



**NOTICE OF ADVERSE BENEFIT DETERMINATION  
About Your Treatment Request  
Termination Notice**

**RE:**

You are currently receiving \_\_\_\_\_. Beginning on \_\_\_\_\_ we will no longer approve this treatment. This is because

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You may appeal this decision if you think it is incorrect. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed “Your Rights” information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call Sonoma County BHD (24-Hour Access Line) at 1-707-565-6900 or 1-800-870-8786 (toll free).

If you want to keep getting this service while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your plan says services will be stopped or reduced, listed above.

This notice does not affect any of your other Medi-Cal services.

The Plan can help you with any questions you have about this notice. For help, you may call Sonoma County BHD 24-Hour Access Line) at 1-707-565-6900 or 1-800-870-8786 (toll-free). If you have trouble speaking or hearing, please call TTY/TDD: 711 (24 hours a day, 7 days a week), for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Sonoma County BHD by calling 1-707-565-6900 or 1-800-870-8786 (toll-free) 24-Hour Access Line.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

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Enclosed: Your Rights under Medi-Cal Managed Care  
Member Non-Discrimination Notice  
Notice of Availability



## **NOABD YOUR RIGHTS UNDER MEDI-CAL**

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Sonoma County BHD by calling 1-707-565-6900 or 1-800-870-8786 (toll-free) 24-Hour Access Line. Or, if you have trouble speaking or hearing, please call TTY/TDD: 711 (24 hours a day, 7 days a week), for help.

**IF YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH SONOMA COUNTY BHD.**

### **HOW TO FILE AN APPEAL**

You have **60 days** from the date of this “Notice of Adverse Benefit Determination” letter to file an appeal. If your Plan decided to reduce, suspend or terminate treatment you are already getting, you have a right to request that the Plan continue providing that treatment while your appeal is being reviewed. This is called Aid Paid Pending. To qualify for Aid Paid Pending, you must ask your Plan for an appeal within 10 days from the date on this letter, or before the date your Plan says the services will stop, whichever is later. Even though your Plan must give you Aid Paid Pending when you ask for an appeal within these timelines above, you should let your Plan know when you ask for an appeal that you want to get Aid Paid Pending until your appeal is decided. You will not be held liable for the cost of continued treatment if the appeal decision upholds the Plan’s adverse benefit determination.

If you miss the 10-day period to request an appeal OR do not ask for an appeal before the date your Plan says the services will stop, you still have 60 days from the date of this Notice of Adverse Benefit Determination letter to ask for an appeal. However, you will not get Aid Paid Pending while your appeal is being decided.

You can file an appeal by phone or in writing. If you file an appeal by phone, you must follow up with a written signed appeal. The Plan will provide you with free assistance if you need help.

- **To appeal by phone:** Contact the Sonoma County BHD Grievance Coordinator between 8am to 5pm, Monday through Friday, by calling 1-707-565-7895. Or, if you have trouble hearing or speaking, please call TTY/TDD: 711 (24 hours a day, 7 days a week).

- To appeal in writing: Fill out an appeal form or write a letter to Sonoma County BHD and send it to:

**Sonoma County Behavioral Health Division  
c/o Grievance Coordinator  
2227 Capricorn Way  
Santa Rosa, CA 95407-5419**

Your provider will have appeal forms available. Sonoma County Behavioral Health Division can also send a form to you.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, provider, or attorney file the appeal for you. This person is called an “authorized representative.” You can send in any type of information you want your Plan to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

Your Plan has 30 days to give you an answer. At that time, you will get a “Notice of Appeal Resolution” letter. This letter will tell you what the Plan has decided. **If you do not get a letter with the Plan’s decision within 30 days, you can ask for a “State Hearing” and a judge will review your case.** Please read the section below for instructions on how to ask for a State Hearing.

### **EXPEDITED APPEALS**

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an “**expedited appeal**.”

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### **STATE HEARING**

If you filed an appeal and received a “Notice of Appeal Resolution” letter telling you that your Plan will still not provide the services, or **you never received a letter telling you of the decision and it has been past 30 days**, you can ask for a “State Hearing” and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within **120 days** from the date of the “Notice of Appeal Resolution” letter. If your Plan continued to provide you with the disputed treatment during the Plan’s appeal process, you have a right to request that the Plan continue providing that treatment until there is a decision on your State Hearing. **If you are currently getting treatment and you want to continue your treatment while your State Hearing request is being reviewed, you must ask for a State Hearing within 10 days** from the date the “Notice of Appeal Resolution” was postmarked or delivered to you. When you ask for a State Hearing, you must say that you want to keep getting your treatment. You will not be held liable for the cost of continued treatment if the State Hearing decision upholds the Plan’s adverse benefit determination. You will not have to pay for a State Hearing.

You can ask for a State Hearing by phone, electronically, or in writing:

- By phone: Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- Electronically: You may request a State Hearing online. Please visit the California Department of Social Services' website to complete the electronic form:  
<https://acms.dss.ca.gov/acms/login.request.do>
- In writing: Fill out a State Hearing form or send a letter to:

**California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, CA 94244-2430**

Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. You may want to ask your provider or Plan to write a letter for you, or you can write one yourself. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an "expedited hearing" and provide the letter with your request for a hearing.

### **Second Opinion**

Upon your request, you have the right to a second opinion from a qualified health care professional within or outside of the network at no extra cost.

### **Authorized Representative**

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, provider, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an "authorized representative."

### **LEGAL HELP**

You may be able to get free legal help. You may also call the local Legal Aid program in your county at 1-888-804-3536.



## **NONDISCRIMINATION NOTICE**

Discrimination is against the law. Sonoma County follows State and Federal civil rights laws. Sonoma County 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.

Sonoma County 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, braille, audio or accessible electronic formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Sonoma County between 8:00am-5:00pm by calling 1-707-565-7895. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

### **HOW TO FILE A GRIEVANCE**

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

- **By phone:** Contact BHD Grievance Coordinator between 8:00am-5:00pm by calling 707-565-7895. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711.
- **In writing:** Fill out a complaint form or write a letter and send it to:  
BHD Grievance Coordinator  
2227 Capricorn Way  
Santa Rosa, CA 95407-5419
- **In person:** Visit your doctor's office or BHD and say you want to file a grievance.
- **Electronically:** Visit Sonoma County BHD website at  
<https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials>

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## **OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES**

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

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California State Relay)**.

- In writing: Fill out a complaint form or send a letter to:

**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/discrimination-grievance-procedures>

- Electronically: Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov).
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## **OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- 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  
<http://www.hhs.gov/ocr/office/file/index.html>.

- Electronically: Visit the Office for Civil Rights Complaint Portal at  
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>



## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

### English

ATTENTION: If you need help in your language call 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-870-8786 or 1-707-565-6900 (TTY: 711). These services are free of charge.

### العربية (Arabic)

يرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل والخط الكباري. اتصل بـ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). هذه الخدمات مجانية.

### Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-870-8786 or 1-707-565-6900 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-870-8786 or 1-707-565-6900 (TTY: 711): Այդ ծառայություններն անվճար են:

### ខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-870-8786 or 1-707-565-6900 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរព្រួញ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-870-8786 or 1-707-565-6900 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

### 繁體中文 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-870-8786 or 1-707-565-6900 (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-800-870-8786 or 1-707-565-6900 (TTY: 711)。这些服务都是免费的。

### فارسی (Farsi)

تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-870-8786 or 1-707-565-6900 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

### हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-870-8786 or 1-707-565-6900 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-870-8786 or 1-707-565-6900 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।



### **Hmoob (Hmong)**

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

### **日本語 (Japanese)**

注意日本語での対応が必要な場合は 1-800-870-8786 or 1-707-565-6900 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。1-800-870-8786 or 1-707-565-6900 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

### **한국어 (Korean)**

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-870-8786 or 1-707-565-6900 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-870-8786 or 1-707-565-6900 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

### **ພາສາລາວ (Laotian)**

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໃບທາດປີ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໃບທາດປີ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

### **Mien**

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluc mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

### **ਪੰਜਾਬੀ (Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

### **Русский (Russian)**

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-870-8786 or 1-707-565-6900 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-870-8786 or 1-707-565-6900 (линия TTY: 711). Такие услуги предоставляются бесплатно.

### **Español (Spanish)**

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-870-8786 or 1-707-565-6900 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Estos servicios son gratuitos.

### **Tagalog (Filipino)**

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Libre ang mga serbisyo ng ito.

### **ภาษาไทย (Thai)**

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-870-8786 or 1-707-565-6900 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-870-8786 or 1-707-565-6900 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้.

### **Українська (Ukrainian)**

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Ці послуги безкоштовні.

### **Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Các dịch vụ này đều miễn phí.