



Policy and Procedure No: MS 9.5	Revision No: 5
Division: Care Management	
Department: Member Services	
Title: PHC-CA Enrollee Rights and Responsibilities	
Effective Date: 2/29/2008	
Supersedes Policy No: 91009, MS 9.0, MS 9.1, MS 9.2, MS 9.3, MS 9.4	
Reviewed/Revised by: Michael O'Malley	Review/Revision Date: 10/15/2025
Approving Committee: Member Provider Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe enrollees' rights and responsibilities as a member of PHC California (the Health Plan) pursuant to the Health Plan's contract with the California Department of Health Care Services (DHCS) and how this information is collected and disseminated to enrollees and participating providers.

Policy:

1. The Health Plan publishes a list of enrollee rights and responsibilities in its Evidence of Coverage and Disclosure Form/Membership Guide (EOC) for its Medi-Cal managed care plan following those listed in the DHCS contract and DHCS-issued model EOC:
 - a. PHC California enrollee rights are as follows:
 - i. To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
 - ii. To be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities
 - iii. To get fully translated written member information in your preferred language, including all grievance and appeals notices.
 - iv. To make recommendations about PHC California's member rights and responsibilities policy.
 - v. To be able to choose a primary care provider within PHC California's network
 - vi. To have timely access to Network Providers.
 - vii. To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
 - viii. To voice grievances, either verbally or in writing, about the organization or the care you received.
 - ix. To know the medical reason for PHC California's decision to deny, delay, terminate (end) or change a request for medical care.

- x. To get care coordination.
 - xi. To ask for an appeal of decisions to deny, defer, or limit services or benefits.
 - xii. To get free interpreting and translation services for your language.
 - xiii. To get free legal help at your local legal aid office or other groups.
- To have a valid Advance Directive in place, and an explanation of what an Advance Directive is.

- xiv. To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with PHC California 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.
- xv. To disenroll (drop) from PHC California and change to another health plan in the county upon request.
- xvi. To get free written member information in other formats (such as braille, large size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12).
- xvii. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- xviii. 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.
- xix. 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.
- xx. Freedom to exercise these rights without adversely affecting how you are treated by PHC California, your providers, or the State.
- xxi. To have access to family planning services, Federally Qualified Health Centers, Indian Health Care Providers, Rural Health Centers, sexually transmitted infection services, and emergency services outside PHC California's network pursuant to federal law.

b. PHC California Enrollee responsibilities are as follows:

- i. Provide accurate information to the professional staff.
- ii. Participate in your health care and the health care of your family. This means taking care of medical problems before they become more serious.
- iii. Keep in touch with and regularly visit your PHC California primary care provider



(PCP).

- iv. Cooperate with your PCP, follow his or her instructions regarding your care and take all of your prescribed medications as directed.
 - v. Arrive on time for your doctor visits. Call if you will be late or need to cancel or reschedule your appointment.
 - vi. Be courteous and cooperative with people who provide you or your family with health care services.
 - vii. Not let anyone else use your PHC California member identification card or Medi-Cal beneficiary identification card (BIC) or pretend to be you.
 - viii. Not participate in Medi-Cal fraud or any inappropriate use of your Medi-Cal coverage through PHC California or the Medi-Cal fee-for-service system.
2. The Health Plan publishes the following enrollee rights information in its Provider Manual and provider newsletters, etc. pursuant to DHCS's model language as referenced in paragraph 1 above.
 3. The Health Plan publishes the following enrollee rights information in its Provider Manual and provider newsletters, etc. pursuant to the DHCS contract:
 - a. Right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing
 - b. Right to file grievances and appeals and their requirements and timeframes for filing
 - c. Availability of assistance in filing
 - d. Toll-free numbers to file oral grievances and appeals
 - e. Right to request continuation of benefits during and appeal or State Fair Hearing
 4. The Health Plan publishes enrollee rights and responsibilities information in its newsletters, website, etc.
 5. The Health Plan makes the list enrollee rights and responsibilities available to members and providers upon request, in addition to publishing it as described above.

Procedure:

1. The Health Plan Administrator is responsible to maintain the list enrollee rights and responsibilities and update it as necessary at the direction of the DHCS and obtain approval for any changes. The Health Plan Administrator or his/her designee is responsible to publish this list in the Health Plan's Evidence of Coverage and Disclosure Form (EOC)/Membership Guide and Provider Manual.
2. The Health Plan Administrator or his/her designee is responsible to communicate any changes to the list of enrollee rights and responsibilities to Health Plan members and providers through either an updated EOC and Provider Manual, or errata sheets that describe the changes. They are responsible to disseminate revised material containing the changes to members and plan providers.



3. The Health Plan provides electronic information to members and potential members if the information is available upon request, readily accessible, available in paper form, free of charge and easy-to-understand language within five (5) business days.
1. The Director of Member Services and Call Center Operations is responsible to train the Member Services agents on enrollees' rights and responsibilities.
2. The Health Plan Administrator is responsible to work with the Health Equity Officer and Director of Health Education to periodically disseminate enrollees' rights and responsibilities information to plan members and Network Providers through educational materials, i.e., newsletters, fact sheets, etc.

Monitoring:

1. Member rights information is included in annual Enrollee and Provider newsletters.
2. Information is included in the newsletter editorial calendar, which is reviewed and approved annually by the Member Provider Committee.
3. Member rights information is included in Member Handbook and Provider Manual, which are reviewed and approved annually by the Member Provider Committee.
4. This policy is updated, as necessary, reviewed and approved annually by the Member Provider Committee.

Definitions:

1. Grievance: means any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to: the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or Health Plan's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Health Plan to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Health Plan processes. If Health Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.
2. Member or Enrollee: means a Potential Member who has enrolled with the Health Plan.
3. Member Handbook or Evidence of Coverage (EOC): means the document that describes the health care benefits and Covered Services that are available to a Member.
4. Network: means Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Health Plan enters into a Network Provider Agreement
5. Network Provider: means any Provider or entity that has a Network Provider Agreement with Health Plan, Health Plan's Subcontractor, or Health Plan's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

6. Primary Care Provider (PCP): means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
7. Provider: means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Reference(s):

1. DHCS contract 23-30211, Exhibit A, Attachment III, Section 5.1.
2. DHCS Evidence of Coverage and Disclosure Form
3. 45 CFR sections 164.524 and 164.526
4. CFR sections 84.52(d), 92.202, and 438.10

Regulatory Agency Approvals:

Date	Version	Agency	Purpose	Response
9/20/2023	MS 9.2	Dept. of Health Care Services (DHCS)	2024 Operational Readiness (O/R) R.0159	Approved
12/6/2023	MS 9.3	DHCS	2024 O/R R.0153	Approved
10/9/2025	MS 9.4	DHCS	D.0362 Member’s Rights and Responsibilities	AIR1
11/5/2025	MS 9.5	DHCS	D.0362 AIR1	Approved

