-800-675-6110. If you cannot hear or speak well, call (TYY 711). Your authorized representative or provider can ask for a State Hearing for you with your written permission.

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

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

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

You can ask for a State Hearing in these ways:

- **Online:** Request a hearing online at **www.CDSS.CA.GOV**
- **Fax:** Fill out the form that came with your appeals resolution notice and fax it to the State Hearings Division at 1-833-281-0905

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

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-442
Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you no-cost language services. Call 1-800-675-6110 (TTY 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. Health Net must follow what the judge decides.

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

Fraud, waste, and abuse

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

Provider fraud, waste, and abuse includes:

- Falsifying medical records
- Prescribing more medicine than is medically necessary
- Giving more health care services than medically necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service
- Offering free or discounted items and services to members to influence which provider is selected by the member

- Changing member's primary care provider without the knowledge of the member

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

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

Centene Special Investigations Unit
7700 Forsyth Blvd.
Clayton, MO 63105
1-866-685-8664
Special_Investigations_Unit@centene.com

7. Rights and responsibilities

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

Your rights

These are your rights as a member of Health Net:

- 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 health plan and its services, including covered services, practitioners, and member rights and responsibilities
- To get fully translated written member information in your preferred language, including all grievance and appeals notices
- To make recommendations about Health Net's member rights and responsibilities policy
- To be able to choose a primary care provider within Health Net's network
- To have timely access to network providers
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care you got
- To know the medical reason for Health Net's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination
- To ask for an appeal of decisions to deny, defer or limit services or benefits
- To get no-cost interpreting and translation services for your language
- To get free legal help at your local legal aid office or other groups
- To formulate advance directives

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Health Net and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible
- To disenroll (drop) from Health Net 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 and Institutions (W&I) Code section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how you are treated by Health Net, 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 Health Net's network pursuant to the federal law
- To request an Appeal of an adverse benefit determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.

Your responsibilities

Health Net members have these responsibilities:

- **Act courteously and respectfully.** You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for

being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.

- **Give up-to-date, accurate and complete information.** You are responsible for giving correct information and as much information as you can to all of your providers, and to Health Net. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- **Follow your doctor's advice and take part in your care.** You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.
- **Use the Emergency Room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- **Report wrong-doing.** You are responsible for reporting health care fraud or wrong-doing to Health Net Community Solutions. You can do this without giving your name by calling Health Net Fraud and Abuse Hotline toll-free at 1-866-685-8664. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Notice of non-discrimination

Discrimination is against the law. Health Net follows state and federal civil rights laws. Health Net does not unlawfully discriminate, exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

Health Net 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)
- No-cost language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Health Net 24 hours a day, 7 days a week by calling 1-800-675-6110. Or, if you cannot hear or speak well, call 711 to use the California Relay Service.

How to file a grievance

If you believe that Health Net has failed to provide these services or unlawfully discriminated in another way based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with Health Net's Member Services. You can file a grievance in writing, in person, or electronically:

- **By phone**: Contact Health Net 24 hours a day, 7 days a week by calling 1-800-675-6110. Or, if you cannot hear or speak well, please call TTY 711 to use the California Relay Service.
- **In writing:** Fill out a complaint form or write a letter and send it to:
  Health Net Civil Rights Coordinator
  P.O. Box 10348
  Van Nuys, CA 91410
- **In person:** Visit your doctor's office or Health Net and say you want to file a grievance.
- **Electronically:** Visit Health Net's website at www.healthnet.com.

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 1-916-440-7370. If you cannot speak or hear well, 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, 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

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

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Community Advisory Committee

Health Net has a group called Community Advisory Committee (CAC).The CAC comprises key community stakeholders reflective of the Medi-Cal population in the Plan's service areas such as Medi-Cal consumers (including those from hard-to-reach or remote populations and members with disabilities), community advocates, community-based organizations, and providers. The group talks about how to improve Health Net policies and is responsible for:

- Input on Health Net's quality improvement, health education, and health equity efforts.
- Input on Health Net's cultural and linguistic services program and other programs that may promote and improve a member's overall health.
- Identification of barriers to care due to culture, discrimination, language, or disability.

If you would like to be a part of this group, call 1-800-675-6110 (TTY 711).

Public Policy Committee

Health Net has a group called the Public Policy Committee. This group is made up of health plan members and providers. Joining this group is voluntary. The group talks about how to improve Health Net policies and is responsible for:

- Giving advice to the Health Net Board of Directors on policy issues that affect the health plan and our members.

If you would like to be a part of this group, call 1-800-675-6110 (TTY 711)

You can also call member services if you have any questions about these groups.

Notice of privacy practices

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

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

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

Health Net will honor your requests to get confidential communications in the form and format you asked for. Or we will make sure your communications are easy to put in the form and format you asked for. We will send them to the place you choose. Your request for confidential communications lasts until you cancel it or submit new request for confidential communications.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. ***Effective 08.14.2017***

Covered Entities Duties:

Health Net* (referred to as “we” or “the Plan”) is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. PHI is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Health Net reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Health Net will promptly revise and distribute this Notice whenever there is a material change to the following:

- Uses or disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website and in our Member Handbook.

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** **-** We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.

- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - processing claims
  - determining eligibility or coverage for claims
  - issuing premium billings
  - reviewing services for medical necessity
  - performing utilization review of claims
- ***Health Care Operations*** - We may use and disclose your PHI to perform our health care operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination
  - conducting medical review of claims and other quality assessment
  - improvement activities

In our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its health care operations. This includes the following:

- quality assessment and improvement activities
- reviewing the competence or qualifications of health care professionals
- case management and care coordination
- detecting or preventing health care fraud and abuse

- ***Group Health Plan/Plan Sponsor Disclosures*** - We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** - We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out or stop receiving such communications in the future.
- ***Underwriting Purposes*** - We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if we have a reasonable belief of abuse, neglect, or domestic violence.

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - an order of a court
  - administrative tribunal
  - subpoena
  - summons
  - warrant
  - discovery request
  - similar legal request
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - court order
  - court-ordered warrant
  - subpoena
  - summons issued by a judicial officer
  - grand jury subpoena

We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** - We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking, or transplantation of:
  - cadaveric organs
  - eyes
  - tissues
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - to authorized federal officials for national security and intelligence activities
  - the Department of State for medical suitability determinations
  - for protective services of the President or other authorized persons
- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** - We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care, to protect your health or safety, or the health or safety of others, or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI - We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing - We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes - We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment, or health care operation functions.

Impermissible Use of PHI – We will not use your language, race, ethnic background, sexual orientation, gender identity, and social needs information to deny coverage, services, benefits, or for underwriting purposes.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

The State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc., and Health Net Life Insurance Company (Health Net, LLC.) comply with applicable federal civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time; the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications*** - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered. A confidential communications request shall be implemented by the health insurer within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. We shall not disclose medical information related to Sensitive Services provided to a Protected Individual to the Group, Subscriber, or any plan enrollees other than the Protected Individual receiving care, absent an express written authorization of the Protected Individual receiving care. Refer to the customer service phone number on the back of your member identification card or the plan's website for instructions on how to request confidential communication.
- ***Right to Access and Receive a Copy of your PHI*** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI*** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information, you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision, and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Health Net Privacy Office
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 91409

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

For Medi-Cal members only, if you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:

Privacy Officer
c/o Office of Legal Services

California Department of Health Care Services
1501 Capitol Avenue, MS 0010

P.O. Box 997413
Sacramento, CA 95899-7413

Phone: 1-916-445-4646 or 1-866-866-0602 (TTY/TDD: 1-877-735-2929)
E-mail: DHCSPrivacyofficer@dhcs.ca.gov

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW **FINANCIAL INFORMATION** ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect: We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information, and Social Security number;
- Information about your transactions with us, our affiliates, or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security: We maintain physical, electronic, and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice:

If you have any questions about this notice:

Please call the toll-free phone number on the back of your ID card or contact Health Net at 1-800-522-0088.

*This Notice of Privacy Practices applies to enrollees in any of the following Health Net entities:

Health Net of California, Inc., Health Net Community Solutions, Inc., Managed Health Network, LLC and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies.

Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are state and federal laws about the Medi-Cal program. Other federal and state laws may apply too.

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

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

Medi-Cal members may have other health coverage (OHC), also referred to as private health insurance. As a condition of Medi-Cal eligibility, you must apply for or retain any available OHC when there is no cost to you.

Federal and state laws require Medi-Cal members to report OHC and any changes to an existing OHC. You may have to repay DHCS for any benefits paid by mistake if you don't report OHC quickly. Submit your OHC online at http://dhcs.ca.gov/OHC.

If you do not have access to the internet, you can report OHC to Health Net. Or call 1-800-541-5555 (TTY 1-800-430-7077 or 711) inside California, or 1-916-636-1980 (outside California).

The California Department of Health Care Services (DHCS) has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. 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 https://dhcs.ca.gov/PI
- Workers' Compensation Recovery Program at https://dhcs.ca.gov/WC

To learn more, visit https://dhcs.ca.gov/tplrd or call 1-916-445-9891.

Notice about estate recovery

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-for-Service (FFS) and managed care premiums or capitation payments for nursing facility services, home and community-based services, and related hospital and

prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the DHCS estate recovery website at http://dhcs.ca.gov/er or call 1-916-650-0590.

Notice of Action

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

Contents in notices

If Health Net bases denials, delays, terminations, or changes in whole or in part on medical necessity, your NOA must contain the following:

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

Translations

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

The fully translated notice must include the medical reason for Health Net's decision to deny, delay, change, reduce, suspend, or stop a request for health care services.

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

Third Party Liability

Health Net will not make any claim for recovery of the value of covered services provided to a member when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. However, Health Net will notify the DHCS of such potential cases and will help the DHCS in pursuing the State's right to reimbursement of such recoveries. Members are obligated to assist Health Net and the DHCS in this regard.

Independent contractors

The relationship between Health Net and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Health Net and neither Health Net, nor any employee of Health Net, is an employee or agent of a participating provider. In no case will Health Net be liable for the negligence, wrongful act, or omission of any participating provider or other health care provider. Participating providers, and not Health Net, maintain the physician-patient relationship with the member. Health Net is not a provider of health care.

Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, member, employer, or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-866-685-8664. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Circumstances beyond Health Net’s control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, or other similar events not within the control of Health Net, results in Health Net’s facilities or personnel not being available to provide or arrange for services or benefits under this Member Handbook, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good-faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.

8. Important numbers and words to know

Important phone numbers

- Health Net member services 1-800-675-6110 (TTY 711)
- Medi-Cal Rx at 1-800-977-2273 (TTY 1-800-977-2273) and press 7 or 711
- **Disability Services**
  - Website: https://www.ada.gov/
  - California Relay Service (CRS): TTY/TDD: 711
  - Sprint 1-888-877-5379 (Voice)
  - MCI 1-800-735-2922 (Voice)
  - Americans Disabilities Act (ADA) Information: 1-800-514-0301 (Voice); 1-800-514-0383 (TDD)
- **Children's Services (CCS Program)**
  - Website: https://www.dhcs.ca.gov/services
  - Amador County: 1-209-223-6630
  - Calaveras County: 1-209-754-6460
  - Inyo County: 1-760-873-7868
  - Los Angeles County: 1-800-288-4584
  - Mono County: 1-760-924-1841
  - Sacramento County: 1-916-875-9900
  - San Joaquin County: 1-209-468-3900
  - Stanislaus County: 1-209-558-7515
  - Tuolumne County: 1-209-533-7404
  - Tulare County: 1-559-685-5800
- **Child Health and Disability Prevention (CHDP) Program**
  - Website: https://www.dhcs.ca.gov/services/chdp
  - Amador County: 1-209-223-6630

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.

- Calaveras County: 1-209-754-6460
- Inyo County: 1-760-873-7868
- Los Angeles County: 1-800-993-2437
- Mono County: 1-760-924-1841
- Sacramento County: 1-916-875-7151
- San Joaquin County: 1-209-468-8335
- Stanislaus County: 1-209-558-8860
- Tuolumne County: 1-209-533-7404
- Tulare County: 1-559-687-6915

- **California State Services**
  - DHCS Ombudsman Office: 1-888-452-8609 (website: https://www.dhcs.ca.gov/services/MH/Pages/MH-Ombudsman.aspx)
  - Department of Social Services: 1-800-952-5253 (TDD: 1-800-952-8349) (website: https://www.cdss.ca.gov/county-offices)
  - Department of Managed Health Care (DMHC): 1-888-466-2219 (1-888-HMO-2219) (website: http://dmhc.ca.gov/)
- **Social Security Administration**
  - Supplemental Security Income (SSI): 1-800-772-1213 (TTY/TDD: 1-800-325-0778)
  - Website: https://www.ssa.gov/
- **County Offices**
  - Website: http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx
  - Mental Health website: https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx
  - **Amador County**
    - Department of Social Services: 1-209-223-6550
      Mental Health Services: 1-888-310-6555
  - **Calaveras County**
    - Health and Human Services Agency: 1-209-754-6448
      Mental Health Services: 1-800-499-3030
  - **Inyo County**
    - Department of Social Services: 1-760-872-1394
      Mental Health Services: 1-800-841-5011

- **Los Angeles County**
  - Department of Public Social Services (DPSS)
  - Central Help Line (includes language services): 1-877-481-1044
  - DPSS Customer Service Center: 1-866-613-3777; 1-310-258-7400
  - Los Angeles County Department of Mental Health: 1-800-854-7771
- **Mono County**
  - Department of Social Services: 1-760-924-1770 (South county office); 1-760-932-5600 (North county office)
    Mental Health Services: 1-800-687-1101
- **Sacramento County**
  - Department of Human Assistance: 1-916-874-3100
  - Department of Health & Human Services (Mental Health): 1-888-881-4881
- **San Joaquin County**
  - Department of Public Health: 1-209-468-3400
  - Behavioral Health: 1-888-468-9370
  - Human Services Agency: 1-209-468-1000
- **Stanislaus County**
  - Community Services Agency: 1-877-652-0734
  - Behavioral Health & Recovery Services: 1-888-376-6246
- **Tuolumne County**
  - Behavioral Health Department: 1-209-533-6245
  - Public Health: 1-209-533-7401
- **Tulare County**
  - Health & Human Services Agency: 1-800-540-6880
  - Department of Mental Health: 1-800-320-1616

Words to know

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

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

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

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

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

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

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

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

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

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

Chronic condition: A disease or other medical problem that cannot be completely cured or that gets worse over time or that must be treated so 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 a service covered by Medi-Cal, Health Net, a county mental health plan, or a Medi-Cal provider. A complaint is the same as a grievance.

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

Contract Drugs List (CDL): The approved drug list for Medi-Cal Rx from which your provider 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.

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 (co-pay): A payment you make, generally at the time of service, in addition to the insurer's payment.

Coverage (covered services): Medi-Cal services for which Health Net is responsible for payment. Covered services are 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: 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. Health Net decides whether to rent or buy DME. Rental costs must not be more than the cost to buy.

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 might 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 bodily function
- Cause a body part or organ to not work right

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

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

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

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

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 or animal studies before 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 Medi-Cal Rx.

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

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

Freestanding Birth Centers (FBCs): Health facilities where childbirth is planned to occur away from the pregnant 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 Health Net, a provider, the quality of care, or the services provided. A complaint filed with Health Net about a network provider 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.

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 Health Net or are in the Health Net network. Health Net network providers must have a license to practice in California and give you a service Health Net covers.

You usually need a referral from your PCP to go to a specialist. Your PCP must get pre-approval from Health Net before you get care from the specialist

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

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 expectancy of 6 months or less.

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

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

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

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

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

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

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

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

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. Health Net 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.

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

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

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

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

Mental health services provider: Licensed persons 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 Health Net to provide care.

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

Non-covered service: A service that Health Net does not cover.

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 Health Net 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, or Medicare supplemental plans (Part C & D).

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

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

Out-of-network provider: A provider who is not part of the Health Net 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 Health Net to provide services to members at the time a member gets care. The covered services that some participating hospitals might offer to members are limited by Health Net's utilization review and quality assurance policies or Health Net's contract with the hospital.

Participating provider (or participating doctor): A doctor, hospital or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with Health Net 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 keep the member stabilized. Post-stabilization care services are covered and paid for. Out-of-network hospitals might need pre-approval (prior authorization).

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

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

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

Primary care: Go to “Routine care.”

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need.

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): The process by which you or your provider must request approval from Health Net for certain services to ensure Health Net will cover them. A referral is not an approval. A prior authorization is the same as pre-approval.

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

Provider Directory: A list of providers in the Health Net 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 whole population. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified provider: 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 related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

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

Service area: The geographic area Health Net serves. This includes the counties of Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tuolumne, and Tulare.

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

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

Specialist (or specialty doctor): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, 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 higher than a mild to moderate level of impairment.

Subacute care facility (adult or pediatric): A long-term care facility that provides comprehensive care for medically fragile persons that need special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.

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

Tort recovery: When benefits are provided or will be provided to a Medi-Cal member because of an injury for which another party is liable, DHCS recovers the reasonable value of benefits provided to the member for that injury.

Triage (or screening): The evaluation of 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 in-network providers are temporarily not available or accessible.

Call member services at 1-800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. The call is free. Or call the California Relay Line at 711. Visit online at www.healthnet.com.