
3. How to get care

Pre-approval (prior authorization)

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

Medically necessary services are services that 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.

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

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

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

For standard pre-approval (prior authorization) requests, PHC California must respond to your request as soon as your health condition requires, but no more than five business days from when PHC California gets the information it asked for that it



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reasonably needs to decide (approve, change or deny) your request. PHC California must respond, no more than seven calendar days from when PHC California gets your request.

If a provider or PHC California finds that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, PHC California will make a faster expedited pre-approval (prior authorization) decision. PHC California will respond as soon as your health condition requires, no longer than 72 hours from when PHC California gets your request.

In certain cases, PHC California may need more information to decide (approve, change, or deny) your pre-approval (prior authorization) request. If this happens, PHC California has up to 14 more calendar days to decide. Once PHC California gets the needed information, it must make a decision as soon as your health condition requires, but no later than five business days for standard requests or 72 hours for expedited requests. Your provider can ask for an extension for PHC California to respond to standard requests. You can request an extension for standard or expedited requests. Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

PHC California does not influence the reviewers' decision to deny, change, or approve coverage or services in any way. If PHC California does not approve the request, PHC California 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.

PHC California will contact you if PHC California 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 PHC California 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 1-800-263-0067 (TTY 711).



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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. PHC California 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 PHC California to get a second opinion from an in-network provider. If you want to get a second opinion, we will refer you to a qualified in-network provider who can give you one.

To ask for a second opinion and get help choosing a provider, call 1-800-263-0067 (TTY 711). Your in-network provider can also help you get a referral for a second opinion if you want one.

If there is no provider in the PHC California network who can give you a second opinion, PHC California will pay for a second opinion from an out-of-network provider. PHC California will tell you if the provider you choose for a second opinion is approved as fast as your medical condition requires, but no more than five business days from when PHC California gets the information it asked for that it reasonably needs to decide your request, PHC California must respond no more than seven calendar days from when PHC California gets your request.

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, PHC California will tell you in writing within 72 hours of getting your request.

If PHC California denies your request for a second opinion, you can file a grievance. To learn more about grievances, read "Complaints" in Chapter 5 of this handbook.



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4. Benefits and services

Medi-Cal benefits covered by PHC California

Dental services

Starting July 1, 2026:

Medi-Cal uses Medi-Cal Dental Plans (Dental Managed Care Plans) to provide your dental services. There are some exceptions. If you do not qualify for federal full-scope Medi-Cal and are aged 19 or older, you may be disenrolled from your Medi-Cal Dental Plan (Dental Managed Care Plan) if:

- You are not pregnant or within one year postpartum (after pregnancy) or designated by the county as foster youth or former foster youth. You can go to any Fee-for-Service (FFS) Medi-Cal Dental provider for **dental emergencies** only.
- You are designated by the county as pregnant or within one year postpartum (after pregnancy). You can go to any FFS Medi-Cal Dental provider for **full-scope** Medi-Cal.
- You are designated by the county as foster youth or former foster youth under age 26 and were in foster care on your 18th birthday. You can go to any FFS Medi-Cal Dental provider for **full-scope** Medi-Cal.

Starting July 1, 2026:

You can stay in Fee-for-Service (FFS) Medi-Cal Dental or you can choose Medi-Cal Dental Plan (Dental Managed Care Plan). There are some exceptions. If you do not



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qualify for federal full-scope Medi-Cal and are aged 19 or older, you may be disenrolled from your Medi-Cal Dental Plan (Dental Managed Care Plan if:

- You are not pregnant or within one year postpartum (after pregnancy) or are designated by the county as foster youth or former foster youth. You can go to any FFS Medi-Cal Dental provider for **dental emergencies** only.
- You are designated by the county as pregnant or within one year postpartum (after pregnancy). You can go to any FFS Medi-Cal Dental provider for **full-scope** Medi-Cal.
- You are designated by the county as foster youth or former foster youth under age 26 who were in foster care on your 18th birthday. You can go to any FFS Medi-Cal Dental provider for **full-scope** Medi-Cal.

To choose or change your dental plan, call Medi-Cal Health Care Options at 1-800-430-4263. You may not be enrolled in a PACE or SCAN plan and a Medi-Cal Dental Plan (Dental Managed Care Plan) at the same time.

Starting July 1, 2026, Medi-Cal covers dental services for:

- Members who qualify for federal full-scope Medi-Cal
- Members who do not qualify for federal full-scope Medi-Cal and meet at least one of the three exceptions below:
 - Designated by the county as pregnant (and up to one year after pregnancy ends), and/or
 - Designated by the county as foster youth or former foster youth under age 26 who were in foster care on their 18th birthday

Dental services include:

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



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If you have questions or want to learn more about dental services and are enrolled in a Medi-Cal Dental Plan (Dental Managed Care Plan), call your assigned Medi-Cal Dental Plan (Dental Managed Care Plan).

Other Medi-Cal programs and services

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

PHC California does not cover some services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. PHC California will coordinate with other programs to make sure you get all medically necessary services, including those covered by another program and not PHC California. This section lists some of these services. To learn more, call 1-800-263-0067 (TTY 711).



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5. Reporting and solving problems

State Hearings

A State Hearing is a meeting with PHC California and a judge from the California Department of Social Services (CDSS). The judge will help to resolve your problem and decide whether PHC California made the correct decision or not. You have the right to ask for a State Hearing if you already asked for an appeal with PHC California 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 Notice of Appeal Resolution (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 PHC California between 8:00 am and 8:00 pm, Monday through Friday by calling 1-800-263-0067. If you cannot hear or speak well, call 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 PHC California 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 Notice of Action (NOA) or NAR letter available to you in your



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preferred language

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

You can ask for a State Hearing in these ways:

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

California Department of Social Services
State Hearings Division
744 P Street, MS 09-17-433
Sacramento, CA 95814
- **Online:** Request a hearing online at www.cdss.ca.gov
- **By email:** Fill out the form that came with your appeals resolution notice and email it to Scopeofbenefits@dss.ca.gov
 - Note: If you send it by email, there is a risk that someone other than the State Hearings Division could intercept your email. Consider using a more secure method to send your request.
- **By Fax:** Fill out the form that came with your appeals resolution notice and fax it to the State Hearings Division toll free at 1-833-281-0903

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call 1-800-263-0067 (TTY 711).

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



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5 | Reporting and solving problems

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 three business days after it gets your complete case file from PHC California.



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6. Rights and responsibilities

As a member of PHC California, 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 PHC California.

Notice of Action

PHC California will send you a Notice of Action (NOA) letter any time PHC California denies, delays, terminates, or modifies a request for health care services. If you disagree with PHC California's decision, you can always file an appeal with PHC California. Go to the "Appeals" section in Chapter 5 of this handbook for important information on filing your appeal. When PHC California sends you a NOA, it will tell you all the rights you have if you disagree with a decision we made. If you get this notice from anyone other than PHC California or VSP, contact PHC California right away.

Contents in notices

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

- A statement of the action PHC California intends to take
- A clear and concise explanation of the reasons for PHC California's decision
- How PHC California decided, including the rules PHC California used
- The medical reasons for the decision. PHC California must clearly state how your condition does not meet the rules or guidelines.
- Information about your right to request free of charge copies of all documents and records relevant to the NOA



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Translations

PHC California 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 PHC California's decision to deny, delay, modify, terminate, suspend or reduce a request for health care services.

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



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