Kaiser Permanente Dual Complete (HMO D-SNP), offered by Kaiser Foundation Health Plan, Inc.

Member Handbook

January 1, 2027 – December 31, 2027

Your Health and Drug Coverage under Kaiser Permanente Dual Complete (HMO D-SNP)

Member Handbook Introduction

This *Member Handbook,* otherwise known as the *Evidence of Coverage,* tells you about your coverage under our plan through December 31, 2027. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Member Handbook.*

This is an important legal document. Keep it in a safe place.

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means Kaiser Permanente Dual Complete.

This document is available for free in Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Spanish, Tagalog, or Vietnamese.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at 1-800-443-0815 (TTY 711), 8 a.m. to 8 p.m., 7 days a week, 8 a.m. to 8 p.m. The call is free.

Call Member Services to request the following:

- Preferred language other than English and/or alternate format,
- A standing request for future mailings and communications, **and**
- Change a standing request for preferred language and/or format.

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

ENGLISH

ATTENTION: If you need help in your language, call 1-800-443-0815 (TTY 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-443-0815 (TTY 711). These services are free of charge.

ARABIC

تنبيه: إذا كنت بحاجة إلى المساعدة بلغتك، فاتصل على الرقم 1-800-443-0815 (TTY 711). وتتوفر لدينا أيضًا مساعدات وخدمات للأشخاص الذين يعانون إعاقات، مثل مستندات بلغة برايل والطباعة بخط كبير. اتصل بالرقم 1-800-443-0815 (TTY 711). هذه الخدمات مجانية بدون تكلفة.

ARMENIAN

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք 1-800-443-0815 (TTY 711): Հասանելի են նաև աջակցություն և ծառայություններ հաշմանդամություն ունեցող անձանց համար, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ մեծ տառատեսակով: Զանգահարեք 1-800-443-0815 (TTY 711): Այս ծառայություններն անվճար են:

CHINESE

請注意：如果您需要語言協助，請致電 1-800-443-0815 (TTY 711)。殘障人士亦有提供協助和服務，例如點字和大字體的文件。請致電 1-800-443-0815 (TTY 711)。以上服務為免費提供。

PUNJABI

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ 1-800-443-0815 (TTY 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਕਲਾਂਗ ਵਿਅਕਤੀਆਂ ਲਈ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਵੀ ਉਪਲਬਧ ਹਨ। 1-800-443-0815 (TTY 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

HINDI

ध्यान दें: अगर आपको अपनी भाषा संबंधी कोई सहायता चाहिए, तो 1-800-443-0815 (TTY 711) पर कॉल करें। विकलांग व्यक्तियों के लिए सहायताएँ और सेवाएँ, जैसे कि ब्रेल और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। 1-800-443-0815 (TTY 711) पर कॉल करें। ये सेवाएँ मुफ़्त दी जाती हैं।

HMONG

CEEB TOOM: Yog koj xav tau kev pab ua koj yam lus, hu rau 1-800-443-0815 (TTY 711). Kuj muaj cov kev pab cuam rau cov neeg uas muaj kev xiam oob qhab, xws li cov ntawv xuas rau cov dig muag thiab cov ntawv luam loj. Hu 1-800-443-0815 (TTY 711). Cov kev pab cuam no yog muab pab dawb.

JAPANESE

注意：言語でのサポートをご希望の場合は、1-800-443-0815 (TTY 711) までご連絡ください。点字を用いた資料や大きな文字で書かれた資料など、障害を持つお客様向けの支援とサービスをご利用いただけます。1-800-443-0815 (TTY 711) までご連絡ください。これらのサービスは、無料でご利用いただけます。

KOREAN

주의: 귀하의 언어로 도움이 필요하시면 1-800-443-0815 (TTY 711) 번으로 전화하십시오. 점자 및 큰 활자로 된 문서 등 장애인을 위한 지원 및 서비스도 제공됩니다. 1-800-443-0815 (TTY 711) 번으로 전화하십시오. 이러한 서비스는 무료입니다.

LAOTIAN

ໝາຍເຫດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ກະລຸນາໂທຫາ 1-800-443-0815 (TTY 711). ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການແມ່ນມີໃຫ້ສຳລັບຄົນທີ່ມີຄວາມພິການນຳ ເຊັ່ນ: ເອກະສານເປັນຕົວໜັງສືນູນ ແລະ ຕົວໜັງສືໃຫຍ່.
ໂທຫາ 1-800-443-0815 (TTY 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ໄດ້ເສຍຄ່າ.

MIEN

CAU FIM JANGX OC: Beiv hnangv meih qiemx zuqc longc mienh faan benx meih nyei waac bun muangx, mborqv finx lorz 1-800-443-0815 (TTY 711). Maaih jaa-sic tengx aengx caux tengx nzie weih bun wuaaic fangx mienh, liepc duqv maaih nzangc-pokc bun hluo aengx caux aamx cuotv domh zeiv daan bun longc. mborqv finx lorz 1-800-443-0815 (TTY 711). Wangv henh tengx naaiv deix gong mv zuqc ndortv nyaanh cingv oc.

CAMBODIAN

យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមហៅទូរសព្ទទៅលេខ 1-800-443-0815 (TTY 711)។ ជំនួយ និងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងអក្សរធំៗក៏មានផងដែរ។ ហៅទូរសព្ទទៅលេខ 1-800-443-0815 (TTY 711)។ សេវាកម្មទាំងនេះគឺមិនគិតថ្លៃទេ។

FARSI

توجه :در صورت نیاز به کمک به زبان خود، با شمارهٔ 1-800-443-0815 تماس بگیرید .کمک‌ها و خدمات برای افراد دچار معلولیت، مانند اسناد (TTY 711) با خط بریل و چاپ بزرگ نیز در دسترس است .با شماره 1-800-443-0815 تماس بگیرید .این خدمات رایگان است (TTY 711).

RUSSIAN

ВНИМАНИЕ! Если вам нужна помощь на вашем языке, позвоните на номер 1-800-443-0815 (TTY 711). Также доступны вспомогательные средства и услуги для лиц с инвалидностью, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Звоните на номер 1-800-443-0815 (TTY 711). Эти услуги бесплатны.

SPANISH

ATENCIÓN: Si necesita ayuda en su idioma, llame al 1-800-443-0815 (TTY 711). Se encuentran disponibles ayudas y servicios para personas con discapacidad, como documentos en braille y letra grande. Llame al 1-800-443-0815 (TTY 711). Estos servicios son gratuitos.

TAGALOG

PAUNAWA: Kung kailangan ninyo ng tulong na nasa inyong wika, tumawag sa 1-800-443-0815 (TTY 711). Ang mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento na nasa braille at malalaking letra, ay available rin. Tumawag sa 1-800-443-0815 (TTY 711). Ang mga serbisyong ito ay walang bayad.

THAI

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาติดต่อที่หมายเลข 1-800-443-0815 (TTY 711) นอกจากนี้ ยังมีการให้ความช่วยเหลือและบริการแก่คนพิการ เช่น เอกสารอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่อีกด้วย ติดต่อที่หมายเลข 1-800-443-0815 (TTY 711) บริการเหล่านี้ไม่มีค่าใช้จ่าย

UKRAINIAN

УВАГА! Якщо вам потрібна допомога вашою мовою, телефонуйте за номером 1-800-443-0815 (TTY 711). Також доступні допоміжні засоби й послуги для людей з інвалідністю, наприклад документи, надруковані шрифтом Брайля чи великим шрифтом. Телефонуйте за номером 1-800-443-0815 (TTY 711). Ці послуги є безкоштовними.

VIETNAMESE

CHÚ Ý: Nếu quý vị cần được trợ giúp bằng ngôn ngữ của mình, hãy gọi 1-800-443-0815 (TTY 711). Trợ giúp và dịch vụ dành cho người khuyết tật như bản in chữ nổi Braille và chữ cỡ lớn cũng được cung cấp. Xin gọi 1-800-443-0815 (TTY 711). Những dịch vụ này được cung cấp miễn phí.

Other languages

You can get this *Member Handbook* and other plan materials in other languages for free. Kaiser Permanente Dual Complete provides written translations from qualified translators. Call Member Services at 1-800-443-0815 (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 a timely manner, in other formats such as braille, 20-point font large print, audio format, and accessible electronic formats (data CD) at no cost to you. Call Member Services at 1-800-443-0815 (TTY 711). The call is free.

Language Access Services

Kaiser Permanente Dual Complete provides oral interpretation services, as well as sign language, from a qualified interpreter, on a 24-hour basis, at no cost to you. You don't have to use a family member or friend as an interpreter. We discourage the use of family or friends, especially minors, as interpreters unless it’s an emergency. Language access services, including interpreter services, are available for free. Interpreter services are available 24 hours a day, 7 days a week. For help in your language, or to get this handbook in a different language, call Member Services at 1-800-443-0815 (TTY 711). The call is free.

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Disclaimers

- Kaiser Permanente is an HMO D-SNP plan with a Medicare contract and a contract with the Medi-Cal program. Enrollment in Kaiser Permanente depends on contract renewal.
- The health care services provided to Members of Kaiser Permanente under Medi-Cal are subject to the terms, conditions, limitations and exclusions of the contract between Kaiser Foundation Health Plan, Inc. and the California Department of Health Care Services (DHCS), and as listed in this *Member Handbook* and any amendments.
- **Southern California members only:** The healthy food benefit is part of a special supplemental program for the chronically ill. Not all members qualify. Members must have specific chronic conditions, like diabetes, obesity, cardiovascular disorders, osteoarthritis, or chronic kidney disease, to be eligible. There are other conditions that may qualify you for the benefit. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.
- Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Member Services number or see this *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.
- Benefits and/or copayments may change on January 1, 2028.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about **Kaiser Permanente Dual Complete**, a health plan that covers all of your Medicare services and coordinates all of your Medicare and Medi-Cal services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Welcome to our plan

Our plan provides Medicare and Medi-Cal services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

Kaiser Permanente Dual Complete is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. Kaiser Permanente Dual Complete is designed for people who have Medicare and who are also entitled to assistance from Medi-Cal.

Kaiser Permanente provides health care services directly to members through an integrated medical care program. Health Plan, Plan Hospitals, The Permanente Medical Group, and the Southern California Permanente Medical Group ("Medical Group") work together to provide our members with quality care. Our medical care program gives you access to covered services you may need, such as routine care, hospital care, laboratory services, emergency care, urgent care, and other benefits described in this *Member Handbook*. Plus, our health education programs offer you great ways to protect and improve your health.

This *Member Handbook* describes the following plans:

- Kaiser Permanente Dual Complete South P1 (HMO D-SNP), referred to in this document as the "South P1 plan"
- Kaiser Permanente Dual Complete South P6 (HMO D-SNP), referred to in this document as the "South P6 plan"
- Kaiser Permanente Dual Complete South P7 (HMO D-SNP), referred to in this document as the "South P7 plan"
- Kaiser Permanente Dual Complete South P9 (HMO D-SNP), referred to in this document as the "South P9 plan"
- Kaiser Permanente Dual Complete South P10 (HMO D-SNP), referred to in this document as the "South P10 plan"
- Kaiser Permanente Dual Complete South P11 (HMO D-SNP), referred to in this document as the "South P11 plan"
- Kaiser Permanente Dual Complete North P2 (HMO D-SNP), referred to in this document as the "North P2 plan"
- Kaiser Permanente Dual Complete North P16 (HMO D-SNP), referred to in this document as the "North P16 plan"
- Kaiser Permanente Dual Complete North P17 (HMO D-SNP), referred to in this document as the "North P17 plan"

- Kaiser Permanente Dual Complete North P18 (HMO D-SNP), referred to in this document as the “North P18 plan”
- Kaiser Permanente Dual Complete North P19 (HMO D-SNP), referred to in this document as the “North P19 plan”
- Kaiser Permanente Dual Complete North P20 (HMO D-SNP), referred to in this document as the “North P20 plan”
- Kaiser Permanente Dual Complete North P21 (HMO D-SNP), referred to in this document as the “North P21 plan”
- Kaiser Permanente Dual Complete North P22 (HMO D-SNP), referred to in this document as the “North P22 plan”
- Kaiser Permanente Dual Complete North P23 (HMO D-SNP), referred to in this document as the “North P23 plan”
- Kaiser Permanente Dual Complete North P24 (HMO D-SNP), referred to in this document as the “North P24 plan”
- Kaiser Permanente Dual Complete North P25 (HMO D-SNP), referred to in this document as the “North P25 plan”

If you’re not certain which plan you’re enrolled in, please call Member Services at the numbers at the bottom of this page or refer to the cover of your *Annual Notice of Change* (or for new members, your enrollment form or enrollment confirmation letter).

Note: Please refer to **Section D** in this chapter for the geographic service area of each plan included in this *Member Handbook*. For the purposes of cost-sharing, enrollment, and disenrollment, there are multiple Dual Complete plans in our Region service areas, which are described in this *Member Handbook*. But, for the purposes of obtaining covered services, you get care from network providers anywhere inside your Region’s service area.

B. Information about Medicare and Medi-Cal

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medi-Cal

Medi-Cal is the name of California’s Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources pay

for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of California approved our plan. You can get Medicare and Medi-Cal services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of California allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medi-Cal services isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and Medi-Cal services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and Medi-Cal benefits work better together for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.

- Your test results are shared with all of your doctors and other providers, as appropriate.

New members to Kaiser Permanente Dual Complete: In most instances you'll be enrolled in Kaiser Permanente Dual Complete Plan for your Medicare benefits the 1st day of the month after you request to be enrolled in Kaiser Permanente Dual Complete. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you'll receive your Medi-Cal services through Kaiser Permanente Dual Complete. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-443-0815 (TTY 711) if you have any questions.

D. Our plan's service area

Our Southern California region includes the following South plans:

- **Kaiser Permanente Dual Complete South P1 plan**, which includes these **San Diego County** zip codes only:
  - 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–46, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–61, 92163, 92165–79, 92182, 92186–87, 92191–93, and 92195–99
- **Kaiser Permanente Dual Complete South P6 plan**, which includes:
  - Parts of **Riverside County**, in these zip codes only: 91752, 92028, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–14, 92516–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
  - Parts of **San Bernardino County**, in these zip codes only: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 92305, 92307–08, 92313–18, 92321–22, 92324–25, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–11, 92413, 92415, 92418, 92423, 92427, 92880.
- **Kaiser Permanente Dual Complete South P7 plan**, which includes these **Kern County** zip codes only:
  - 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, and 93581.
- **Kaiser Permanente Dual Complete South P9 plan**, which includes all of **Los Angeles County** except Catalina Island.
- **Kaiser Permanente Dual Complete South P10 plan**, which includes all of **Orange County**.

- **Kaiser Permanente Dual Complete South P11 plan**, which includes these **Ventura County** zip codes only:
    - 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, and 93252.

Our Northern California region includes the following North plans:

- **Kaiser Permanente Dual Complete North P2 plan**, which includes:
    - All of **Sacramento County**.
    - **Amador County**, in these zip codes only: 95640 and 95669.
    - **El Dorado County**, in these zip codes only: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, and 95762.
- **Kaiser Permanente Dual Complete North P16 plan**, which includes all of **Alameda County**.
- **Kaiser Permanente Dual Complete North P17 plan**, which includes all of **Contra Costa County**.
- **Kaiser Permanente Dual Complete North P18 plan**, which includes:
    - **Fresno County**, in these zip codes only: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888.
    - **Kings County**, in these zip codes only: 93230, 93232, 93242, 93631, 93656.
    - **Madera County**, in these zip codes only: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720.
    - **Mariposa County**, in these zip codes only: 93601, 93623, and 93653.
    - **Tulare County**, in these zip codes only: 93238, 93261, 93618, 93631, 93646, 93654, 93666, and 93673.
- **Kaiser Permanente Dual Complete North P19 plan**, which includes all of **San Francisco County**.
- **Kaiser Permanente Dual Complete North P20 plan**, which includes all of **San Joaquin and Stanislaus** counties.
- **Kaiser Permanente Dual Complete North P21 plan**, which includes all of **Santa Cruz County**.
- **Kaiser Permanente Dual Complete North P22 plan**, which includes all of **San Mateo County**.
- **Kaiser Permanente Dual Complete North P23 plan**, which includes these **Santa Clara County** zip codes only:

- 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, and 95196.

- **Kaiser Permanente Dual Complete North P24 plan**, which includes:
  - **Placer County**, in these zip codes only: 95602–04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95703, 95722, 95736, 95746–47, and 95765.
  - **Yolo County**, in these zip codes only: 95605, 95607, 95612, 95615–18, 95620, 95645, 95691, 95694–95, 95697–98, 95776, and 95798–99.
  - **Yuba County**, in these zip codes only: 95692, 95903, and 95961.

- **Kaiser Permanente Dual Complete North P25 plan**, which includes:
  - All of **Marin, Napa, and Solano** counties.
  - **Sonoma County**, in these zip codes only: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, and 95492.

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- are age 21 and older at the time of enrollment, **and**
- have both Medicare Part A and Medicare Part B, and
- are a United States citizen or national, or an eligible non-citizen, and
- are currently eligible for Medi-Cal.
- If you lose your full-scope Medi-Cal eligibility but can be expected to regain it within four month(s), we'll continue to provide all Medicare benefits covered by Kaiser Permanente Dual Complete. When your Medi-Cal coverage ends, we won't pay for your Medi-Cal benefits. Your cost-sharing for benefits covered by Kaiser Permanente Dual Complete will change as described in the Benefits Chart in this *Member Handbook*. You may also lose Extra Help from Medicare to help pay for your Medicare Part D drugs.

  If your full-scope Medi-Cal eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your Medi-Cal benefits and your enrollment with us will continue. If you can't regain Medi-Cal within four month(s), we'll disenroll you

from Kaiser Permanente Dual Complete. If you regain full-scope Medi-Cal eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

If you lose full-scope Medi-Cal eligibility but can be expected to regain eligibility within 4 months, then you're still eligible for our plan.

Call Member Services for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We'll reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail. We'll reach out to you annually to see if any of your needs have changed.

We'll send you more information about this HRA.

If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, even if they're not in our network. We call this continuity of care. If they're not in our network, you can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.
    - We determine an existing relationship by reviewing your available health information or information you give us.
    - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. You can make this request by calling 1-800-443-0815. If you're at risk of harm, we must respond within three days.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: You can make this request for providers of Durable Medical Equipment (DME) for at least 90 days until we authorize a new DME rental and have a network provider deliver the rental. Although you can't make this request for providers of transportation or other ancillary providers, you can make a request for services of transportation or other ancillary services not included in our plan.

After the continuity of care period ends, you'll need to use doctors and other providers in the Kaiser Permanente Dual Complete Plan network, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Refer to **Chapter 3** of this *Member Handbook* for more information on getting care.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, your specialists, or other health professionals that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS or other services.

Your care plan includes:

- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Summary of Important Costs

Our plan has no premium.

H1. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from our plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2 Section M3 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. This *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal

our decision. For information about appeals, refer to **Chapter 9** of this *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website at the web address at the bottom of the page.

The contract is in effect for the months you're enrolled in our plan between January 1, 2027, and December 31, 2027.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*, also known as a *Drug* List or *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services, including Long-Term Services and Supports (LTSS), certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here are sample Member ID Cards for each Region:





If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your Medi-Cal card to get most services. Keep those cards in a safe place, in case you need them

later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out what to do if you get a bill from a provider.

Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access the following services:

- Behavioral health services that you may get from the county mental health plan (MHP)
- Medi-Cal Rx services
- In-Home Supportive Services
- 1915(c) Home and Community Based Waiver services
- Medi-Cal dental services

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days.

You can also refer to the *Provider and Pharmacy Directory* at kp.org/directory.

The *Provider and Pharmacy Directory* lists our network providers and durable medical equipment suppliers. All of our network providers accept both Medicare and Medicaid, except where noted otherwise. In the event that you need a service not covered by our plan that is covered by Medi-Cal, we may refer you to the state Medi-Cal agency to locate an out-of-network provider who can provide your Medi-Cal-covered care.

Definition of network providers

- Our network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and,**
    - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they've been removed and replaced as described in **Chapter 5, Section E.** Medicare approved the Kaiser Permanente Dual Complete *Drug List.*

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this *Member Handbook* for more information.

Each year, we send you information about how to access the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at kp.org/seniorrx.

J4. The *Explanation of Benefits*

When you use your Medicare Part D drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

You can also choose to view your **Part D EOB** online instead of by mail. Please visit kp.org/goinggreen and sign on to learn more about choosing to view your **Part D EOB** securely online.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network. use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**,
- if you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this *Member Handbook*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Member Services

CALL	1-800-443-0815. This call is free. 7 days a week, 8 a.m. to 8 p.m. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Your local Member Services office (see the *Provider and Pharmacy Directory* for locations).
WEBSITE	kp.org

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing

Coverage Decisions, Appeals and Complaints about medical care

CALL	1-800-443-0815. This call is free. 7 days a week, 8 a.m. to 8 p.m. We have free interpreter services for people who don't speak English. If your coverage decision, appeal, or complaint qualifies for a fast decision as described in **Chapter 9**, call the Expedited Review Unit at 1-888-987-7247, 8:30 a.m. to 5 p.m., 7 days a week.
TTY	711. This call is free. 7 days a week, 8 a.m. to 8 p.m.
FAX	If your coverage decision, appeal, or complaint qualifies for a fast decision, fax your request to our Expedited Review Unit at 1-888-987-2252.

CALL	1-800-443-0815. This call is free. 7 days a week, 8 a.m. to 8 p.m. We have free interpreter services for people who don't speak English. If your coverage decision, appeal, or complaint qualifies for a fast decision as described in **Chapter 9**, call the Expedited Review Unit at 1-888-987-7247, 8:30 a.m. to 5 p.m., 7 days a week.
WRITE	For a standard coverage decision or complaint, write to your local Member Services office (see the *Provider and Pharmacy Directory* for locations). For a standard appeal, write to the address shown on the denial notice we send you. If your coverage decision, appeal, or complaint qualifies for a fast decision, write to: Kaiser Permanente Expedited Review Unit P.O. Box 1809 Pleasanton, CA 94566
WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/my/medicare-complaint.

- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Member Services.

- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section E**).
  - You can call us and explain your complaint at 1-800-443-0815 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can make a complaint about our plan to the Medicare Medi-Cal Ombudsperson Program by calling 1-855-501-3077.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.

Coverage decisions for Part D drugs

CALL	South plans: 1-888-791-7213 North plans: 1-877-645-1282 This call is free. 7 days a week, 8 a.m. to 8 p.m. We have free interpreter services for people who don't speak English.
TTY	711 This call is free. 7 days a week, 8 a.m. to 8 p.m.
FAX	1-844-403-1028
WRITE	OptumRx c/o Prior Authorization P.O. Box 2975 Mission, KS 66201
WEBSITE	kp.org

- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**

  - the amount we pay for your drugs.

- Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (www.medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

- For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Member Handbook*.

Appeals for Part D drugs

CALL	1-866-206-2973. This call is free. 7 days a week, 8:30 a.m. to 5 p.m. We have free interpreter services for people who don't speak English.
TTY	711.This call is free. 7 days a week, 8:30 a.m. to 5 p.m.
FAX	1-866-206-2974
WRITE	Kaiser Permanente Medicare Part D Unit P.O. Box 1809 Pleasanton, CA 94566
WEBSITE	kp.org

- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Member* Handbook.

Complaints for Part D drugs

CALL	1-800-443-0815. This call is free. 7 days a week, 8 a.m. to 8 p.m. If your complaint qualifies for a fast decision, call the Part D Unit at 1-866-206-2973, 8:30 a.m. to 5 p.m., 7 days a week. See **Chapter 9** to find out if your issue qualifies for a fast decision. We have free interpreter services for people who don't speak English.
TTY	711.This call is free. 7 days a week, 8 a.m. to 8 p.m.
FAX	If your complaint qualifies for a fast decision, fax your request to our Part D Unit at 1-866-206-2974.
WRITE	For a standard complaint, write to your local Member Services office (see the *Provider and Pharmacy Directory* for locations). If your complaint qualifies for a fast decision, write to: Kaiser Permanente Medicare Part D Unit P.O. Box 1809 Pleasanton, CA 94566
WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/my/medicare-complaint.

- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to Chapter 9 of this Member Handbook.

Payment requests

CALL	1-800-443-0815. This call is free. 7 days a week, 8 a.m. to 8 p.m. **Note:** If you're requesting payment of a Part D drug that was prescribed by a network provider and obtained from a network pharmacy, call our Part D Unit at 1-866-206-2973. 8:30 a.m. to 5 p.m., 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	For medical care, write to: **South plans:** Kaiser Permanente Claims Department P.O. Box 7004 Downey, CA 90242-7004 **North plans:** Kaiser Permanente Claims Department P.O. Box 12923 Oakland, CA 94604-2923 **For Part D drugs:** If you're requesting payment of a Part D drug that was prescribed and provided by a network provider, you can fax your request to 1-866-206-2974 or mail it to: Kaiser Permanente Medicare Part D Unit P.O. Box 1809 Pleasanton, CA 94566
WEBSITE	kp.org

- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7 of this Member Handbook.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Ch**apter 9** of this *Member Handbook*.

B. Your Care Coordinator

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. There is no cost to you. We will coordinate with other programs to ensure that you receive all medically necessary services covered by Medi-Cal or Medicare, even if those services are covered by another program and not us. Call us at the numbers below for more information about your care coordinator and care team or to change your care coordinator.

CALL	1-800-443-0815. This call is free. 7 days a week, 8 a.m. to 8 p.m. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Your local Member Services office (see the *Provider and Pharmacy Directory* for locations).
WEBSITE	kp.org

Contact your care coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about dental benefits
- questions about transportation to medical appointments
- questions about Long-term Services and Supports (LTSS), including Community-Based Adult Services (CBAS) and Nursing Facilities (NF)

You might be able to get these services:

- Community-Based Adult Services (CBAS)
- skilled nursing care
- physical therapy
- occupational therapy
- speech therapy

- medical social services
- home health care
- In-Home Supportive Services (IHSS) through your county social service agency
- sometimes you can get help with your daily health care and living needs

C. Health Insurance Counseling and Advocacy Program (HICAP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	1-800-434-0222 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	Your HICAP office for your county. To find the address for your county, click on the link below and refer to “How to Find Services In My Area” section.
WEBSITE	https://www.aging.ca.gov/HICAP/

Contact HICAP for help with:

- questions about Medicare
- HICAP counselors can answer your questions about changing to a new plan and help you:
    - understand your rights,
    - understand your plan choices,
    - answer questions about switching plans,
    - make complaints about your health care or treatment, **and**
    - assist with billing or claims issues.

D. Nurse Advice Call Line

We know that sometimes it's difficult to know what type of care you need. We have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. You can:

- Talk to a healthcare professional who will answer medical questions, give care advice, and help you decide if you should see a provider right away
- Get help with medical conditions such as diabetes or asthma, including advice about what kind of provider can be right for your condition
- Get help on what to do if you need care and a plan facility is closed, or you're outside our service area

When you call, a trained support person can ask you questions to help determine how to direct your call. You can contact the Nurse Advice Call Line with questions about your health or health care.

CALL	1-833-574-2273. This call is free. 24 hours a day, seven days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. 24 hours a day, seven days a week.

E. Quality Improvement Organization (QIO)

Our state has an organization called Commence Health. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

CALL	1-877-588-1123
TTY	711
WRITE	Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23450
WEBSITE	www.livantaqio.cms.gov

Contact Commence Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

F. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone
WRITE	Write to Medicare at P.O. Box 1270, Lawrence, KS 66044
WEBSITE	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots, or vaccines, and yearly “wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program

G. Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals, including families with children, seniors, persons with disabilities, children and youth in foster care, and pregnant women. Medi-Cal is financed by state and federal government funds.

Medi-Cal benefits include medical, dental, behavioral health, and long-term services and supports.

You're enrolled in Medicare and in Medi-Cal. If you have questions about your Medi-Cal benefits, call your plan care coordinator. If you have questions about Medi-Cal plan enrollment, call Health Care Options.

CALL	1-800-430-4263 Monday through Friday, 8 a.m. to 6 p.m.
TTY	1-800-430-7077 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
WEBSITE	www.healthcareoptions.dhcs.ca.gov/

H. Medi-Cal Managed Care and Mental Health Office of the Ombudsman

The Office of the Ombudsman helps solve problems from a neutral standpoint to ensure that our members receive all medically necessary covered services. They will listen, answer your questions analyze your situation, explain policies and procedures, provide information, advice, and options, and suggest appropriate referrals. It's their job to help develop fair solutions to health care access problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-888-452-8609. Monday through Friday, 8 a.m. to 5 p.m.
TTY	1-800-430-7077 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
EMAIL	MMCDOmbudsmanOffice@dhcs.ca.gov
WEBSITE	www.dhcs.ca.gov/services/MH/Pages/mh-ombudsman.aspx

I. County Social Services

If you need help with your Medi-Cal fee-for-service benefits, contact your local County Social Services agency.

Contact your County Social Services agency to apply for In-Home Supportive Services, which will help pay for services provided to you so that you can remain safely in your own home. Types of services may include help with preparing meals, bathing, dressing, laundry, shopping, or transportation.

Contact your County Social Services agency for any questions about your Medi-Cal eligibility. Identify the table for your county below to find the contact information for your county's social services agency.

Alameda County Social Services Agency

CALL	1-888-999-4772 This call is free. Monday through Friday, 7:30 a.m. to 5 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.alamedacountysocialservices.org/contact-us/Our-Offices
WEBSITE	https://www.alamedacountysocialservices.org/contact-us/Our-Offices

Amador County Social Services Agency

CALL	1-844-835-3685 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.amadorgov.org/services/social-services
WEBSITE	https://www.amadorgov.org/services/social-services

Contra Costa County Social Services Agency

CALL	1-866-663-3225 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	40 Douglas Drive Martinez, CA 94553
WEBSITE	https://www.contracosta.ca.gov/

El Dorado County Social Services Agency

CALL	1-530-642-7300 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.eldoradocounty.ca.gov/Health-Well-Being/Human-Services
WEBSITE	https://www.eldoradocounty.ca.gov/Home

Fresno County Department of Social Services

CALL	1-855-832-8082 This call is free. Monday through Friday, 7:30 a.m. to 4:30 p.m.
TTY	711
WRITE	Fresno County DSS P.O. Box 1912 Fresno, CA 93718-1912
WEBSITE	https://www.fresnocountyca.gov/Departments/Social-Services

Kern County Social Services Agency

CALL	1-877-410-8812 Monday through Friday, 7:30 a.m. to 4 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.kcdhs.org/about-dhs/about-us/office-hours-and-locations
WEBSITE	https://www.kcdhs.org/

Kings County Human Services Agency

CALL	1-877-410-8813 This call is free. Monday through Thursday, 8 a.m. - 5 p.m., and Friday 8 a.m. - 12 p.m.
TTY	711
WRITE	1400 W. Lacey Blvd., Bldg. #8 Hanford, CA 93230
WEBSITE	https://www.countyofkingsca.gov/departments/human-services-agency

Los Angeles County Department of Public Social Services

CALL	1-866-613-3777 This call is free. Monday through Friday, 7:30 a.m. to 7:30 p.m. Saturday, 8 a.m. to 4:30 p.m. Excluding Holidays
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://dpss.lacounty.gov/en/resources/offices.html.
WEBSITE	https://dpss.lacounty.gov

Madera County Department of Public Social Services

CALL	1-559-675-7841 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	1626 Sunrise Ave Madera, CA 93638
WEBSITE	https://www.maderacounty.com/government/social-services

Marin County Social Services Agency

CALL	1-877-410-8817 Monday through Friday, 8 a.m. to 4:30 p.m.
TTY	711
WRITE	10 N San Pedro Rd, San Rafael, CA 94903
WEBSITE	https://www.marinhhs.org

Mariposa County Social Services Agency

CALL	1-800-266-3609 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	P.O. Box 99 Mariposa, CA 95338
WEBSITE	https://www.mariposacounty.org/

Napa County Social Services Agency

CALL	1-707-253-4279 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	2751 Napa Valley Corporate Drive Building B Napa, CA 94558
WEBSITE	https://www.countyofnapa.org/156/HHSA

Orange County Social Services Agency

CALL	1-800-281-9799 This call is free. 24 hours a day, 7 days a week
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://ssa.ocgov.com/about-us/office-locations/office-location-list.
WEBSITE	https://ssa.ocgov.com/

Placer County Social Services Agency

CALL	1-530-886-1870 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	11434 B Ave Auburn, CA 95603
WEBSITE	https://www.placer.ca.gov/1679/Health-Human-Services

Riverside County Department of Public Social Services

CALL	1-877-410-8827 This call is free. Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	4060 County Cir Dr Riverside, CA 92503
WEBSITE	https://rivcodpss.org/

Sacramento County Department of Human Assistance

CALL	1-800-560-0976 This call is free. Monday through Friday, 8 a.m. to 4 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://ha.saccounty.gov/benefits/medi-cal/Pages/Medi-Cal.aspx
WEBSITE	https://dcfas.saccounty.net/SAS/Pages/SAS-Home.aspx

San Bernardino County Aging and Adult Services

CALL	1-909-891-3900 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	784 E. Hospitality Lane San Bernardino, CA 92415
WEBSITE	https://hss.sbcounty.gov/daas/

San Diego County Dept. of Health & Human Services Agency

CALL	1-866-262-9881 This call is free. Monday through Friday, 7 a.m. to 5 p.m.
TTY	711
WRITE	Health and Human Services Agency County of San Diego 1600 Pacific Highway, Room 206 San Diego, CA 92101
WEBSITE	https://www.sandiegocounty.gov/hhsa/programs/ssp/medi-cal_program/index.html

San Francisco County Social Services Agency

CALL	1-415-557-5000 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.sfhsa.org/contact-us/locations
WEBSITE	https://www.sfhsa.org/

San Joaquin County Human Services Agency

CALL	1-209-468-1000 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.sjchsa.org/About-Us/Contact-Us
WEBSITE	https://www.sjchsa.org/

San Mateo County Health

CALL	Aging and Older Adults Emergency and Advice Line 1-844-868-0938 This call is free. 24 hours a day, 7 days a week
TTY	711
WRITE	San Mateo County Aging and Adult Services 225 W. 37th Avenue San Mateo, CA 94403
WEBSITE	https://www.smchealth.org

Santa Clara County Social Services Agency

CALL	1-877-962-3633 This call is free. Monday through Friday, 8 a.m. to 5 p.m. except on county holidays
TTY	711
WRITE	353 West Julian San Jose, CA 95110
WEBSITE	https://socialservices.sccgov.org

Santa Cruz County Social Services Agency

CALL	1-888-421-8080 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.santacruzhumanservices.org/ContactUs
WEBSITE	https://www.santacruzhumanservices.org/

Solano County Social Services Agency

CALL	1-707-784-8400 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	275 Beck Avenue Fairfield, CA 94533
WEBSITE	https://www.solanocounty.com/depts/hss/default.asp

Sonoma County Social Services Agency

CALL	1-707 565-4700 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	1450 Neotomas Avenue, Suite 200 Santa Rosa, CA 95405
WEBSITE	https://sonomacounty.ca.gov/health-and-human-services

Stanislaus County Social Services Agency

CALL	1-877-652-0734 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	P.O. Box 3271 Modesto, CA 95353
WEBSITE	https://www.stancounty.com/

Tulare County Social Services Agency

CALL	1-800-540-6880 Monday through Friday, 7:30 a.m. to 5 p.m. Friday 8 a.m. to 12 p.m.
TTY	711
WRITE	5957 South Mooney Blvd. Visalia, California 93277
WEBSITE	https://tchhsa.org/

Ventura County Social Services Agency

CALL	1-888-472-4463 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	HSA Administration 855 Partridge Drive, Ventura, CA 93003
WEBSITE	https://www.ventura.org/human-services-agency/

Yolo County Social Services Agency

CALL	1-833-744-4472 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	To identify a mailing address for an office location near you, please visit https://www.yolocounty.gov/government/general-government-departments/health-human-services/contact-us
WEBSITE	https://www.yolocounty.gov/government/general-government-departments/health-human-services

Yuba County Social Services Agency

CALL	1-877-652-0739 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711
WRITE	Yuba County Health and Human Services P.O. Box 2320 Marysville, CA 95901
WEBSITE	https://www.yuba.gov/departments/health_and_human_services

J. County Behavioral Health Services Agency

Medi-Cal specialty mental health services and substance use disorder services are available to you through the county if you meet access criteria. Identify the table for your county below to find the contact information for your county's behavioral health services agency.

Alameda Behavioral Health Services

CALL	Mental Health: 1-800-491-9099. This call is free. Substance Abuse: 1-844-682-7215. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	1-800-533-5018. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Amador Health Services

CALL	1-888-310-6555. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Contra Costa Health Services

CALL	1-888-678-7277. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

El Dorado Behavioral Health Services

CALL	1-800-929-1955. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Fresno County Department of Behavioral Health

CALL	1-800-654-3937. This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Kern Behavioral Health Services

CALL	1-800-991-5272. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Kings County Behavioral Health

CALL	1-800-655-2553. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Los Angeles County Department of Mental Health

CALL	1-800-854-7771. This call is free. Calls to this number are free, 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Madera County Behavioral Health

CALL	1-888-275-9779. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Marin Behavioral Health Services

CALL	1-888-818-1115. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Mariposa Behavioral Health Services

CALL	1-800-549-6741. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Napa Behavioral Health Services

CALL	1-800-648-8650. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Orange County Mental Health and Recovery Services

CALL	1-855 625-4657. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Placer Health Services

CALL	1-888-886-5401. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Riverside County Department of Mental Health

CALL	1-800-499-3008. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Sacramento County Behavioral Health Services

CALL	1-888-881-4881. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

San Bernardino County Department of Behavioral Health

CALL	1-888 743-1478. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

San Diego County Department of Behavioral Health Services

CALL	1-888-724-7240. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

San Francisco Behavioral Health Services

CALL	1-888-246-3333. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

San Joaquin Behavioral Health Services

CALL	1-888-468-9370. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

San Mateo County Behavioral Health and Recovery Services

CALL	1-800-686-0101. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Santa Clara Behavioral Health Services

CALL	1-800-704-0900. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Santa Cruz Behavioral Health Services

CALL	1-800-952-2335. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Solano Behavioral Health Services

CALL	1-800-547-0495. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Sonoma Behavioral Health Services

CALL	1-800-870-8786. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Stanislaus Behavioral Health Services

CALL	1-888-376-6246. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Tulare Behavioral Health Services

CALL	Mental health: 1-800-320-1616. This call is free. Substance use disorder: 1-866-732-4114. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Ventura Behavioral Health Services

CALL	1-866-998-2243. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Yolo Behavioral Health Services

CALL	1-888-965-6647. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	1-800-735-2929. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Yuba Behavioral Health Services

CALL	1-888-923-3800. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free.

Contact the county Behavioral Health agency for help with:

- questions about specialty mental health services provided by the county
- questions about substance use disorder services provided by the county

K. California Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. The DMHC Help Center can help you with appeals and complaints about Medi-Cal services.

CALL	1-888-466-2219 DMHC representatives are available between the hours of 8 a.m. and 6 p.m., Monday through Friday.
TDD	1-877-688-9891 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Help Center California Department of Managed Health Care 980 Ninth Street, Suite 500 Sacramento, CA 95814-2725
FAX	1-916-255-5241
WEBSITE	www.dmhc.ca.gov

L. Health Consumer Alliance (HCA)

The Health Consumer Alliance (HCA) is a statewide partnership that offers free on-line, over-the-phone, or in-person legal assistance to help California residents struggling to get or maintain health coverage and resolve problems with their health plans. To learn more about the HCA or to get possible assistance, call 1-888-804-3536 or visit www.healthconsumer.org/

M. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

M1. Extra Help from Medicare

Because you're eligible for Medi-Cal, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either Medi-Cal or Social Security office that confirms you're qualified for "Extra Help." The evidence can also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.
- You or your appointed representative need to provide the evidence to a network pharmacy when obtaining covered Part D drugs so that we can charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS for updating:
  - Write to Kaiser Permanente at
    California Service Center Attn:
    Best Available Evidence
    P.O. Box 232400
    San Diego, CA 92193-2400
  - Fax it to 1-877-528-8579.
  - Take it to a network pharmacy or your local Member Services office at a network facility.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them debt, we may make the

payment directly to the pharmacy. If the state paid on your behalf, we may make payment directly to the state. Call Member Services at the number at the bottom of the page if you have questions.

M2. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the California AIDS Drug Assistance Program (ADAP). Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the ADAP call center at 1-844-421-7050 between 8 a.m. and 5 p.m., Monday through Friday (excluding holidays).

M3. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Services at the phone number at the bottom of the page or visit www.medicare.gov.

N. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, it's important that you contact Social Security to let them know.

CALL	1-800-772-1213. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov

O. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

CALL	1-877-772-5772. Calls to this number are free. Press "0" to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	www.rrb.gov

P. Medicare Medi-Cal Ombudsperson Program

The Medicare Medi-Cal Ombudsperson Program offers FREE assistance to help people who are struggling to get or maintain health coverage and resolve problems with their health plans.

If you have problems with:

- Medi-Cal
- Medicare
- your health plan
- accessing medical services
- appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- medical billing
- IHSS (In-Home Supportive Services)

The Medicare Medi-Cal Ombudsperson Program assists with complaints, appeals, and hearings. The phone number for the Ombudsperson Program is 1-855-501-3077.

Q. Medi-Cal Dental

Certain dental services are available through Medi-Cal Dental, including but not limited to, services such as:

- initial examinations, X-rays, cleanings, sealants, and fluoride treatments;
- restorations and crowns;
- root canal therapy; and
- partial and complete dentures, adjustments, repairs, and relines

Dental benefits are available through Medi-Cal Dental Fee-for-Service (FFS) or Dental Managed Care (Dental MC) depending on your county.

Medi-Cal Dental FFS (for counties other than Los Angeles and Sacramento)

CALL	1-800-322-6384. The call is free. Medi-Cal Dental FFS representatives are available to assist you from 8 a.m. to 5 p.m., Monday through Friday.
TTY	1-800-735-2922 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.dental.dhcs.ca.gov/ smilecalifornia.org/

Dental managed care plan for Los Angeles and Sacramento counties

Instead of Medi-Cal Dental Fee-for-Service, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Sacramento and Los Angeles Counties. If you want more information about dental plans, or want to change dental plans, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8 a.m. to 6 p.m. The call is free. Dental managed care plan contacts are also available here: www.dhcs.ca.gov/services/Pages/ManagedCarePlanDirectory.aspx.

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment, and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare, and most Medi-Cal services. This includes certain behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services, and many LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean services that are reasonable and necessary to diagnose and treat your medical condition. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (go to **Section D1** for more information).
    - In most cases, your network PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
    - You don't need referrals from your PCP for emergency care or urgently needed care, to use a women's health provider, or any other services listed in **Section D1**.
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for

services you get. Here are some cases when this rule doesn't apply:

- If you need emergency or urgently needed care from an out-of-network provider (for more information, go to **Section H**).
- If you need care that our plan covers and our network providers can't provide it, you can get care from an out-of-network provider if we or our Medical Group authorize the services before you get the care. In this situation, we cover the care as if you got it from a network provider. For information about getting approval to use an out-of-network provider, go to **Section D4**.
- If you need kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible, you can get care from an out-of-network provider. The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider, your cost-sharing for the dialysis may be higher. If possible, call Member Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- If you're a new member to our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to Chapter 1 of this Member Handbook. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network. After 12 months, we'll no longer cover your care if you continue to use providers that aren't in our network.

Other Health Coverage: You must utilize all other health coverage prior to Medi-Cal when the same service is available under your primary health coverage since Medi-Cal is the payer of last resort. This means that in most cases, Medi-Cal will be the secondary payer to Medicare, covering allowable costs not paid by Medicare or other health coverage up to the Medi-Cal rate.

New members to Kaiser Permanente Dual Complete: In most instances you'll be enrolled in Kaiser Permanente Dual Complete Plan for your Medicare benefits the 1st day of the month after you request to be enrolled in Kaiser Permanente Dual Complete. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for up to two months. After that, you'll receive your Medi-Cal services through Kaiser Permanente Dual Complete. There will be no gap in your Medi-Cal coverage. Please call the number at the bottom of the page if you have any questions.

C. Your care coordinator

C1. What a care coordinator is

Your Special Needs Plan Program Coordinator is responsible for coordinating your care. They'll contact you annually for a health risk assessment and also after a hospital discharge. (For more information about this, refer to **Chapter 2**, **Section G**.)

C2. How you can contact your care coordinator

Refer to **Chapter 2**, **Section G** for information on how to contact your care coordinator.

C3. How you can change your care coordinator

To change your care coordinator, contact your care coordinator (refer to **Chapter 2**, **Section G** for information).

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of a PCP and what a PCP does for you

Your primary care provider is a physician who meets state requirements and is trained to give you primary medical care. Your PCP will also coordinate your care. "Coordinating" your care includes checking or consulting with other network providers about your care and how it's going. In some cases, your PCP will need to get prior authorization (prior approval) from us (see **D2** in this chapter for more information).

Your choice of PCP

Your PCP will usually practice general medicine (also called adult or internal medicine and family practice) and sometimes obstetrics/gynecology. At some network facilities, if you prefer, you can choose an available nurse practitioner or physician assistant to be your primary care provider. PCPs are identified in the *Provider and Pharmacy Directory*.

Your PCP provides, prescribes, or authorizes medically necessary covered services. Your PCP will provide most of your routine or basic care and provide a referral as needed to see other network providers for other care you need. For example, to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). There are a few types of covered services you can get on your own without contacting your PCP first (see "Services you can get without approval from your PCP" in this chapter).

Please see your *Provider and Pharmacy Directory* or call Member Services for more information about selecting a PCP and which providers are accepting new patients.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network. Your PCP selection will be effective immediately.

To choose or change your PCP, please call **our personal physician selection number at** 1-888-956-1616 (TTY 711), Monday through Friday, 7 a.m. to 7 p.m. **You can also make your selection at** kp.org/finddoctors.

When you call, tell us if you're seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment) so we can tell you if you need to get a referral from your new PCP to continue the services. Also, if there is a particular network specialist or hospital that you want to use, check with us to find out if your PCP makes referrals to that specialist or uses that hospital.

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. If you call Member Services before you leave the service area, we can help you receive dialysis while you're away.
- Flu shots and COVID-19 vaccine as well as hepatitis B vaccines and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Second opinions from another network provider.
- Appointments in the following areas: optometry, substance abuse, and psychiatry.
- In our Southern California region, Medicare-covered chiropractic care as long as you

get them from a network provider.

Additionally, if you're an American Indian Member, you may get Covered Services from an Indian Health Care Provider of your choice, without requiring a referral from a Network PCP or Prior Authorization.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists who care for patients with cancer.
- Cardiologists who care for patients with heart problems.
- Orthopedists who care for patients with bone, joint, or muscle problems.

Referrals from your PCP

You'll usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get on your own, without getting approval from your PCP first, which are described above in **Section D1**.

A written referral can be for a single visit or it can be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that's serious or complex enough to require treatment by a specialist.

If you don't get a written referral when needed, the bill cannot be paid. For more information, call Member Services at the number at the bottom of this page.

Referrals to network providers

When your PCP prescribes care that isn't available from a PCP (for example, specialty care), he or she will give you a referral to see a network specialist or another network provider as needed. If your PCP refers you to a network specialist, the referral will be for a specific treatment plan. Your treatment plan can include a standing referral if ongoing care from the specialist is prescribed. We'll send you a written referral to authorize an initial consultation or a specified number of visits with a network specialist. After your initial consultation with the network specialist, you must then return to your PCP unless we have authorized more visits as specified in the written referral that we gave you. Don't return to the network specialist after your initial consultation visit unless we have authorized additional visits in your referral. Otherwise, the services cannot be covered.

Prior authorization

For the services and items listed below, your network provider will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. If you ever disagree with authorization decisions, you can file an appeal as described in **Chapter 9.**

- Services and items identified in **Chapter 4** with a footnote (†).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and aren't available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which can include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you aren't certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- After we that you need post-stabilization care from an out-of-network provider following emergency care, we'll discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we'll authorize your care from the out-of-network provider only if we can't arrange to have a network provider (or other designated provider) provide the care. Please see **Section H** in this chapter for more information.
- Medically necessary transgender surgery and associated procedures.
- Care from a religious non-medical health care institution described in **Section K** of this chapter.
- Northern California members only: If your network provider makes a written or electronic referral for a transplant evaluation, Medical Group's regional transplant advisory committee or board or case conference (if one exists) will authorize the referral if it determines that you're a potential candidate for organ transplant and the service is covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the services if the transplant center's physician(s) determine that they are medically necessary or covered in accord with Medicare guidelines. Note: A network physician can provide or authorize a corneal

transplant without using this Medical Group transplant authorization procedure.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers changes during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We'll help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask, to continue getting medically necessary treatment or therapies from another provider in our network. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit's unavailable or inadequate to meet your medical needs. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and aren't available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which can include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you're not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both.

(Refer to **Chapter 9** for more information.)

D4. Out-of-network providers

If you use an out-of-network provider, the provider must accept Medicare and/or Medi-Cal.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Medi-Cal.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

LTSS can help you stay at home and avoid a hospital or skilled nursing facility stay. You have access to certain LTSS through our plan, including skilled nursing facility care, Community Based Adult Services (CBAS), and Community Supports. Another type of LTSS, the In-Home Supportive Services program, is available through your county social service agency.

You can ask your doctor or your care coordinator for more information on LTSS including IHSS. Your care coordinator can help you apply for IHSS by contacting the appropriate county social services agency indicated in **Chapter 4, Section F4** of this *Member Handbook*.

F. Behavioral health (mental health and substance use disorder) services

You have a right to access medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan doesn't provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through your county behavioral health agency, which are identified below:

- Alameda County Department of Mental Health at 1-800-491-9099 (TTY 1-800-533-5018)
- Alameda County Department of Substance Abuse at 1-844-682-7215 (TTY 1-800-533-5018)
- Amador County Behavioral Health at 1-888-310-6555 (TTY 711)
- Contra Costa County Behavioral Health at 1-888-678-7277 (TTY 711)
- El Dorado County Behavioral Health at 1-800-929-1955 (TTY 711)
- Fresno County Behavioral Health at 1-800-654-3937 (TTY 711)
- Kern County Behavioral Health at 1-800-991-5272 (TTY 711)
- Kings County Behavioral Health at 1-800-655-2553 (TTY 711)
- Los Angeles County Department of Mental Health at 1-800-854-7771 (TTY 711)
- Madera County Behavioral Health at 1-888-275-9779 (TTY 711)

- Marin County Behavioral Health at 1-888-818-1115 (TTY 711)
- Mariposa County Behavioral Health at 1-800-549-6741 (TTY 711)
- Napa County Behavioral Health at 1-800-648-8650 (TTY 711)
- Orange County Mental Health and Recovery Services at 1-855-625-4657 (TTY 711)
- Placer County Behavioral Health at 1-888-886-5401 (TTY 711)
- Riverside County Behavioral Health at 1-800-499-3008 (TTY 711)
- San Bernardino Department of Behavioral Health at 1-888-743-1478 (TTY 711)
- San Diego County Behavioral Health Services at 1-888-724-7240 (TTY 711)
- Sacramento County Behavioral Health Services at 1-888-881-4881 (TTY 711)
- San Mateo County Behavioral Health and Recovery Services at 1-800-686-0101 (TTY 711)
- San Francisco County Behavioral Health at 1-888-246-3333 (711)
- San Joaquin County Behavioral Health at 1-888-468-9370 (711)
- Santa Clara County Behavioral Health Services at 1-800-704-0900 (TTY 711)
- Santa Cruz County Behavioral Health at 1-800-952-2335 (711)
- Solano County Behavioral Health at 1-800-547-0495 (711)
- Sonoma County Behavioral Health at 1-800-870-8786 (711)
- Stanislaus County Behavioral Health at 1-888-376-6246 (711)
- Tulare County Department of Mental Health at 1-800-320-1616 (TTY 711)
- Tulare County Department of Substance Abuse at 1-866-732-4114 (TTY 711)
- Ventura County Behavioral Health at 1-866-998-2243 (TTY 711)
- Yolo County Behavioral Health at 1-888-965-6647 (TTY 1-800-735-2929)
- Yuba County Behavioral Health at 1-888 923-3800 (TTY 711)

F1. Medi-Cal behavioral health services provided outside our plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by your county behavioral health agency (identified in **Section F** of this chapter) include:

- mental health services
- medication support services
- day treatment intensive services
- day rehabilitation
- crisis intervention services
- crisis stabilization services
- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services
- targeted case management
- justice-involved reentry, where available
- assertive community treatment (ACT), where available
- forensic assertive community treatment (FACT), where available
- coordinated specialty care (CSC) for first episode psychosis (FEP), where available
- clubhouse services, where available
- enhanced community health worker (CHW) Services, where available
- supported Employment, where available
- peer support services, where available
- community-based mobile crisis intervention services, where available
- therapeutic behavioral services
- therapeutic foster care

Drug Medi-Cal (DMC) services provided by your county include:

- intensive outpatient treatment services
- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program
- medications for addiction treatment (also called Medication Assisted Treatment)
- peer support services, where available
- community-based mobile crisis intervention services, where available

Drug Medi-Cal Organized Delivery System (DMC-ODS) services are available to you through your County Behavioral Health Agency, if you meet criteria to receive these services. DMC-ODS services include:

- outpatient treatment services
- intensive outpatient treatment services
- partial hospitalization services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- peer support services, where available
- community-based mobile crisis intervention services, where available
- contingency management services, where available
- inpatient treatment services

In addition to the services listed above, you can have access to voluntary inpatient detoxification services if you meet the criteria.

G. Transportation services

G1. Non-Emergency Medical Transportation

You're entitled to non-emergency medical transportation (NEMT) if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. NEMT can be provided for all Medi-Cal covered services such as medical, dental, mental health, substance use, and pharmacy appointments. If you need NEMT, you can talk to your network provider, dentist, or

substance use disorder provider and ask for it. Your provider will decide the best type of transportation to meet your needs. If you need NEMT, they'll prescribe it by completing a form and submitting it to Kaiser Permanente Dual Complete for approval. Depending on your medical need, you may be able to get approval for up to 12 months. Your PCP will reassess your need for NEMT as necessary or upon the expiration of your prescription, and may re-approve the NEMT for up to 12 months.

NEMT is an ambulance, litter van, wheelchair van, or air transport. Kaiser Permanente Dual Complete allows the lowest cost covered transportation mode and most appropriate NEMT for your medical needs when you need a ride to your appointment. For example, if you can physically or medically be transported by a wheelchair van, Kaiser Permanente Dual Complete won't pay for an ambulance. You're only entitled to air transport if your medical condition makes any form of ground transportation impossible.

NEMT must be used when:

- You physically or medically need it as determined by written authorization from a network provider, dentist, or substance use disorder provider because you aren't able to use a bus, taxi, car, or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle, or place of treatment due to a physical or mental disability.

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call Kaiser Permanente Dual Complete at least three business days (Monday-Friday) before your appointment. For **appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Medical transportation limits

Kaiser Permanente Dual Complete covers the lowest cost medical transportation that meets your medical needs from your home to the closest provider where an appointment is available. Medical transportation won't be provided if Medicare or Medi-Cal doesn't cover the service. If the appointment type is covered by Medi-Cal but not through the health plan, Kaiser Permanente Dual Complete will help you schedule your transportation. A list of covered services is in **Chapter 4** of this handbook. Transportation isn't covered outside Kaiser Permanente Dual Complete's network or service area unless pre-authorized.

G2. Non-medical transportation

Non-medical transportation (NMT) benefits include traveling to and from your appointments for a service authorized by your provider. You can get a ride, at no cost to you, when you're:

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

Kaiser Permanente Dual Complete plan allows you to use a car, taxi, bus, or other public/private way of getting to your appointment for services authorized by your provider. Kaiser Permanente

Dual Complete uses vendors to arrange for NMT. We cover the lowest cost, NMT type that meets your needs.

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Kaiser Permanente Dual Complete plan must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. You can tell us by calling or emailing, or in person. **You can't be reimbursed for driving yourself**.

Mileage reimbursement requires all of the following:

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

To ask for a ride for services that have been authorized, call our transportation line at 1-844-299-6230 (TTY 711) at least three business days (Monday through Friday) before your appointment. For **urgent appointments**, call as soon as possible. You can also call if you need more information. Please have all of the following when you call:

- Your Kaiser Permanente ID card.
- The date and time of your medical appointments.
- The address of where you need to be picked up and the address of where you're going.
- If you'll need a return trip.
- If someone will be traveling with you (for example, a parent/legal guardian or caregiver).

Note: American Indian Members may contact their local Indian Health Clinic to ask for non-medical transportation.

Non-medical transportation limits

Kaiser Permanente Dual Complete plan provides the lowest cost NMT that meets your needs from your home to the closest provider where an appointment is available. **You can't drive yourself or be reimbursed directly.**

NMT doesn't apply if:

- An ambulance, litter van, wheelchair van, or other form of non-emergency medical transportation is needed to get to a service.
- You need assistance from the driver to and from the residence, vehicle, or place of treatment due to a physical or medical condition.
- You're in a wheelchair and are unable to move in and out of the vehicle without help from the driver.
- The service isn't covered by Medicare or Medi-Cal.

H. Covered services in a medical emergency, when urgently needed, or during a disaster

H1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life or to that of your unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant woman in active labor, when:
  - There isn't enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as** fast **as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care, whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license, even if they're not part of our network.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. The number to call is listed on the back of your plan membership card.

Covered services in a medical emergency

Our plan covers ambulance services in situations when getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

We'll partner with the doctors who are providing the emergency care to help manage and follow up on your care. After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make

plans for additional care. we'll cover your follow-up post-stabilization care in accord with applicable law. it's very important that your provider call us to get authorization for post-stabilization care **before** you receive the care from the out-of-network provider. The provider treating you must get authorization from us before we'll pay for post-stabilization care. In most cases, you'll only be held financially liable if you're notified by the out-of-network provider or us about your potential liability.

To request pre-approval for you to receive post-stabilization care from an out-of-network provider, the provider must call us at 1-800-225-8883 (TTY 711). They can also call the phone number on the back of your Kaiser Permanente ID card. The provider must call us before you get the services.

When the provider calls, we'll talk to the doctor who is treating you about your health issue. If we determine you need post-stabilization care, we'll authorize the covered services. In some cases, we can arrange to have a network provider provide the care.

If we decide to have a network hospital, skilled nursing facility, or other provider provide the care, we can authorize transport services that are medically necessary to get you to the provider. This can include special transport services that we would not normally cover.

You should ask the provider what care (including any transport) we have authorized. We cover only the services or related transport that we authorized. If you ask for and get services that aren't covered, we can not pay the provider for the services.

Post-stabilization care also includes durable medical equipment ("DME") only when all of the following conditions are met:

- The DME item is covered under as described in **Chapter 4** of this *Member Handbook*.
- It's medically necessary for you to have the DME item after you leave the hospital.
- The DME item is related to the emergency care you received in the hospital.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider or
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

H2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

We cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances, we cover urgently needed care you get from an out-of-network provider.

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you're calling for advice or to make an appointment, you can speak to an advice nurse.

They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, 7 days a week or make an appointment, please refer to your *Provider and Pharmacy Directory* for appointment and advice telephone numbers.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed, even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan covers worldwide urgent care services outside the United States under the following circumstances:

- You're temporarily outside of our service area.
- The services were necessary to treat an unforeseen illness or injury to prevent serious deterioration of your health.
- It was not reasonable to delay treatment until you returned to our service area.
- The services would have been covered had you received them from a network provider.

H3. Care during a disaster

If the governor of California, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: kp.org.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at the in-network cost-sharing rate. If you can't use a network pharmacy during a declared

disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Member Handbook* for more information.

I. What if you're billed directly for covered services

If you paid more than your plan cost-sharing for covered services or if you got a bill for the full cost of covered medical services, refer to **Chapter 7** of this *Member Handbook* to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

I1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, and
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this Member Handbook), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself**, unless it's covered by another Medi-Cal program outside our plan.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

J. Coverage of health care services in a clinical research study

J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us, but we encourage you to tell us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and

investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you'll take part in a clinical trial.

J2. Payment for services when you participate in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study, as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare **hasn't** approved, you pay any costs for being in the study.

J3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/coverage/clinical-research-studies). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

K. How your health care services are covered in a religious non-medical health care institution

K1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

K2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's not voluntary and is required under federal, state, or local law.

- To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:
- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in **Chapters 4 and 12**.

L. Durable medical equipment (DME)

L1. Getting DME as a member of our plan

Durable medical equipment ("DME") includes items that meet the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to a person who has an illness, injury, functional impairment, or congenital anomaly
- The item is appropriate for use in or out of the home
- The item is needed to help you with activities of daily living ("ADLs")

Durable medical equipment requires pre-approval. Coverage is limited to the lowest cost item that adequately meets your medical needs. We select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you **won't** own the rented DME items, no matter how long you rent it.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you **won't** own the equipment.

L2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

If you no longer have Medi-Cal, you'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan**.

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

L4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above. Medicare and Medi-Cal cover these payments if you're still enrolled in Medicare and Medi-Cal.

If oxygen equipment is medically necessary **after you rent it for 36 months,** your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to five years if medically necessary

If oxygen equipment is still medically necessary **at the end of the five-year period:**

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new five-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every five years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services and how much you pay for each service. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

New members to Kaiser Permanente Dual Complete: In most instances you'll be enrolled in Kaiser Permanente Dual Complete Plan for your Medicare benefits the 1st day of the month after you request to be enrolled in Kaiser Permanente Dual Complete. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you'll receive your Medi-Cal services through Kaiser Permanente Dual Complete. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-443-0815 (TTY 711) if you have any questions. Hours are 8 a.m. to 8 p.m., 7 days a week.

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A. Your covered services and your out-of-pocket costs

This chapter tells you about services our plan covers and how much you pay for each service. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. This chapter also explains limits on some services.

For some services, you're charged an out-of-pocket cost called a copay. This is a fixed amount (for example, $5) you pay each time you get that service. You pay the copay at the time you get the medical service.

If you need help understanding what services are covered, call Member Services at 1-800-443-0815 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.

B. Rules against providers charging you for services

We don’t allow our providers to bill you for in-network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this *Member Handbook* or call Member Services.

C. About our plan’s Benefits Chart

The Benefits Chart tells you the services our plan pays for. (Drug coverage is in **Chapter 5.**) It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met.

- We provide covered Medicare and Medi-Cal covered services according to the rules set by Medicare and Medi-Cal
- The services including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it’s an emergency or urgently needed care or unless our plan or a network provider gave you a referral. This means that you may need to pay the provider in full for out-of-

network services you get. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers

- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this *Member Handbook* has more information about getting a referral and when you don't need one

- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with a footnote (†). In addition, see **Chapter 3**, for more information about PA, including other services that require PA that aren't listed in the Benefits Chart.

- If our plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.

- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You* 2027 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)

- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

- If you lose your Medi-Cal within the 4-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, your Medi-Cal coverage may end sooner than your Medicare coverage with us. When your Medi-Cal coverage ends, we won't pay for your Medi-Cal benefits. Your cost-sharing for benefits covered by Kaiser Permanente Dual Complete will change as described in the Benefits Chart in this *Member Handbook*. You may also lose Extra Help from Medicare to help pay for your Medicare Part D drugs.

  We'll assist you to regain your Medi-Cal eligibility. If your Medi-Cal eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your Medi-Cal benefits and your enrollment with us will continue. If you regain Medi-Cal eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.

Important Benefit Information for Members with Certain Chronic Conditions - Only for Southern California Members

- If you have any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill:

  - Chronic alcohol use disorder and other substance use disorders (SUDs)

- Autoimmune disorders:
  - Polyarteritis nodosa
  - Polymyalgia rheumatica
  - Polymyositis
  - Dermatomyositis
  - Rheumatoid arthritis
  - Systemic lupus erythematosus
  - Psoriatic arthritis
  - Scleroderma
- Cancer
- Cardiovascular disorders:
  - Cardiac arrhythmias
  - Coronary artery disease
  - Peripheral vascular disease
  - Valvular heart disease
- Chronic heart failure
- Dementia
- Diabetes mellitus
- Overweight, obesity, and metabolic syndrome
- Chronic gastrointestinal disease:
  - Chronic liver disease
  - Non-alcoholic fatty liver disease (NAFLD)
  - Hepatitis B
  - Hepatitis C
  - Pancreatitis
  - Irritable bowel syndrome
  - Inflammatory bowel disease
- Chronic kidney disease (CKD):
  - CKD requiring dialysis/End-stage renal disease (ESRD)
  - CKD not requiring dialysis
- Severe hematologic disorders:
  - Aplastic anemia
  - Hemophilia
  - Immune thrombocytopenic purpura
  - Myelodysplastic syndrome
  - Sickle-cell disease (excluding sickle-cell trait)
  - Chronic venous thromboembolic disorder
- HIV/AIDS
- Chronic lung disorders:
  - Asthma, chronic bronchitis
  - Cystic fibrosis
  - Emphysema
  - Pulmonary fibrosis
  - Pulmonary hypertension
  - Chronic Obstructive Pulmonary Disease (COPD)
- Chronic and disabling mental health conditions:
  - Bipolar disorders
  - Major depressive disorders
  - Paranoid disorder
  - Schizophrenia
  - Schizoaffective disorder

  - Post-traumatic stress disorder (PTSD)
  - Eating disorders
  - Anxiety disorders
- Neurologic disorders:
  - Amyotrophic lateral sclerosis (ALS)
  - Epilepsy
  - Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia)
  - Huntington's disease
  - Multiple sclerosis.
  - Parkinson's disease
  - Polyneuropathy
  - Fibromyalgia
  - Chronic fatigue syndrome
  - Spinal cord injuries
  - Spinal stenosis
  - Stroke-related neurologic deficit
- Stroke
- Post-organ transplantation care
- Immunodeficiency and Immunosuppressive disorders
- Conditions associated with cognitive impairment:
  - Alzheimer's disease
  - Intellectual disabilities and developmental disabilities
  - Traumatic brain injuries
  - Disabling mental illness associated with cognitive impairment
  - Mild cognitive impairment
- Conditions with functional challenges and require similar services:
  - Spinal cord injuries
  - Paralysis
  - Limb loss
  - Stroke
  - Arthritis
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- To qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI) benefits, you must meet **all** of the following criteria:
  - Have one or more comorbid and medically complex chronic conditions listed above that is life-threatening or that significantly limits your overall health or function, *and*
  - Have a high risk of hospitalization or other significant adverse health outcomes, *and*
  - Require intensive care coordination

  For more information on Kaiser Permanente's SSBCI policies and objective criteria, please visit our website at kp.org/Medicare/SSBCI

- You do not need to take any action. The plan will determine your eligibility through review of your medical claims history and health record to verify diagnosis of eligible chronic condition(s), high risk for hospitalization, and need for intensive care coordination.
- In select circumstances, when there may be insufficient medical claims history or health records available to determine SSBCI eligibility, such as when you are new to Kaiser Permanente, a provider may attest to your qualification by completing and submitting the Provider Attestation Form. The Provider Attestation Form may only be used to validate *preliminary* SSBCI eligibility for an initial benefit period of six months. Submission of the form does not guarantee eligibility for SSBCI. At the end of this preliminary period, ongoing eligibility must be verified through review of your medical claims history and health record.
- For more details, go to the Special Supplemental Benefits for the Chronically Ill row in the Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

- All preventive services are free. This apple 🍎 shows the preventive services in the Benefits Chart.

The Benefits Chart below describes the medical benefits of the following Kaiser Permanente Dual Complete plans included in this *Member Handbook*:

- South P1 plan
- South P6 plan
- South P7 plan
- South P9 plan
- South P10 plan
- South P11 plan
- North P2 plan
- North P16 plan
- North P17 plan
- North P18 plan
- North P19 plan
- North P20 plan
- North P21 plan

- North P22 plan
- North P23 plan
- North P24 plan
- North P25 plan

If you're not certain which plan you're enrolled in, please call Member Services or refer to the cover of your *Annual Notice of Change* (or for new members, your enrollment form or enrollment confirmation letter).

Note: Please refer to **Chapter 1** for the geographic service area of each plan included in this *Member Handbook*. For the purposes of cost-sharing, enrollment, and disenrollment, there are multiple Dual Complete plans in our Region service areas, which are described in this *Member Handbook*. But, for the purposes of obtaining covered services, you get care from network providers anywhere inside your Regions service areas.

D. Our plan's Benefits Chart

Covered Service		What you pay
	**Abdominal aortic aneurysm screening** We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	$0 Talk to your provider and get a referral.
	Acupuncture† We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they're medically necessary. We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; • not associated with pregnancy. **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Acupuncture† (continued) In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission for Acupuncture and Herbal Medicine; and, • a current, full, active, and unrestricted license to practice acupuncture in the state where you're getting care. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations. We also cover acupuncture services not covered by Medicare typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.	
	You may also be able to access acupuncture services under your Medi-Cal coverage. Under Medi-Cal, we cover acupuncture services that are medically necessary to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Medi-Cal outpatient acupuncture services do not require a referral or pre-approval. These acupuncture services are covered when obtained through our Network Providers or American Specialty Health network providers. For more information on acupuncture services covered by Medi-Cal, please call American Specialty Health at 1-800-678-9133 (TTY 711).	$0

Covered Service		What you pay
	**Alcohol misuse screening and counseling** We pay for alcohol-misuse screening (Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT)) for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0
	Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter). The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren’t emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. See Chapter 3 for additional information about non-emergency transportation. We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services.	$0 **If you lose full-scope Medi-Cal coverage**, you pay the following per one-way trip, depending upon the plan which you are enrolled: • South P1 – **$620** • South P6 – **$630** • South P7 – **$620** • South P9 – **$290** • South P10 – **$630** • South P11 – **$540** • North P2 – **$620** • North P16 – **$630** • North P17 – **$590** • North P18 – **$610** • North P19 – **$630** • North P20 – **$630** • North P21 – **$620** • North P22 – **$620** • North P23 – **$630** • North P24 – **$450** • North P25 – **$630**

Covered Service	What you pay
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare visit. However, you don't need to have had a Welcome to Medicare visit to get annual wellness visits after you've had Part B for 12 months. We also cover annual routine physical exams as medically appropriate preventive care in accordance with generally accepted professional standards of practice.	$0
Asthma preventive services You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.	$0 Talk to your provider and get a referral.
Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0 Talk to your provider and get a referral.
Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39. • one screening mammogram every 12 months for women age 40 and over. • clinical breast exams once every 24 months. Additionally, women with a family history of breast cancer may qualify for risk assessment, genetic testing, and genetic counseling.	$0

Covered Service		What you pay
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We cover these comprehensive programs if you've had at least one of these conditions: • heart attack in the last 12 months • coronary artery bypass surgery • stable angina pectoris (chest pain) • heart valve repair or replacement • coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • heart or heart and lung transplant • stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have two sessions per day (each lasting one hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, you pay the following per **specialty care visit**, depending upon the plan which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0** • South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$5** • North P25 – **$0**
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0

Covered Service	What you pay
Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. We also pay for blood tests to check for cardiovascular disease if your doctor orders it.	$0 Talk to your provider and get a referral.
Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months. • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months. • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months. • for women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years.	$0 Talk to your provider and get a referral.
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment. This Medicare-covered service is provided by a network chiropractor or, for †Northern California members, a chiropractor authorized by a network provider. For a list of network chiropractors, please refer to the *Provider and Pharmacy Directory*. • Medi-Cal may cover chiropractic services when received at a Federally Qualified Health Center (FQHC) or Rural Health Clinics (RHC) in Kaiser Permanente's network. FQHCs and RHCs may require a referral to get services. To get more information about services available at an FQHC or RHC, call Member Services. • Medi-Cal may also cover chiropractic services for pregnant members through the 60 days after the end of a pregnancy and for residents in a skilled nursing facility, intermediate care facility, or subacute care facility. We work with American Specialty Health (ASH) to arrange chiropractic services for these members. ASH can be reached at 1-800-678-9133 (TTY 711).	$0

Covered Service	What you pay
Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (ten years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral.

Covered Service		What you pay
	Colorectal cancer screening (continued) • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. • Procedures performed during a screening colonoscopy (for example, removal of polyps). • Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening.	
	Dental services† We pay for certain dental services, as indicated below. What we don't cover is available through Medi-Cal Dental, described in **Section F2** below. We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, you pay the following per **specialty care visit**, depending upon the plan which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0** • South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$5** • North P25 – **$0**

Covered Service	What you pay
Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0 Talk to your provider and get a referral.

Diabetic self-management training, services, and supplies†
 	
We pay for the following services for all people who have diabetes (whether they use insulin or not):
• Supplies to monitor your blood glucose, including the following:
  ○ a blood glucose monitor
  ○ blood glucose test strips
  ○ lancet devices and lancets
  ○ glucose-control solutions for checking the accuracy of test strips and monitors.
 	
This benefit is continued on the next page
	$0

Covered Service		What you pay
	Diabetic self-management training, services, and supplies† (continued) • For people with diabetes who have severe diabetic foot disease, we pay for the following: ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, or one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes).	$0 **If you lose full-scope Medi-Cal coverage**, you pay the following **coinsurance** depending upon the plan in which you are enrolled: • South P1 – **20%** • South P6 – **20%** • South P7 – **20%** • South P9 – **0%** • South P10 – **20%** • South P11 – **20%** • North P2 – **20%** • North P16 – **20%** • North P17 – **20%** • North P18 – **20%** • North P19 – **20%** • North P20 – **20%** • North P21 – **20%** • North P22 – **20%** • North P23 – **20%** • North P24 – **20%** • North P25 – **20%**
	• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. **Note:** You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare.	$0
	Doula services For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery. Up to nine additional postpartum visits may be provided as well with an additional written recommendation from a physician or other licensed practitioner.	$0

Covered Service	What you pay
Durable medical equipment (DME) and related supplies† Refer to the **Chapter 12** of this *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs, including electric wheelchairs • crutches • powered mattress systems • dry pressure pad for mattress • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at kp.org/directory. We also cover the following DME not covered by Medicare when medically necessary: • bed accessories for a hospital bed when bed extension is required **This benefit is continued on the next page**	$0. **If you lose full-scope Medi-Cal coverage**, you pay the following **coinsurance** depending upon the plan in which you are enrolled, except you pay $0 for peak flow meters and ultraviolet light therapy equipment: • South P1 – **20%** • South P6 – **20%** • South P7 – **20%** • South P9 – **0%** • South P10 – **20%** • South P11 – **20%** • North P2 – **20%** • North P16 – **20%** • North P17 – **20%** • North P18 – **20%** • North P19 – **20%** • North P20 – **20%** • North P21 – **20%** • North P22 – **20%** • North P23 – **20%** • North P24 – **20%** • North P25 – **20%** **Oxygen equipment** **If you lose full-scope Medi-Cal coverage**, your cost-sharing for Medicare oxygen equipment coverage is the same amount listed above, every time you receive equipment. Your cost-sharing won't change after you're enrolled for 36 months.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies† (continued) • heel or elbow protectors to prevent or minimize advanced pressure relief equipment us • iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example skin infection) or is preventing daily living activities • resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag • ultraviolet light therapy equipment for conditions other than psoriasis as medically necessary, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through our plan's prior authorization process, as described in **Chapter 3** and (2) the equipment is provided inside our service area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)	
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health or to that of your unborn child; **or** **This benefit is continued on the next page**	$0 **If you lose your full-scope Medi-Cal coverage**, you pay the following per Emergency Department visit, depending upon the plan in which you are enrolled: • South P1 – **$115** • South P6 – **$115** • South P7 – **$115** • South P9 – **$0** • South P10 – **$115** • South P11 – **$115**

	Covered Service	What you pay

	Emergency care (continued)
	• serious harm to bodily functions; **or**
	• serious dysfunction of any bodily organ; **or**
	• loss of a limb, or loss of function of a limb.
	• In the case of a pregnant woman in active labor, when:
	  ○ There isn't enough time to safely transfer you to another hospital before delivery.
	  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	You have worldwide emergency care coverage.
		• North P2 – **$115**
		• North P16 – **$115**
		• North P17 – **$115**
		• North P18 – **$115**
		• North P19 – **$115**
		• North P20 – **$115**
		• North P21 – **$115**
		• North P22 – **$115**
		• North P23 – **$115**
		• North P24 – **$115**
		• North P25 – **$115**
		Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.
		†If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

	Family planning services The law lets you choose any provider – whether a network provider or a Medi-Cal out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Family planning services (continued) • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • limited fertility services such as counseling and education about fertility awareness techniques, and/or preconception health counseling, testing, and treatment for sexually transmitted infections (STIs). • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant) • treatment for AIDS and other HIV-related conditions • genetic testing	
	Fitness benefit (One Pass®) A fitness benefit is provided through the One Pass program to help members take control of their health and feel their best. The One Pass program includes: • Gyms and Fitness Locations: You receive a membership with access to a wide variety of in-network gyms through the core and premium network. Fitness locations include national, local, and community fitness centers and boutique studios. You can use any in-network location, and you may use multiple participating fitness locations during the same month. Participating gyms and fitness centers may vary by location and are subject to change. **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Fitness benefit (One Pass®) (continued) • Online Fitness: You have access to live, digital fitness classes and on-demand workouts through the One Pass member website or mobile app. • Fitness and Social Activities: You also have access to groups, clubs, and social events through the One Pass member website. • Home Fitness Kits: If you prefer to work out at home, you can also select one home fitness kit per calendar year for Strength, Yoga, or Dance. Kits are subject to change and once selected cannot be exchanged. • Brain Health: Access to online brain health cognitive training programs. For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, please visit www.YourOnePass.com or call 1-877-614-0618 (TTY 711), Monday through Friday, 6 a.m. to 7 p.m. The following are not covered: Additional services (such as personal training, fee-based group fitness classes, expanded access hours, or additional classes outside of the standard membership offering). One Pass® is a registered trademark of One Pass Solutions, Inc. in the U.S. and other jurisdictions and is a voluntary program. The One Pass program and amenities vary by plan, area, and location. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. One Pass is not responsible for the services or information provided by third parties. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them.	
	**Health and wellness education programs** We offer many programs that focus on certain health conditions. These include: • health education classes; • nutrition education classes; • smoking and tobacco use cessation; **and** **This benefit is continued on the next page**	$0

	Covered Service	What you pay
	Health and wellness education programs (continued) • nursing hotline As part of our Healthy Lifestyle Programs, our plan covers a number of group health education classes including: healthy heart, living with chronic conditions and depression. The Healthy Lifestyle Programs are provided by a certified health educator or other qualified health professional. We cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for chronic conditions (such as diabetes and asthma). You can also participate in programs that we don't cover, which may require that you pay a fee. For more information about our health education counseling, programs, and materials, please contact your local Health Education Department, call Member Services or go to our website at kp.org/classes.	
	Hearing services (including hearing aids) We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$0 **If you lose full-scope Medi-Cal coverage**, you pay the following per **specialty care visit**, depending upon the plan which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0** • South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$5** • North P25 – **$0**

Covered Service		What you pay
	We also pay for hearing aids if: • You are tested for hearing loss. • The hearing aids are medically necessary. • You receive a prescription from your doctor or other qualified provider. Coverage is limited to the lowest cost aid that meets your medical needs. We will choose who will supply the hearing aid. We cover one hearing aid unless an aid for each ear is needed for results significantly better than you could get with one hearing aid. We cover the following: • molds, supplies, and inserts • repairs • an initial set of batteries • six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid • trial period rental of hearing aids • assistive listening devices, surface-worn bone conduction hearing devices • hearing aid-related audiology and post-evaluation services 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. Coverage does not include replacement hearing aid batteries.	$0
	HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral.

	Covered Service	What you pay
	HIV screening (continued) If you're pregnant, we pay for up to three HIV screening tests during a pregnancy. We also pay for additional HIV screening(s) when recommended by your provider.	
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	$0 Talk to your provider and get a referral. **Note:** There is no cost-sharing for home health care services and items provided in accordance with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
	Home infusion therapy† Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; **This benefit is continued on the next page**	$0 for professional services, training, and monitoring. **Note:** The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Benefits Chart depending on the item.

Covered Service		What you pay
	Home infusion therapy† (continued) • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	
	We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary; • We approved your prescription drug for home infusion therapy; and • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	$0 **Note:** If a covered home infusion supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost-sharing listed elsewhere in this document depending on the service.
	Home medical care not covered by Medicare for North P16, P17, P19, and P23 members (Advanced Care At Home) We cover medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status, to provide you with an alternative to receiving acute care in a hospital and post-acute care services in the home to support your recovery. Services in the home must be: • Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home. • Elected by you because you prefer to receive the care described in your treatment plan in your home. Our network provider will provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by a network hospitalist: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, home health aides, and other healthcare professionals in accord with the home care treatment plan and the provider's scope of practice and license. **This benefit is continued on the next page**	Talk to your provider and get a referral. **North P16, P17, P19, and P23:** $0 **Not covered for all other members.**

	Covered Service	What you pay
	Home medical care not covered by Medicare for North P16, P17, P19, and P23 members (Advanced Care At Home) (continued) • Communication devices to allow you to contact the Advanced Care at Home's command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable communication, and a PERS alert device to contact the command center if you are unable to get to a phone. • The following equipment necessary to ensure that you are monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer. • Mobile imaging and tests such as X-rays, labs, and EKGs. • The following safety items: shower stools, raised toilet seats, grabbers, long handle shoehorn, and sock aid. • Up to 21 meals per week while you are receiving acute care in the home.	

	In addition, for Medicare-covered services and items listed below, the cost-sharing indicated elsewhere in this Medical Benefits Chart does not apply when the services and items are prescribed as part of your home treatment plan:
	• Durable medical equipment.
	• Medical supplies.
	• Non-emergent ambulance transportation to and from network facilities when scheduled ambulance transport is medically necessary.
	• Physician assistant and nurse practitioner house calls or office visits.
	• The following services at a network facility if the services are part of your home treatment plan:
	  ○ Network Emergency Department visits associated with this benefit.
	  ○ Physical, speech, or occupational therapy office visits.
	  ○ X-rays, labs, ultrasounds, and EKGs.
	The cost-sharing indicated elsewhere in this Medical Benefits Chart will apply to all other services and items that aren't part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. **Note:** For prescription drug cost-sharing information, please refer to the Medicare Part B prescription drug section in this chart and Chapter 6 for Medicare Part D prescription drugs.
		North P16, P17, P19, and P23: $0
		Not covered for all other members.

Covered Service	What you pay
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care When you're admitted to a hospice, you have the right to stay in our plan. **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. • While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay our plan's cost-sharing amount for these services **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Hospice care (continued) For drugs that may be covered by our plan's Medicare Part D **benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this *Member Handbook* **Note:** If you have a serious illness, you may be eligible for palliative care, which provides team-based patient and family-centered care to improve your quality of life. You may receive palliative care at the same time as curative/regular care. Please see Palliative Care section below for more information **Note:** If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that isn't related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	
	Immunizations We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • human papillomavirus (HPV) vaccine • other vaccines if you're at risk and they meet Medicare Part B coverage rules. We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Member Handbook* to learn more.	$0

Covered Service	What you pay
Inpatient hospital care We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • (†Northern California members) in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. Northern California plan members must get approval from our plan to get these services • If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, you pay the following per day for days 1–5 of a hospital stay (cost-sharing is charged for each inpatient stay), depending upon the plan in which you are enrolled: • South P1 – **$400** • South P6 – **$420** • South P7 – **$440** • South P9 – **$0** • South P10 – **$490** • South P11 – **$120** • North P2 – **$470** • North P16 – **$480** • North P17 – **$400** • North P18 – **$400** • North P19 – **$490** • North P20 – **$450** • North P21 – **$480** • North P22 – **$490** • North P23 – **$480** • North P24 – **$455** • North P25 – **$460** Thereafter you pay $0 for the remainder of your covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. †If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

	Covered Service	What you pay
	Inpatient hospital care (continued) • If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person, in accordance with our travel and lodging guidelines, which are available from Member Services • blood, including storage and administration. • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available at es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**Note:** If you are admitted to the hospital in 2027 and are not discharged until sometime in 2028, the 2027 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. • If you're 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD). **This benefit is continued on the next page**	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, you pay the following per day for days 1–5 of a hospital stay (cost-sharing is charged for each inpatient stay), depending upon the plan in which you are enrolled: • South P1 – **$400** • South P6 – **$400** • South P7 – **$400** • South P9 – **$0** • South P10 – **$400** • South P11 – **$120** • North P2 – **$400**

Covered Service		What you pay
	Inpatient services in a psychiatric hospital (continued)	• North P16 – **$400** • North P17 – **$400** • North P18 – **$400** • North P19 – **$400** • North P20 – **$400** • North P21 – **$400** • North P22 – **$400** • North P23 – **$400** • North P24 – **$400** • North P25 – **$400** Thereafter you pay **$0** for the remainder of your covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. **Note:** If you are admitted to the hospital in 2027 and are not discharged until sometime in 2028, the 2027 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay† We don't pay for your inpatient stay if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or a nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services **This benefit is continued on the next page**	Talk to your provider and get a referral. If your inpatient or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Benefits Chart when provided by network providers.

Covered Service		What you pay

	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay† (continued)
	• surgical dressings
	• splints, casts, and other devices used for fractures and dislocations
	• prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of:
	  ○ an internal body organ (including contiguous tissue), **or**
	  ○ the function of an inoperative or malfunctioning internal body organ
	• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition
	• physical therapy, speech therapy, and occupational therapy	

	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments. • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. • Home dialysis equipment and supplies. **This benefit is continued on the next page**	$0

	Covered Service	What you pay
	Kidney disease services and supplies (continued) • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible.	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, you pay **20% coinsurance**.
	• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care.	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Benefits Chart for the cost-sharing applicable to inpatient stays.
	Medicare Part B pays for some drugs for dialysis. For information, refer to drugs" in this chart.	
	Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50-80, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least one pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral.

Covered Service		What you pay
	Medical nutrition therapy (continued) We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary. We also cover nutrition/dietary counseling with a network provider not related to diabetes or kidney disease without dialysis.	
	Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0
	Medicare Part B drugs† These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized **This benefit is continued on the next page**	$0 **Administered Part B drugs** **If you lose full-scope Medi-Cal coverage**, for Medicare Part B drugs when administration or observation by medical personnel is required and the drugs are administered to you by a network provider, you pay the following **coinsurance** depending upon the plan in which you are enrolled: • South P1 – **0%-20%** • South P6 – **0%-20%** • South P7 – **0%-20%** • South P9 – **0%**

Covered Service	What you pay
Medicare Part B drugs† (continued) • the Alzheimer's drug, Leqembi® (generic lecanemab) which is given intravenously (IV). In addition to medication costs, you may need additional scans and tests before and/or during treatment. Talk to your doctor about what scans and tests you may need as part of your treatment. • clotting factors you give yourself by injection if you have hemophilia • transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug **This benefit is continued on the next page**	• South P10 – **0%-20%** • South P11 – **0%** • North P2 – **0%-20%** • North P16 – **0%-20%** • North P17 – **0%-20%** • North P18 – **0%-20%** • North P19 – **0%-20%** • North P20 – **0%-20%** • North P21 – **0%-20%** • North P22 – **0%-20%** • North P23 – **0%-20%** • North P24 – **0%-20%** • North P25 – **0%-20%** Please call Member Services to find out which drugs are provided at the **20%** coinsurance. Some drugs may be less than **20%** if those drugs are determined to exceed the amount of inflation. **Part B drugs from a network pharmacy** You pay the following for Part B drugs on our formulary when obtained from a network pharmacy: • **$0** for home infusion drugs (up to a 100-day supply) and Epogen for home dialysis (up to a 30-day supply). • **$0** for all other generic and brand-name drugs (up to a 30-day supply).

Covered Service		What you pay
	Medicare Part B drugs† (continued) • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan.	
	Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) **This benefit is continued on the next page**	$0 Talk to your provider and get a referral.

Covered Service	What you pay
Nursing facility care (continued) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital	

Covered Service		What you pay
	**Obesity screening and therapy to keep weight down** If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
	Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing) • intake activities • periodic assessments	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, for clinically administered Medicare Part B drugs when provided by an Opioid Treatment Program, you pay the following **coinsurance** depending upon the plan in which you are enrolled: • South P1 – **0%-20%** • South P6 – **0%-20%** • South P7 – **0%-20%** • South P9 – **0%** • South P10 – **0%-20%** • South P11 – **0%** • North P2 – **0%-20%** • North P16 – **0%-20%** • North P17 – **0%-20%** • North P18 – **0%-20%** • North P19 – **0%-20%** • North P20 – **0%-20%** • North P21 – **0%-20%** • North P22 – **0%-20%** • North P23 – **0%-20%** • North P24 – **0%-20%** • North P25 – **0%-20%** Some drugs may be less than **20%** if those drugs are determined to exceed the amount of inflation.

	Covered Service	What you pay
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • Ultrasounds	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, you pay the following per encounter, depending upon the plan in which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0** • South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$50** • North P25 – **$0**
	• lab tests • blood, including storage and administration • radiation (radium and isotope) therapy, including technician materials and supplies • †surgical supplies, such as dressings • †splints, casts, and other devices used for fractures and dislocations	$0 Talk to your provider and get a referral.
	• diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition **This benefit is continued on the next page**	$0 Talk to your provider and get a referral.

Covered Service		What you pay
	Outpatient diagnostic tests and therapeutic services and supplies (continued)	**If you lose full-scope Medi-Cal coverage**, you pay the following per procedure for Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET), depending upon the plan in which you are enrolled: • South P1 – **$375** • South P6 – **$375** • South P7 – **$375** • South P9 – **$50** • South P10 – **$375** • South P11 – **$375** • North P2 – **$375** • North P16 – **$375** • North P17 – **$375** • North P18 – **$375** • North P19 – **$375** • North P20 – **$375** • North P21 – **$375** • North P22 – **$375** • North P23 – **$375** • North P24 – **$365** • North P25 – **$375**
	• Any diagnostic test or special procedure that is provided in an outpatient department of a hospital or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort **This benefit is continued on the next page**	$0 Talk to your provider and get a referral. **If you lose full-scope Medi-Cal coverage**, you pay the following per procedure, depending upon the plan in which you are enrolled: • South P1 – **$400** • South P6 – **$420** • South P7 – **$440** • South P9 – **$0** • South P10 – **$490**

Covered Service		What you pay
	Outpatient diagnostic tests and therapeutic services and supplies (continued)	• South P11 – **$0** • North P2 – **$470** • North P16 – **$480** • North P17 – **$400** • North P18 – **$400** • North P19 – **$490** • North P20 – **$450** • North P21 – **$480** • North P22 – **$490** • North P23 – **$480** • North P24 – **$455** • North P25 – **$460**
	• other outpatient diagnostic tests	$0 Talk to your provider and get a referral.
	Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf **This benefit is continued on the next page**	$0 **If you lose full-scope Medi-Cal coverage**, you pay the following per stay when admitted directly to the hospital for observation as an outpatient, depending upon the plan in which you are enrolled: • South P1 – **$115** • South P6 – **$115** • South P7 – **$115** • South P9 – **$0** • South P10 – **$115** • South P11 – **$115** • North P2 – **$115** • North P16 – **$115** • North P17 – **$115** • North P18 – **$115** • North P19 – **$115** • North P20 – **$115** • North P21 – **$115**

	Covered Service	What you pay
	Outpatient hospital observation (continued)	• North P22 – **$115** • North P23 – **$115** • North P24 – **$115** • North P25 – **$115** **Note:** There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or following outpatient surgery.
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services **This benefit is continued on the next page**	**Emergency Department** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per visit, depending upon the plan in which you are enrolled: • South P1 – **$115** • South P6 – **$115** • South P7 – **$115** • South P9 – **$0** • South P10 – **$115** • South P11 – **$115** • North P2 – **$115** • North P16 – **$115** • North P17 – **$115** • North P18 – **$115** • North P19 – **$115** • North P20 – **$115** • North P21 – **$115** • North P22 – **$115** • North P23 – **$115** • North P24 – **$115** • North P25 – **$115**

Covered Service		What you pay
	Outpatient hospital services (continued)	**Outpatient surgery** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per procedure, depending upon the plan in which you are enrolled: • South P1 – **$400** • South P6 – **$420** • South P7 – **$440** • South P9 – **$0** • South P10 – **$490** • South P11 – **$0** • North P2 – **$470** • North P16 – **$480** • North P17 – **$400** • North P18 – **$400** • North P19 – **$490** • North P20 – **$450** • North P21 – **$480** • North P22 – **$490** • North P23 – **$480** • North P24 – **$455** • North P25 – **$460**
	• Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • †Medical supplies, such as splints and casts	Talk to your provider and get a referral. $0
	• Some drugs and biologicals that you can't give yourself	$0 **If you lose full-scope Medi-Cal coverage**, for Medicare Part B drugs when administration or observation by medical personnel is required and the drugs are administered to you by a network provider, you pay the following **coinsurance**

Covered Service		What you pay
		depending upon the plan in which you are enrolled: • South P1 – **0%-20%** • South P6 – **0%-20%** • South P7 – **0%-20%** • South P9 – **0%** • South P10 – **0%-20%** • South P11 – **0%** • North P2 – **0%-20%** • North P16 – **0%-20%** • North P17 – **0%-20%** • North P18 – **0%-20%** • North P19 – **0%-20%** • North P20 – **0%-20%** • North P21 – **0%-20%** • North P22 – **0%-20%** • North P23 – **0%-20%** • North P24 – **0%-20%** • North P25 – **0%-20%** Please call Member Services to find out which drugs are provided at the **20%** coinsurance. Some drugs may be less than **20%** if those drugs are determined to exceed the amount of inflation.
	• X-rays and other radiology services billed by the hospital **This benefit is continued on the next page**	Talk to your provider and get a referral. **X-rays and ultrasounds** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per encounter, depending upon the plan in which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0**

Covered Service		What you pay
	Outpatient hospital services (continued)	• South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$50** • North P25 – **$0** **Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET)** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per procedure, depending upon the plan in which you are enrolled: • South P1 – **$375** • South P6 – **$375** • South P7 – **$375** • South P9 – **$50** • South P10 – **$375** • South P11 – **$375** • North P2 – **$375** • North P16 – **$375** • North P17 – **$375** • North P18 – **$375** • North P19 – **$375** • North P20 – **$375** • North P21 – **$375** • North P22 – **$375** • North P23 – **$375** • North P24 – **$365** • North P25 – **$375**

Covered Service		What you pay

	Outpatient hospital services (continued)
	• †For dental procedures at a network facility, we provide general anesthesia and the facility's services associated with the anesthesia if all of the following are true:
	  ○ You are developmentally disabled, or your health is compromised
	  ○ Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
	  ○ The dental procedure would not ordinarily require general anesthesia
	We do not cover any other services related to the dental procedure, such as the dentist's services, unless the services are covered by Medi-Cal Dental (see “Dental services” in this Benefits Chart).
		$0
		If you lose full-scope Medi-Cal coverage, refer to “Outpatient surgery” listed at the beginning of this section for the cost-sharing applicable to outpatient hospital facility charges.

	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker (CSW) • a clinical nurse specialist (CNS) • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws. We pay for the following services, and maybe other services not listed here: • clinic services • day treatment • psychosocial rehab services **This benefit is continued on the next page**	$0

	Covered Service	What you pay
	Outpatient mental health care (continued) • partial hospitalization or Intensive outpatient programs • individual and group mental health evaluation and treatment • psychological testing when clinically indicated to evaluate a mental health outcome • outpatient services for the purposes of monitoring drug therapy • outpatient laboratory, drugs, supplies and supplements • psychiatric consultation	
	Outpatient rehabilitation services† We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. We also cover: • Physical therapy to prevent falls for adults who are at risk for falls when ordered by your doctor. **This benefit is continued on the next page**	$0 **If you lose full-scope Medi-Cal coverage**, you pay the following per visit, depending upon the plan in which you are enrolled: **Individual therapy visits** • South P1 – **$0** • South P6 – **$0** • South P7 – **$20** • South P9 – **$0** • South P10 – **$20** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$35** • North P25 – **$0**

Covered Service		What you pay
	Outpatient rehabilitation services† (continued)	**Group therapy visits** • South P1 – **$0** • South P6 – **$0** • South P7 – **$10** • South P9 – **$0** • South P10 – **$10** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$17** • North P25 – **$0**
	• Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program.	$0 **If you lose full-scope Medi-Cal coverage**, you pay the following per day, depending upon the plan in which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$20** • South P9 – **$0** • South P10 – **$20** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$35** • North P25 – **$0**

Covered Service		What you pay
	Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended–release Naltrexone (vivitrol) treatment	$0
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. **This benefit is continued on the next page**	**Provider office visits** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per **specialty care visit**, depending upon the plan in which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0** • South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$5** • North P25 – **$0**

Covered Service		What you pay
	Outpatient surgery (continued)	**Outpatient surgery and other procedures** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per procedure, depending upon the plan in which you are enrolled, when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • South P1 – **$400** • South P6 – **$420** • South P7 – **$440** • South P9 – **$0** • South P10 – **$490** • South P11 – **$0** • North P2 – **$470** • North P16 – **$480** • North P17 – **$400** • North P18 – **$400** • North P19 – **$490** • North P20 – **$450** • North P21 – **$480** • North P22 – **$490** • North P23 – **$480** • North P24 – **$455** • North P25 – **$460**
	Over-the-Counter (OTC) Items You will receive a preloaded healthy extras card with the quarterly benefit limit listed on the right to purchase eligible OTC items online and at participating retail stores, including at Kaiser Permanente retail pharmacies. Your card will be reloaded on January 1, April 1, July 1, and October 1. **This benefit is continued on the next page**	You pay $0 up to the quarterly allowance for your plan: • South P1 – **$75** • South P6 – **$100** • South P7 – **$150** • South P9 – **$170** • South P10 – **$125**

	Covered Service	What you pay
	Over-the-Counter (OTC) Items (continued) Any unused portion of the quarterly allowance will not roll over to the next quarter. The cost of eligible OTC items will be covered up to the balance available on your card. If there is a remaining amount to pay, you must use another form of payment. Fees and minimum order requirements vary by retailers. Please review details about fees on the checkout page prior to placing an online order. You will be prompted to enter another form of payment for any tips or fees. To activate your healthy extras card, call 1-833-524-7035 (TTY 711) 5 a.m. to 5 p.m. PST, and provide your card number and membership ID number. If you already have a healthy extras card, you will not receive a new card. Please keep your card and your benefit will be available on your existing card. To set up your online account, view a list of eligible OTC items, find participating stores, request reimbursement, check your balance and transaction history, shop online, or replace a lost or stolen card, please visit mybenefitscenter.com or call 1-833-524-7035 (TTY 711) 5 a.m. to 5 p.m. PST. You may also visit mybenefitscenter.com and download the OTC Network mobile app to find participating retailers, search for eligible items, review your transaction history and check your card balance. You can also use the OTC mobile app at stores to scan items for eligibility during shopping and view your balance before you check out. Members can download the OTC Network mobile app directly from the iTunes App Store or GooglePlay. Search “OTC Network” to download. Note: Any unused amounts are forfeited upon disenrollment from our plan.	• South P11 – **$150** • North P2 – **$50** • North P16 – **$75** • North P17 – **$75** • North P18 – **$75** • North P19 – **$75** • North P20 – **$75** • North P21 – **$75** • North P22 – **$75** • North P23 – **$75** • North P24 – **$75** • North P25 – **$75** **Southern California members only:** If you qualify for SSBCI benefits described in the Special Supplemental Benefits for the Chronically Ill row in this Benefits Chart, you may use your quarterly OTC allowance to also purchase healthy foods.
	Over-the-Counter (OTC) Items (continued) You may have additional coverage for certain OTC items covered under Medi-Cal through the Medi-Cal Rx program. For more information on Medi-Cal Rx, 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 visit the Medi-Cal Rx website at https://www.Medi-CalRx.dhcs.ca.gov/home/.	$0

Covered Service		What you pay
	Over the Counter (OTC) items for nicotine replacement We cover certain FDA-approved nicotine replacement therapies for over-the-counter use. The items must be ordered by a network provider and obtained from a network pharmacy. We will provide up to a 100-day supply twice during the calendar year.	$0
	Palliative care Palliative care is covered by our plan. Palliative care is for people with serious illness. It provides patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative Care isn't hospice, therefore you don't have to have a life expectancy of six months or less to qualify for palliative care. Palliative care is provided at the same time as curative/regular care. Palliative care includes the following: • advance care planning • palliative care assessment and consultation • a plan of care including all authorized palliative and curative care, including mental health and medical social services • services from your designated care team • care coordination • pain and symptom management You may not get hospice care and palliative care at the same time. If you're getting palliative care and meet the eligibility for hospice care, you can ask to change to hospice care at any time.	$0 Talk to your provider and get a referral.
	Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral.

Covered Service		What you pay
	Partial hospitalization services and intensive outpatient services (continued) Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.	

	Physician/provider services, including doctor's office visits
	We pay for the following services:
	• medically necessary health care or surgery services given in places such as:
	  ○ physician's office
	  ○ certified ambulatory surgical center
	  ○ hospital outpatient department
	  ○ any other location
	• consultation, diagnosis, and treatment by a specialist
	• basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment
	This benefit is continued on the next page
		Talk to your provider and get a referral for specialty care.
		Telehealth
		$0
		Provider office visits
		$0
		If you lose full-scope Medi-Cal coverage, you pay the following per **specialty care visit**, depending upon the plan in which you are enrolled:
		• South P1 – **$0**
		• South P6 – **$0**
		• South P7 – **$0**
		• South P9 – **$0**
		• South P10 – **$0**
		• South P11 – **$0**
		• North P2 – **$0**
		• North P16 – **$0**
		• North P17 – **$0**
		• North P18 – **$0**
		• North P19 – **$0**
		• North P20 – **$0**
		• North P21 – **$0**
		• North P22 – **$0**
		• North P23 – **$0**
		• North P24 – **$5**
		• North P25 – **$0**

	Physician/provider services, including doctor's office visits (continued)
	
	• Certain telehealth services, including primary and specialty care, which includes inpatient hospital services, skilled nursing facility services, cardiac rehabilitation services, pulmonary rehabilitation services, emergency services, urgently needed services, partial hospitalization, home health services, occupational therapy services, mental health, podiatry, psychiatric services, physical therapy and speech-language pathology services, opioid treatment program services, outpatient X-ray services, outpatient hospital services, observation services, outpatient substance abuse, dialysis services, nutritional/dietary services, health education, kidney disease education services, diabetes self-management training, and hearing exams, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service.
	  ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth:
	  ○ Interactive video visits for professional services when care can be provided in this format as determined by a network provider
	  ○ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider
	• telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home.
	• telehealth services to diagnose, evaluate, or treat symptoms of a stroke.
	
	This benefit is continued on the next page
		Outpatient surgery and other procedures
		
		$0
		
		If you lose full-scope Medi-Cal coverage, you pay the following per procedure, depending upon the plan in which you are enrolled, when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort:
		
		• South P1 – **$400**
		• South P6 – **$420**
		• South P7 – **$440**
		• South P9 – **$0**
		• South P10 – **$490**
		• South P11 – **$0**
		• North P2 – **$470**
		• North P16 – **$480**
		• North P17 – **$400**
		• North P18 – **$400**
		• North P19 – **$490**
		• North P20 – **$450**
		• North P21 – **$480**
		• North P22 – **$490**
		• North P23 – **$480**
		• North P24 – **$455**
		• North P25 – **$460**

Covered Service	What you pay

Physician/provider services, including doctor's office visits (continued)
• telehealth services for members with a substance use disorder or co-occurring mental health disorder regardless of your location
• telehealth services for diagnosis, evaluation, and treatment of mental health disorders
• telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.
• virtual check-ins (for example, by phone or video chat) with your doctor for five-ten minutes **if**
  ○ you're not a new patient **and**
  ○ the check-in isn't related to an office visit in the past seven days **and**
  ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment.
• evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**
  ○ you're not a new patient **and**
  ○ the evaluation isn't related to an office visit in the past seven days **and**
  ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient
• second opinion by another network provider before surgery
• house calls by a network physician (or a network provider who is a registered nurse) inside our service area when care can best be provided in your home as determined by a network provider
• ultraviolet light treatments
 	
This benefit is continued on the next page	

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) **Telehealth under your Medi-Cal coverage:** Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider. Or telehealth may involve sharing information with your provider without a live conversation. You can receive many services through telehealth. However, telehealth may not be available for all covered services. You can contact your provider to learn which types of services may be available through telehealth. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. You have the right to in-person services and are not required to use telehealth even if your provider agrees that it is appropriate for you.	
Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs). • routine foot care for members with conditions affecting the legs, such as diabetes. Under your Medi-Cal coverage, we cover podiatry services as Medically Necessary for diagnosis and medical, surgical, mechanical, manipulative, and electrical treatment of the human foot. This includes the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg controlling the functions of the foot. **This benefit is continued on the next page**	Talk to your provider and get a referral. **Provider office visits** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per **specialty care visit**, depending upon the plan in which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0** • South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0** • North P20 – **$0** • North P21 – **$0** • North P22 – **$0**

Covered Service		What you pay
	Podiatry services (continued)	• North P23 – **$0** • North P24 – **$5** • North P25 – **$0** **Outpatient surgery and other procedures** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per procedure, depending upon the plan in which you are enrolled, when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • South P1 – **$400** • South P6 – **$420** • South P7 – **$440** • South P9 – **$0** • South P10 – **$490** • South P11 – **$0** • North P2 – **$470** • North P16 – **$480** • North P17 – **$400** • North P18 – **$400** • North P19 – **$490** • North P20 – **$450** • North P21 – **$480** • North P22 – **$490** • North P23 – **$480** • North P24 – **$455** • North P25 – **$460**

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. • A one-time hepatitis B virus screening	$0
Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0
Prosthetic and orthotic devices and related supplies† Prosthetic devices replace all or part of a body part or function. Orthotic devices support or correct the function of a body part. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections • pacemakers • braces • prosthetic shoes **This benefit is continued on the next page**	$0 **If you lose full-scope Medi-Cal coverage**, for external prosthetic or orthotic devices and supplies (including wound care supplies), and surgical boots when provided during an outpatient visit, you pay the following **coinsurance** depending upon the plan in which you are enrolled. • South P1 – **20%** • South P6 – **20%** • South P7 – **20%** • South P9 – **0%** • South P10 – **20%** • South P11 – **20%** • North P2 – **20%** • North P16 – **20%**

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies† (continued) • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) • prostheses to replace all or part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect • incontinence cream and diapers We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details. We also cover these items not covered by Medicare: • certain surgical boots following surgery when provided during an outpatient visit • vacuum erection device for sexual dysfunction • certain skin sealants, protectants, moisturizers, ointments that are medically necessary wound care Under your Medi-Cal coverage, we cover prosthetics and orthotic devices if all the following conditions are met: • the item is medically necessary to restore how a body part works (for prosthetics only) • the item is prescribed for you • the item is medically necessary to support a body part (for orthotics only) • the item is medically necessary for you to perform activities of daily living • the item makes sense for your overall medical condition • the item is covered by Medi-Cal **This benefit is continued on the next page**	• North P17 – **20%** • North P18 – **20%** • North P19 – **20%** • North P20 – **20%** • North P21 – **20%** • North P22 – **20%** • North P23 – **20%** • North P24 – **20%** • North P25 – **20%** **$0** for surgically implanted internal devices.

Covered Service		What you pay
	Prosthetic and orthotic devices and related supplies† (continued) • the item must be pre-approved for you. This includes implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part. Coverage is limited to the lowest cost item of equipment that adequately meets your medical needs. We select the vendor.	
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 Talk to your provider and get a referral.
	Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0
	Sensitive Services In addition to the services described in the "Family Planning Services" and "Sexually transmitted infections (STIs) screening and counseling" in this Benefits Chart, we also cover Sensitive Services such as sexual assault care, pregnancy testing and counseling, and outpatient abortion services. **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Sensitive Services (continued) For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be part of the Kaiser Permanente network. You can choose any Medi-Cal provider and go to them without a referral or prior authorization. For help finding a Medi-Cal provider who is outside the Kaiser Permanente network, call Member Services. Services from an out-of-network provider that are not related to Sensitive Services may not be covered. For help finding a doctor or clinic giving these services, or for transportation help getting to these services, you can call Member Services. You may also call the Appointment and Advice Line and talk to a licensed health care professional, 24 hours a day, 7 days a week.	
	**Sexually transmitted infections (STIs) screening and counseling** We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
	Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12.** We pay for the following services, and maybe other services not listed here (a prior hospital stay is not required): • a semi-private room, or a private room if it's medically necessary	$0 Talk to your provider and get a referral. We cover up to 100 days per benefit period. **If you lose full-scope Medi-Cal coverage**, you pay the following per benefit period:

Covered Service	What you pay
• meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	• **$0** for days 1–20. • **$221** for days 21–100. A benefit period begins on the first day you go to a Medicare covered skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any SNF for 60 calendar days in a row.
Smoking and tobacco use cessation Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling We cover two quit attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).	$0

Covered Service	What you pay
Special Supplemental Benefits for the Chronically Ill – only for Southern California members** The Healthy Food benefit is a Special Supplemental Benefit for the Chronically Ill available to all Southern California members who meet the criteria. Eligible members with certain chronic conditions who meet specific criteria will be able to use the quarterly OTC allowance to buy approved foods, such as produce, online and at participating retail stores. The list of approved foods is subject to change. Your card will be reloaded on January 1, April 1, July 1, and October 1. Any unused portion of the quarterly allowance will not roll over to the next quarter. The cost of eligible food items will be covered up to the balance available on your card. If there is a remaining amount to pay, you must use another form of payment. Fees and minimum order requirements vary by retailers. Please review details about fees on the checkout page prior to placing an online order. You will be prompted to enter another form of payment for any tips, fees, or non-covered items. This benefit will be available only to plan-identified Southern California members who meet benefit eligibility criteria with the following conditions: • Chronic alcohol use disorder and other substance use disorders (SUDs) • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic heart failure • Dementia • Diabetes mellitus • Overweight, obesity, and metabolic syndrome • Chronic gastrointestinal disease • Chronic kidney disease (CKD) • Severe hematologic disorders • HIV/AIDS • Chronic lung disorders • Chronic and disabling mental health conditions **This benefit is continued on the next page**	**Southern California members:** If you qualify for SSBCI, you may use your quarterly OTC allowance described in the "Over-the-counter (OTC) drugs" row in this Benefits Chart to also purchase healthy foods. You can decide how to use your allowance on your healthy extras card between OTC items and healthy food. **Not covered for Northern California members.**

Covered Service	What you pay
Special Supplemental Benefits for the Chronically Ill – only for Southern California members (continued)** • Neurologic disorders • Stroke • Post-organ transplantation care • Immunodeficiency and Immunosuppressive disorders • Conditions associated with cognitive impairment • Conditions with functional challenges and require similar services • Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell • Conditions that require continued therapy services in order for individuals to maintain or retain functioning **How to use your healthy extras card** To activate your card, call 1-833-524-7035 (TTY 711), 7 days a week, 5 a.m. to 5 p.m. PST, and provide your card number and membership ID number. Once you activate your card, you may start using your card to access your allowance at to purchase approved items at participating retail and online stores. If you already have a healthy extras card, you will not receive a new card. Please keep your card and your benefit will be available on your existing card. To set up your online account, request a catalog, view a list of eligible items, find participating stores, request reimbursement, check your balance and transaction history, shop online, submit a request for reimbursement, or replace a lost or stolen card, please visit mybenefitscenter.com or call 1-833-524-7035 (TTY 711), 7 days a week, 5 a.m. to 5 p.m. PST. If you experience a problem using the card to purchase an eligible item at a participating retailer, you may complete the transaction with another form of payment and submit a reimbursement request, which will require a copy of your itemized receipt. Reimbursement requests are subject to a determination process and must be submitted within 90 days from the date of purchase on your proof of payment or receipt. **This benefit is continued on the next page**	

Covered Service		What you pay
	Special Supplemental Benefits for the Chronically Ill – only for Southern California members (continued)** You may also visit mybenefitscenter.com and download the OTC Network mobile app to find participating healthy food and OTC retailers, search for eligible items, review your transaction history and check your card balance. You can also use the OTC mobile app at stores to scan items for eligibility during shopping and view your balance before you check out. Members can download the OTC Network mobile app directly from the iTunes App Store or GooglePlay. Search "OTC Network" to download. Note: Any unused amounts are forfeited upon disenrollment from our plan. **The healthy food benefit is part of a special supplemental program for the chronically ill. Not all members qualify. Members must have specific chronic conditions, like diabetes, obesity, cardiovascular disorders, osteoarthritis, or chronic kidney disease, to be eligible. There are other conditions that may qualify you for the benefit. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.	

Covered Service	What you pay
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) trained in both basic and advanced life support techniques	$0 Talk to your provider and get a referral.
Transportation: Non-emergency medical transportation **Medicare coverage**: When ordered by a network provider, we cover medically necessary non-emergency medical transportation in a licensed stretcher/gurney van or wheelchair van to home (must be within 100 miles), a skilled nursing facility, or a transfer to another higher level of care immediately following: • an inpatient hospitalization, or • certain emergency, urgent care, or outpatient hospital encounters. **Medi-Cal coverage:** This benefit allows for medical transportation for a service covered by our plan and Medicare. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with paratransit. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral for medical transportation covered by Medi-Cal.

Covered Service		What you pay
	Transportation: Non-emergency medical transportation (continued) The forms of transportation are authorized when: • Your medical provider determines your medical and/or physical condition doesn't allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, **and** • prior authorization is required and you'll need to call your plan to arrange a ride For information on how to request non-emergency medical transportation, refer to **Chapter 3**.	
	Transportation: Non-medical transportation† This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation. Transportation is required for the purpose of obtaining needed medical care covered by Medi-Cal, including travel to dental appointments and to pick up prescription drugs. Transportation for services dually covered by Medi-Cal and Medicare are covered. For information on how to request non-medical transportation, refer to **Chapter 3**.	$0 Talk to your provider and get a referral.
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseen illness, **or** • an injury, **or** • a condition that needs care right away. **This benefit is continued on the next page**	**Office visits** $0 **Emergency Department visits** $0 **If you lose full-scope Medi-Cal coverage**, you pay the following per visit, depending upon the plan in which you are enrolled: • South P1 – **$115** • South P6 – **$115** • South P7 – **$115** • South P9 – **$0** • South P10 – **$115**

Covered Service		What you pay
	Urgently needed (continued) If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances, it's not possible, or it's unreasonable, to get this services from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area.	• South P11 – **$115** • North P2 – **$115** • North P16 – **$115** • North P17 – **$115** • North P18 – **$115** • North P19 – **$115** • North P20 – **$115** • North P21 – **$115** • North P22 – **$115** • North P23 – **$115** • North P24 – **$115** • North P25 – **$115**
	Vision care We pay for the following services: • one routine eye exam every year	$0 Talk to your provider and get a referral for an ophthalmologist.
	We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral for an ophthalmologist. **If you lose full-scope Medi-Cal coverage**, you pay the following **per ophthalmologist visit**, depending upon the plan in which you are enrolled: • South P1 – **$0** • South P6 – **$0** • South P7 – **$0** • South P9 – **$0** • South P10 – **$0** • South P11 – **$0** • North P2 – **$0** • North P16 – **$0** • North P17 – **$0** • North P18 – **$0** • North P19 – **$0**

	Covered Service	What you pay
	Vision care (continued)	• North P20 – **$0** • North P21 – **$0** • North P22 – **$0** • North P23 – **$0** • North P24 – **$5** • North P25 – **$0**
	For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans who are 50 and over • Hispanic Americans who are 65 and over For people with diabetes, we pay for screening for diabetic retinopathy once per year.	$0 Southern California members, talk to your provider and get a referral.
	Eyewear following cataract surgery: We pay for the following: • We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. • If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery. • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant	$0 Talk to your provider and get a referral. **Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
	Eyeglasses and contact lenses: Once every 12 months, we provide an allowance for you to use toward the purchase price of eyewear from a plan optical facility when a physician or optometrist prescribes an eyeglass or contact lens for vision correction. The allowance can be used to pay for the following items: • Eyeglass lenses when a network provider puts the lenses into a frame **This benefit is continued on the next page**	Talk to your provider and get a referral. You pay $0 up to the allowance for your plan: • South P1 – **$350** • South P6 – **$400** • South P7 – **$500** • South P9 – **$500**

Covered Service		What you pay
	Vision care (continued) • Eyeglass frames when a network provider puts two lenses (at least one of which must have refractive value) into the frame • Contact lenses, fitting, and dispensing We will not provide the allowance if we have provided an allowance toward (or otherwise covered) lenses or frames within the previous 12 months. The allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later.	• South P10 – **$500** • South P11 – **$500** • North P2 – **$350** • North P16 – **$350** • North P17 – **$350** • North P18 – **$350** • North P19 – **$350** • North P20 – **$350** • North P21 – **$350** • North P22 – **$350** • North P23 – **$350** • North P24 – **$350** • North P25 – **$350** If the eyewear you purchase costs more than the allowance for your plan, **you pay the difference.**
	Replacement lenses: If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an allowance toward (or otherwise covered) we will provide an allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The allowance toward one of these replacement lenses is **$30** for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and **$45** for a multifocal or lenticular eyeglass lens.	Talk to your provider and get a referral. If the lens you purchase costs more than the **$30** allowance for single vision or **$45** for multifocal or lenticular eyeglass lens, **you pay the amount that exceeds your allowance.**
	Special contact lenses: We cover the following special contact lenses when prescribed by a network physician or network provider who is an optometrist: • Up to two medically necessary contact lenses, fitting, and dispensing per eye every 12 months to treat aniridia (missing iris) **This benefit is continued on the next page**	$0 Talk to your provider and get a referral.

	Covered Service	What you pay
	Vision care (continued) • If contact lenses (other than contact lenses for aniridia) will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 12 months. • However, we will not cover any contact lenses if we provided an allowance toward (or otherwise covered) a contact lens within the previous 12 months, but not including covered contact lenses for aniridia	
	Eyeglasses lenses under your Medi-Cal coverage: Complete eyeglasses (frame and lenses): Medi-Cal covers one complete pair of eyeglasses every 24 months with a valid prescription of at least 0.75 diopter. **Eyeglass lenses:** We will order new or replacement eyeglasses for you from DHCS's eyeglass lens vendor. If DHCS's vendor cannot provide you with the lenses you need, we will arrange for your lenses to be made at another optical lab. You will not have to pay extra if we make arrangements because DHCS's vendor cannot make your eyeglass lenses. If you want eyeglasses lenses or features that are not covered by Medi-Cal, then you may have to pay extra for those upgrades. **Eyeglass Frames:** We cover new or replacement frames that cost **$80** or less. If you choose frames that cost more than **$80**, you must pay the difference between the cost of the frames and **$80**. **Replacement eyeglasses within 24 months:** We cover replacement eyeglasses if you have a change in prescription of at least 0.50 diopter 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. The replacement frames will be the same style as your old frames (up to **$80**) if less than 24 months have passed since you got your eyeglasses. **This benefit is continued on the next page**	$0 Talk to your provider and get a referral. If you want eyeglasses lenses or features that are not covered by Medi-Cal, then **you may have to pay extra for those upgrades.**

Covered Service		What you pay
	Vision care (continued) **Low Vision devices:** We also cover low vision devices under Medi-Cal when the following conditions are met: • The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point • The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means • The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient Coverage is limited to the lowest cost device that meets the Member's needs. Medi-Cal coverage does not include electronic magnification devices and devices that do not incorporate a lens for use with the eye.	$0 Talk to your provider and get a referral.
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots (or vaccines)), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

E. 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 may help you live more independently. They don't replace benefits that you already receive under Medi-Cal.

The following are examples of Community Supports services. They're not available in all areas. Not all Members qualify to receive Community Supports. To qualify, you must meet specific criteria.

Community Support	Description	Who may be eligible
Assisted Living Facility (ALF) Transitions	These services assist individuals to live in the community and/or avoid institutionalization. The goal of the service is to facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care.	Members who: • Have lived in a nursing facility for 60+ days and want to move to an assisted living facility (ALF) and can live safely in an ALF; **or** • Are living in the community, want to remain in the community, can live safely in an ALF, and need a nursing facility level of care, but choose to receive those services in an ALF instead of moving to a nursing facility
Asthma Remediation	This includes physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home with reduced likelihood of experiencing acute asthma episodes.	Members who have completed an in-home environmental trigger assessment within the last 12 months through the Asthma Preventive Services (APS) benefit as described in the Benefits Chart
Community or Home Transition Services	This includes non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement	Members who: • are currently receiving medically necessary nursing facility Level of

Community Support	Description	Who may be eligible
	in a private residence where the person is directly responsible for his or her own living expenses.	Care and are choosing to transition home and continue to receive care; **and** • have resided 60+ days in a nursing facility and/or Recuperative Care setting; **and** • Are interested in moving back to the community; **and** • Are able to reside safely in the community with appropriate and cost-effective supports and services
Day Habilitation	These services are provided in an individual's home or an out-of-home, non- facility setting. The Day Habilitation programs are designed to assist the individual in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.	Members who: • are experiencing homelessness; **or** • exited homelessness and entered housing in the last 24 months; **or** • are at risk of homelessness or institutionalization, whose housing stability could be improved through participation in a day habilitation program
Environmental Accessibility Adaptations (Home Modifications)	These services include physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home, without which the participant would require institutionalization.	Members who are at risk of institutionalization in a nursing facility.

Community Support	Description	Who may be eligible
Housing Deposits	These services assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board.	Members who: • meet the Housing and Urban Development ('HUD") definition of homeless or at risk of homelessness and one or more clinical risk factor; **or** • are determined eligible for Transitional Rent services; **or** • are prioritized for a permanent supporting housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system are also eligible
Housing Tenancy and Sustaining Services	These services provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.	Members who: • meet the Housing and Urban Development ('HUD") definition of homeless or at risk of homelessness and one or more clinical risk factor; **or** • are determined eligible for Transitional Rent services; **or** • are prioritized for a permanent supporting housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system
Housing Transition/Navigation Services	These services assist members with obtaining housing and include conducting a tenant screening and housing assessment,	Members who: • meet the Housing and Urban Development ('HUD") definition of

Community Support	Description	Who may be eligible
	individualized housing support plan, and securing housing.	homeless or at risk of homelessness and one or more clinical risk factor; **or** • are determined eligible for Transitional Rent services; **or** • are prioritized for a permanent supporting housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system are also eligible
Medically Tailored Meals /Medically Supportive Food	These services include 1) Medically Tailored Meals provided to the member at home that meet the unique dietary needs of those with chronic diseases, tailored by a certified nutrition professional; and/or 2) Medically supportive food and nutrition services.	Members with serious or chronic health conditions that are nutrition sensitive.
Personal Care and Homemaker Services	These services provide assistance with Activities of Daily Living ("ADLs") and assistance with Instrumental Activities of Daily Living ("IADLs").	Members who: • are at risk for hospitalization, or institutionalization in a nursing facility; **or** • have functional deficits and no other adequate support system; **or** • are approved for In-Home Supportive Services
Recuperative Care (Medical Respite)	These services include short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness and whose condition	Members who: • require recovery in order to heal from an injury or illness; **and** • meet the HUD definition

Community Support	Description	Who may be eligible
	would be exacerbated by an unstable living environment.	of homeless or at risk of homelessness
Respite Services	These services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.	Members who live in the community and are compromised in their Activities of Daily Living ("ADLs") and are dependent upon a qualified caregiver who provides support and requires caregiver relief to keep the member from institutional placement.
Sobering Centers	These settings serve as alternative destinations for individuals who are found to be publicly intoxicated and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.	Members who: • are age 18 or older; **and** • are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms); **and** • would otherwise be transported to the emergency department or a jail; **or** • presented at an emergency department and are appropriate to be diverted to a Sobering Center
Transitional Rent	Up to 6 months of rental assistance in interim or permanent settings.	Members who: • have one or more qualifying clinical risk factors; **and** • meet the HUD definition of homelessness or be at

Community Support	Description	Who may be eligible
		risk of homelessness; **and** • are transitioning from one of the two qualifying settings: ○ transitioning out of an institutional or congregate residential setting ○ transitioning out of a carceral setting

If you need help or would like to find out which Community Supports may be available for you, call Member Services at 1-800-443-0815 (TTY 711), or talk to your care coordinator.

F. Benefits covered outside of our plan

We don't cover the following services, but they're available through Medi-Cal fee-for service.

F1. California Community Transitions (CCT)

The California Community Transitions (CCT) program uses local Lead Organizations to help eligible Medi-Cal beneficiaries, who've lived in an inpatient facility for at least 60 consecutive days, transition back to, and remaining safely in, a community setting. The CCT program funds transition coordination services during the pre-transition period and for 365 days post transition to assist beneficiaries with moving back to a community setting.

You can get transition coordination services from any CCT Lead Organization that serves the county you live in. You can find a list of CCT Lead Organizations and the counties they serve on the Department of Health Care Services website at: www.dhcs.ca.gov/services/ltc/Pages/CCT.

For CCT transition coordination services

Medi-Cal pays for the transition coordination services. You pay nothing for these services.

For services not related to your CCT transition

The provider bills us for your services. Our plan pays for the services provided after your transition. You pay nothing for these services.

While you get CCT transition coordination services, we pay for services listed in the Benefits Chart in **Section D**.

No change in drug coverage benefit

The CCT program doesn't cover drugs. You continue to get your normal drug benefit through our plan. For more information, refer to **Chapter 5** of this *Member Handbook*.

Note: If you need non-CCT transition care, call your care coordinator to arrange the services. Non-CCT transition care is care **not** related to your transition from an institution or facility.

F2. Medi-Cal Dental

Certain dental services are available through Medi-Cal Dental. More information is on the smilecalifornia.org website. Medi-Cal Dental includes, but isn't limited to, services such as:

- initial examinations, X-rays, cleanings, sealants, and fluoride treatments
- restorations and crowns
- root canal therapy
- partial and complete dentures, adjustments, repairs, and relines

For more information regarding dental benefits available in Medi-Cal Dental, or if you need help finding a dentist who accepts Medi-Cal, contact the customer service line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental representatives are available to assist you from 8 a.m. to 5 p.m., Monday through Friday. You can also visit the website at smilecalifornia.org for more information.

In Sacramento and Los Angeles counties, you may get Medi-Cal dental benefits through a Dental Managed Care (Dental MC). If you want more information about Medi-Cal dental plans or want to make changes, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8 a.m. to 6 p.m. The call is free. Dental MC contacts are also available here: www.dhcs.ca.gov/services/Pages/ManagedCarePlanDirectory.aspx.

F3. In-Home Supportive Services (IHSS)

- The IHSS Program will help pay enrolled care providers for services provided to you so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.
- To receive services, an assessment is conducted to determine which types of services may be authorized for each participant based on their needs. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.
- Your care coordinator can help you apply for IHSS with your county social service agency. Contact information for your county can be found in **Chapter 2**, **Section I** or at https://www.cdss.ca.gov/inforesources/county-ihss-offices

F4. 1915(c) Home and Community Based Services (HCBS) Waiver Programs

Assisted Living Waiver (ALW)

- The Assisted Living Waiver (ALW) offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.
- Members who are enrolled in ALW can remain enrolled in ALW while also receiving benefits provided by our plan. Our plan works with your ALW Care Coordination Agency to coordinate the services you receive.
- The ALW is currently only available in the following counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma.
- Your care coordinator can help you apply for the ALW. A list of ALW Care Coordination agencies can be found at the following website: https://www.dhcs.ca.gov/services/long-term-care-alternatives-home-and-community-based-service-options/participating-care-coordination-agencies/

HCBS Waiver for Californians with Developmental Disabilities (HCBS-DD)

California Self-Determination Program (SDP) Waiver for Individuals with Developmental Disabilities

- There are two 1915(c) waivers, the HCBS-DD Waiver and SDP Waiver, that provide services to people who have been diagnosed with a developmental disability that begins before the individual's 18th birthday and is expected to continue indefinitely. Both waivers are a way to fund certain services that allow persons with developmental disabilities to live at home or in the community rather than residing in a licensed health facility. Costs for these services are funded jointly by the federal government's Medicaid program and the State of California. Your care coordinator can help connect you to DD Waiver services.

Home and Community-Based Alternative (HCBA) Waiver

- The HCBA Waiver provides care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team comprised of a nurse and social worker. The team coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services, etc.), and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.
- Members who are enrolled in the HCBA Waiver can remain enrolled in the HCBA Waiver while also receiving benefits provided by our plan. Our plan works with your HCBA waiver agency to coordinate the services you receive.
- Your care coordinator can help you apply for the HCBA. A list of HCBA Waiver Agencies can be found at the following website:
  Home and Community-Based Alternatives Waiver | DHCS

Medi-Cal Waiver Program (MCWP)

- The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV as an alternative to nursing facility care or hospitalization. Case management is a participant centered, team approach consisting of a registered nurse and social work case manager. Case managers work with the participant and primary care provider(s), family, caregiver(s), and other service providers, to assess care needs to keep the participant in their home and community.
- The goals of the MCWP are to: (1) provide home and community-based services for persons with HIV who may otherwise require institutional services; (2) assist participants with HIV health management; (3) improve access to social and behavioral health support and (4) coordinate service providers and eliminate duplication of services.
- Members who are enrolled in the MCWP Waiver can remain enrolled in the MCWP Waiver while also receiving benefits provided by our plan. Our plan works with your MCWP waiver agency to coordinate the services you receive.
- Your care coordinator can help you apply for the MCWP. A list of MCWP waiver agencies can be found at the following website:
  https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_MCWP_Provider_List.aspx

Multipurpose Senior Services Program (MSSP)

- The Multipurpose Senior Services Program (MSSP) provides both social and health care management services to assist individuals remain in their own homes and communities.
- While most of the program participants also receive In-Home Supportive Services, MSSP provides on-going care coordination, links participants to other needed

community services and resources, coordinates with health care providers, and purchases some needed services that aren't otherwise available to prevent or delay institutionalization. The total annual combined cost of care management and other services must be lower than the cost of receiving care in a skilled nursing facility.

- A team of health and social service professionals provides each MSSP participant with a complete health and psychosocial assessment to determine needed services. The team then works with the MSSP participant, their physician, family, and others to develop an individualized care plan. Services include:
  - care management
  - adult day care
  - minor home repair/maintenance
  - supplemental in-home chore, personal care, and protective supervision services
  - respite services
  - transportation services
  - counseling and therapeutic services
  - meal services
  - communication services
- Members who are enrolled in the MSSP Waiver can remain enrolled in the MSSP Waiver while also receiving benefits provided by our plan. Our plan works with your MSSP provider to coordinate the services you receive
- Your care coordinator can help you apply for MSSP. A list of MSSP provider agencies can be found at the following website: aging.ca.gov/Providers_and_Partners/Multipurpose_Senior_Services_Program/Service_Area_Map/

F5. County Behavioral Health Services Provided Outside Our Plan (Mental Health and Substance Use Disorder Services)

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan doesn't provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through county behavioral health agencies.

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by your county MHP include:

- mental health services
- medication support services

- day treatment intensive services
- day rehabilitation
- crisis intervention services
- crisis stabilization services
- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services
- targeted case management
- peer support services, where available
- community-based mobile crisis intervention services, where available
- therapeutic behavioral services
- therapeutic foster care
- justice-involved reentry, where available
- assertive community treatment (ACT)
- forensic assertive community treatment (FACT), where available
- coordinated specialty care (CSC) for first episode psychosis (FEP), where available
- clubhouse services, where available
- enhanced community health worker (CHW) services, where available

Drug Medi-Cal (DMC) services are available to you through your county behavioral health agency if you meet criteria to receive these services.

- intensive outpatient treatment services
- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program
- medications for addiction treatment (also called Medication Assisted Treatment)
- peer support services, where available
- community-based mobile crisis intervention services, where available

Drug Medi-Cal Organized Delivery System (DMC-ODS) services include:

- outpatient treatment services
- intensive outpatient treatment services
- partial hospitalization services

- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- peer support services, where available
- community-based mobile crisis intervention services, where available
- contingency management services, where available
- inpatient treatment services

In addition to the services listed above, you may have access to voluntary inpatient detoxification services if you meet the criteria.

G. Benefits not covered by our plan, Medicare, or Medi-Cal

This section tells you about benefits excluded by our plan. “Excluded” means that we don't pay for these benefits. Medicare and Medi-Cal don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not “reasonable and medically necessary,” according to Medicare and Medi-Cal, unless listed as covered services. This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
- experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community. May be covered by Original Medicare under a Medicare-approved clinical research study. (See **Chapter 3** for more information about clinical research studies.)
- a private room in a hospital, except when medically necessary.
- private duty nurses.
- personal items in your room at a hospital or a nursing facility.

- full-time nursing care in your home.
- fees charged by your immediate relatives or members of your household.
- elective or voluntary enhancement procedures or services (including weight loss, hair loss or growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- routine foot care, except as described in "Podiatry services" in the Benefits Chart in **Section D**.
- orthopedic shoes or supportive devices, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- vision correction surgeries (for example, LASIK surgery).
- reversal of sterilization procedures.
- naturopath services (the use of natural or alternative treatments).
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.
- certain exams and services:
    - to get or keep a job
    - to get insurance
    - to get any kind of license
    - by order of a court, or if for parole or probation
    - this exclusion does not apply if a network doctor finds that the services are medically necessary.
- comfort or convenience items. Medi-Cal coverage does not include comfort, convenience, or luxury equipment or features. These include items that are solely for the comfort or convenience of a member, a member's family member, or a member's health care provider. This exclusion does not apply to retail-grade breast pumps that are provided to women after a pregnancy. This exclusion also does not apply to items approved for you under Community Supports.
- cosmetic services or procedures. This exclusion does not apply to the following:
    - testicular implants implanted as part of a covered reconstructive surgery.
    - breast prostheses needed after a mastectomy or lumpectomy.
    - prostheses to replace all or part of an external facial body part.
- disposable supplies. Medi-Cal coverage does not include the following disposable supplies for home use: bandages, gauze, tape, antiseptics, dressings, and Ace-type

bandages. This exclusion does not apply to disposable supplies provided as part of the following benefits described the Benefits Chart:

  - dialysis/hemodialysis treatment.
  - durable medical equipment.
  - home health care.
  - hospice and palliative care.
  - medical supplies, equipment and appliances.
  - prescription drugs.
  - prosthetics devices and related supplies.

- infertility services:
  - Medi-Cal coverage does not include services to help someone get pregnant, including infertility services, artificial insemination, and assisted reproductive technology services. Fertility preservation services are not covered by Medi-Cal.
  - Medicare does not cover conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services).
- items and services that are not health care items and services unless they are approved under your Medi-Cal coverage under the Community Supports or Durable Medical Equipment. For example, we do not cover:
  - teaching manners and etiquette.
  - teaching and support services to develop planning skills such as daily activity planning and project or task planning.
  - items and services for the purpose of increasing academic knowledge or skills.
  - teaching and support services to increase intelligence.
  - academic coaching or tutoring for skills such as grammar, math, and time management.
  - teaching you how to read, whether or not you have dyslexia.
  - educational testing.
  - teaching art, dance, horse riding, music, play, or swimming, except that this exclusion for “teaching play” does not apply to services that are part of a behavioral health therapy treatment plan and covered in this chapter.
  - teaching skills for employment or vocational purposes.
  - vocational training or teaching vocational skills.
  - professional growth courses.
  - training for a specific job or employment counseling.

  - modifications to your home or car, unless they are temporary changes that are determined to be medically necessary or approved for you under Community Supports.

- aquatic therapy and other water therapy. This exclusion for aquatic therapy and other water therapy does not apply to therapy services that are part of a physical therapy treatment plan and covered as part of the following benefits:
  - home health care.
  - hospice and palliative care.
  - rehabilitative and habilitative services.
  - skilled nursing facility services.
- massage therapy. This exclusion does not apply to therapy services that are part of a physical therapy treatment plan and covered as part of the following benefits:
  - home health care.
  - hospice and palliative care.
  - rehabilitative and habilitative services.
  - skilled nursing facility services.
- personal care services (custodial care), such as help with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of coverage described under the following benefits:
  - hospice and palliative care.
  - long-term care services and supports.
  - skilled nursing/intermediate/subacute facility care.
  - Community Supports.
- services not approved by the federal Food and Drug Administration. We do not cover drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (“FDA”) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion does not apply to the following situations:
  - services covered under Clinical Trials.
  - services provided as part of covered investigational services.
- services performed by unlicensed people. Coverage generally does not include services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the member’s condition does not require that the services be provided by a licensed health care provider. This exclusion does not apply to the following covered services:
  - Community Supports approved for you.

  - doula services.
  - community health worker services.

- services related to a noncovered service. When a service is not covered, all services related to the noncovered service are excluded. This exclusion does not apply to treatment of complications that result from the noncovered services, if those complications would be otherwise covered. For example, if you have cosmetic surgery that is not covered, we will not cover the services you get to prepare for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion will not apply and we will cover the services needed to treat the complication, as long as the services are covered under this *Member Handbook*.

Chapter 5: Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Medi-Cal. **Chapter 6** of this *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5, Section F3** "In a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medi-Cal lists.

You generally must use a network pharmacy to fill your prescription. (Refer to **Section A1** for more information.) Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "*Drug List*" for short. (Refer to **Section B** of this chapter.)

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.
- Please also note that the request to cover your prescribed drug will be evaluated under both Medicare and Medi-Cal standards.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website or contact Member Services.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for our share of the cost of your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access Medi-Cal Rx covered drugs.

If you don't have your Member ID Card or BIC with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, contact Member Services right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services.

A3. What to do if you change your network pharmacy

If you need help changing your network pharmacy, contact Member Services.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.

- Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
- If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.

- Indian Health Care Provider (IHCP) Pharmacies. American Indian and Alaska Native Members have access to pharmacies at an Indian Health Care Provider (IHCP) to the extent they have an enrolled retail pharmacy. If you're not American Indian or Alaska Native, you may still receive services from a retail pharmacy at an IHCP if you are assigned to the clinic or for an emergency.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)
- To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory,* visit our website, or contact Member Services.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs available through our plan's mail-order service are marked as mail-order drugs in our *Drug List*.

Our plan's mail-order service allows you to order up to a 100-day supply. A 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get information about filling your prescriptions by mail, visit your local network pharmacy or our website at kp.org/refill. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at kp.org/refill.
- Call the number listed on your prescription plan and follow the prompts (be sure to select the mail delivery option when prompted).
- Call the number below applicable to your plan:

  South plans: 1-866-206-2983 (TTY 711), Monday through Friday, 7 a.m. to 7 p.m.

  North plans: 1-888-218-6245 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m., Saturday 8 a.m. to 6 p.m., and Sunday 9 a.m. to 6 p.m.

- Mail your prescription or refill request on a mail-order form available at any Kaiser Permanente network pharmacy.

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular USPS mail delivery). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed or see our *Drug List* for information about the drugs that can be mailed.

Usually, a mail-order prescription arrives within **5** days. If your mail-order prescription is delayed, please call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network retail pharmacy listed in your *Provider and Pharmacy Directory* or at kp.org/directory. Please be aware that you may pay more if you get a 100-day supply from a network retail pharmacy instead of from our mail-order pharmacy.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. **New prescriptions the pharmacy gets from your provider's office**

   After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

   - This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before you're billed and it's shipped.
   - Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

2. **Refills on mail-order prescriptions**

   For refills, contact your pharmacy at least 5 days before your current prescription will run out to make sure your next order is shipped to you in time.

   You also have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

   If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 5 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by:

- Calling the number below applicable to your plan:

  South plans: 1-866-206-2983 (TTY 711), Monday through Friday, 7 a.m. to 7 p.m.

  North plans: 1-888-218-6245 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m., Saturday 8 a.m. to 6 p.m., and Sunday 9 a.m. to 6 p.m.;

- Visiting our website at kp.org/refill and follow these steps:

View Pharmacy → Auto Refill → Manage Auto Refill → Remove this medication from Auto Refill

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost.

If you pay the full cost for your prescription that may be covered by Medi-Cal Rx, you may be able to be reimbursed by the pharmacy once Medi-Cal Rx pays for the prescription. Alternatively, you may ask Medi-Cal Rx to pay you back by submitting the "Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)" claim. More information can be found on the Medi-Cal Rx website: medi-calrx.dhcs.ca.gov/home/.

To learn more about this, refer to **Chapter 7** of this *Member Handbook*.

B. Our plan's *Drug List*

We have a *List of Covered Drugs.* We call it the "*Drug List*" for short.

We select the drugs on the *Drug List* with the help of a team of doctors and pharmacists. The *Drug List* also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's *Drug List* when you follow the rules we explain in this chapter.

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D.

Most of the drugs you get from a pharmacy are covered by our plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting your prescriptions through Medi-Cal Rx.

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name drugs or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List*.

B2. How to find a drug on our *Drug List*

To find out if a drug you take is on our *Drug List*, you can:

- Visit our plan's website at kp.org/seniorrx. The *Drug List* on our website is always the most current one.
- Call Member Services to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Drugs that are not covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information.
- Use our "Real Time Benefit Tool" at kp.org/seniorrx to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call Member Services.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs are not on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List*. For more information refer to **Chapter 9**.

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.

2. Our plan can't cover a drug purchased outside the United States and its territories.

3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Medi-Cal can't cover the types of drugs listed below:

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms*
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride* preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for the treatment of anorexia, weight loss or weight gain*
- Outpatient drugs made by a company that says you must have tests or services done only by them

*Select products may be covered by Medi-Cal. Please visit the Medi-Cal Rx website (www.medi-calrx.dhcs.ca.gov) for more information.

B4. *Drug List* cost-sharing tiers

Every drug on our *Drug List* is in one of six tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

- Tier 1 for preferred generic drugs (this tier includes some brand-name drugs).
- Tier 2 for generic drugs (this tier includes some brand-name drugs).
- Tier 3 for preferred brand-name drugs.
- Tier 4 for nonpreferred drugs (this tier includes both generic and brand-name drugs).
- Tier 5 for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Tier 6 for Part D vaccines (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look for the drug on our *Drug List*.

Chapter 6 of this *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

Note that sometimes a drug may appear more than once in our *Drug List*. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook.*

1. Limiting use of a brand name drug or original biological products when respectively, a generic or interchangeable biosimilar version is available.

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. If there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.
- Your copay may be greater for the brand name drug or original biological product than for the generic drug original biological product or interchangeable biosimilar.

2. Getting plan approval in advance

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at kp.org/seniorrx.

3. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Member Services or check our website at kp.org/seniorrx. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Member Handbook*.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.
- The drug is covered, but in a cost-sharing tier that makes your cost more expensive than you think it should be.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug isn't on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
   - is no longer on our *Drug List* **or**
   - was never on our *Drug List* **or**
   - is now limited in some way.
2. You must be in one of these situations:

- You were in our plan last year.
  - We cover a temporary supply of your drug **during the first 90 days of the calendar year.**

- This temporary supply is for up to **30 days**.
- If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.

- You're new to our plan.
  - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You've been in our plan for more than 30 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-days supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - If you enter into or are discharged from a hospital, skilled nursing facility, or long-term care facility to a different care setting or home, this is what is known as a level of care change. When your level of care changes, you may require an additional fill of your medication. We will generally cover up to a one-month supply of your Part D drugs during this level of care transition period even if the drug is not on our *Drug List*.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.
  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.
  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't on our *Drug List* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

If a drug you take will be taken off our *Drug List* or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).
- If we approve your request, we'll authorize coverage for the drug before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of this *Member Handbook*.

If you need help asking for an exception, contact Member Services.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *Drug List* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior authorization for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's *Drug List*. For more information on these drug rules, refer to **Section C.**

If you take a drug that we covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

To get more information on what happens when our *Drug List* changes, you can always:

- Check our current *Drug List* online at kp.org/seniorrx **or**
- Call Member Services at the number at the bottom of the page to check our current *Drug List*.

Changes we may make to the *Drug List* that affect you during the current plan year

Some changes to the *Drug List* will happen **immediately**. For example:

A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower. When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.

Removing unsafe drugs and other drugs that are off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. Your prescriber will also know about this change, and can work with you to find another drug for your condition.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our *Drug List*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our *Drug List* **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

Changes to the *Drug List* that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug for the rest of the year.
If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current year. You'll need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

To learn more about drug coverage and what you pay, refer to **Chapter 6** of this *Member Handbook*.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't or if you need more information, contact Member Services.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.

- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers
- Take your medication list with you if you go to the hospital or emergency room

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Member Services.

G3. Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may include:

- Requiring you to get all prescriptions for those medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber
- Limiting the amount of opioid or benzodiazepine medications we cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Member Handbook*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Medi-Cal drugs

Introduction

This chapter tells what you pay for your outpatient drugs. By "drugs," we mean:

- Medicare Part D drugs, **and**
- Drugs and items covered under Medi-Cal Rx, **and**
- Drugs and items covered by our plan as additional benefits.

Because you're eligible for Medi-Cal, you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We'll send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider."

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS".

Other key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

To learn more about drugs, you can look in these places:

- Our List of Covered Drugs.
  - We call this the "*Drug List*." It tells you:
    - which drugs we pay for
    - which of the 6 tiers each drug is in
    - if there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Member Services. You can also find the most current copy of our *Drug List* on our website at kp.org/seniorrx.
  - Most of the drugs you get from a pharmacy are covered by Kaiser Permanente Dual **Complete** plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal

Rx Customer Service Center at 1-800-977-2273**.** Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.

- **Chapter 5** of this *Member Handbook*.
  - Explains how to get your outpatient drugs through our plan.
  - It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call Member Services for more information.
- Our *Provider and Pharmacy Directory*.
  - In most **cases**, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The **Provider** *and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Member Handbook* for more information about network pharmacies.

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A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you got a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits (EOB)*. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1** . This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives**. When applicable, information about other available drugs with lower cost-sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- Most of the drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (www.medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal customer service center at 1-800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.
- To find out which drugs our plan covers, refer to our *Drug List*.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

You can ask us to pay you back for our share of the cost of the drug. To request payment of a Part D drug that was prescribed by a network provider and obtained from a network pharmacy, write to:

Kaiser Permanente
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Here are examples of when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug under special circumstances

For more information about asking us to pay you back for *our* share of the cost of a drug, refer to **Chapter 7** of this *Member Handbook*.

3. Send us information about payments others make for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

4. Check the EOBs we send you.

When you get an EOB in the mail, make sure it's complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?

- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

B1. What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Kaiser Permanente Dual Complete Member Services.

B2. What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- If you suspect that a provider who gets Medi-Cal has committed fraud, waste or abuse, it's your right to report it by calling the confidential toll-free number 1- 800-822-6222. Other methods of reporting Medi-Cal fraud may be found at: www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

If you think something is wrong or missing, or if you have any questions, call Member Services. You can also choose to view your **EOB** online instead of by mail. Please visit kp.org/goinggreen and sign on to learn more about choosing to view your **EOB** securely online. Keep these EOBs. They're an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on your level of Extra Help and which stage you're in when you get a prescription filled or refilled.

These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2026. You begin this stage when you've paid a certain amount of out-of-pocket costs.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's *Drug List* is in one of six cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our *Drug List*.

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for Part D vaccines (this tier includes only brand-name drugs).

D1. Your pharmacy choices

How much you pay for a drug depends on if you get the drug from:

- A network retail pharmacy **or**

- An out-of-network retail pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.
- Our plan's mail-order pharmacy.

To learn more about these choices, refer to **Chapter 5** of this *Member Handbook* and to our *Provider and Pharmacy Directory*.

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Member Handbook* or our plan's *Provider and Pharmacy Directory.*

D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	A network retail pharmacy or our plan's mail-order service	**A network long-term care pharmacy**	**An out-of-network pharmacy** Coverage is limited to certain cases. Refer to **Chapter 5** for details.
	A one-month or up to a 100-day supply	Up to a 31-day supply	Up to a 30-day supply.
Cost-sharing **Tier 1** for preferred generic drugs	**$0-$5.80**, depending on your level of Extra Help		
Cost-sharing **Tier 2** for generic drugs	**$0-$5.80**, depending on your level of Extra Help		
Cost-sharing **Tier 3** for preferred brand-name drugs	**$0-$14.40**, depending on your level of Extra Help		
Cost-sharing **Tier 4** for nonpreferred drugs	**$0-$14.40**, depending on your level of Extra Help		

	A network retail pharmacy or our plan's mail-order service	**A network long-term care pharmacy**	**An out-of-network pharmacy** Coverage is limited to certain cases. Refer to **Chapter 5** for details.
	A one-month or up to a 100-day supply	Up to a 31-day supply	Up to a 30-day supply.
Cost-sharing **Tier 5** for specialty-tier drugs	**$0-$14.40**, depending on your level of Extra Help		
Cost-sharing **Tier 6** for Part D vaccines	**$0** (Mail-order isn't available for drugs in Tier 6)		

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory.*

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$2,400.** At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you have paid for your drugs during the year. We let you know if you reach the **$2,400** limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of **$2,400** for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

Usually, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05

per day. If you get a seven days' supply of the drug, your payment is less than $.05 per day multiplied by seven days, for a total payment less than $0.35.

- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
    - Better plan when to refill your drugs
    - Coordinate refills with other drugs so you can take fewer trips to the pharmacy

G. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List* Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to our plan's *Drug List* or contact Member Services for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

1. The first part is for the cost of **the vaccine itself**.
2. The second part is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

G1. What you need to know before you get a vaccine

We recommend that you call Member Services if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine.
- We can tell you how to keep your costs down by using network pharmacies and providers.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to ask us to pay you back for our share of the cost.

G2. What you pay for a vaccine covered by Medicare Part D

What you pay for a vaccine depends on the type of vaccine (what you're being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's *Drug List*. You may have to pay a copay for Medicare Part D vaccines. If the

vaccine is recommended for adults by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccine.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you'll pay nothing.
   - For other Part D vaccines, you pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay a copay to the doctor for the vaccine.
   - Our plan pays for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay a copay for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay our share of a bill you received for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow Kaiser Permanente providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost, it's your right to be paid back.
    - If you paid for services covered by Medicare, we'll pay you back.
- If you paid for Medi-Cal services you already received, you may qualify to be reimbursed (paid back) if you meet all of the following conditions:
    - The service you received is a Medi-Cal covered service that we're responsible for paying. We won't reimburse you for a service that isn't covered by Kaiser Permanente Dual Complete plan.
    - You received the covered service after you became an eligible Kaiser Permanente Dual Complete member.
    - You ask to be paid back within one year from the date you received the covered service.
    - You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
    - You received the covered service from a Medi-Cal enrolled provider in Kaiser Permanente Dual Complete's network. You don't need to meet this condition if you received 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 provide proof from the provider that shows a medical need for the covered service.
- Kaiser Permanente Dual Complete will tell you if they'll reimburse you in a letter called a Notice of Action. If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, Kaiser Permanente Dual Complete plan will pay you back for the full amount you paid. We'll reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal, but isn't in our network and refuses to pay you back, Kaiser Permanente Dual Complete plan will pay you back, but only up to the amount that FFS Medi-Cal would pay. Kaiser Permanente Dual Complete will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you don't meet one of the above conditions, we won't pay you back.

- We won't pay you back if:
    - You asked for and received services that aren't covered by Medi-Cal, such as cosmetic services.
    - The service isn't a covered service for Kaiser Permanente Dual Complete.
    - You went to a doctor who doesn't take Medi-Cal and you signed a form that said you want to be seen anyway and you'll pay for the services yourself.
- If we don't cover the services or drugs, we'll tell you.

Contact Member Services if you have any questions. If you don't know what you should've paid, or if you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
    - If the provider should be paid, we'll pay the provider directly.
    - If you already paid more than your share of the cost for the Medicare service, we'll figure out how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you receive any services or prescriptions; however, sometimes network providers make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** at the number at the bottom of this page **if you get any bills.**

- As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still don't pay them.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, but feel you paid too much, send us the bill and proof of any payment you made. We'll pay you

back for the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

4. When you use an out-of-network pharmacy to fill a prescription

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Refer to **Chapter 5** of this *Member Handbook* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full Medicare Part D prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full Medicare Part D prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (*Drug List*) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this *Member Handbook*).

  - If you and your doctor or other prescriber think you need the drug right away (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *Member Handbook*).

- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for our share of the cost of it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this *Member Handbook*.

B. Sending us a request for payment

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made for Medicare services. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months (for Part C medical claims) and within 36 months (for Part D drug claims) of the date you received the service.**

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it will help us process the information faster. You can file a claim to request payment by:

- Completing and submitting our electronic form at kp.org and upload supporting documentation.
- Either download a copy of the form from our website (kp.org) or call Member Services at the phone number on the bottom of this page and ask them to send you the form. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below:
  - A statement with the following information:
  - Your name (member/patient name) and medical/health record number.
  - The date you received the services.
  - Where you received the services.
  - Who provided the services.
  - Why you think we should pay for the services.

- Your signature and date signed. (If you want someone other than yourself to make the request, we will also need a completed "Appointment of representative" form, which is available at kp.org.)
- A copy of the bill, your medical record(s) for these services, and your receipt if you paid for the services.

Mail your request for payment together with any bills or receipts to this address:

South plans:
Kaiser Permanente
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

North plans:
Kaiser Permanente
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

To request payment of a Part D drug that was prescribed by a network provider and obtained from a network pharmacy, write to the address below. For all other Part D requests, send your request to the address above.

Kaiser Permanente
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this *Member Handbook* explains the rules for getting your services covered.
Chapter 5 of this *Member Handbook* explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9**.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Member Handbook***:**

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Your right to get services and information in a way that meets your needs

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, audio file, or data CD. To get materials in one of these alternative formats, please call or write to Member Services (refer to **Chapter 2**). Contact Member services to do the following:
    - Request a preferred language other than English and/or alternate format,
    - Keep your information as a standing request for future mailings and communications, and
    - Change a standing request for preferred language and/or format.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Medi-Cal Office of Civil Rights at 916-440-7370. TTY users should call 711.
- U.S Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

أ. حقك في الحصول على الخدمات والمعلومات بالطريقة التي تلبي احتياجاتك

يجب أن نتأكد من تقديم **كل** الخدمات، سواء السريرية أو غير السريرية، لك بطريقة مؤهلة ثقافيًا ويسهل الوصول إليها بما في ذلك الأفراد أصحاب الكفاءة المحدودة في اللغة الإنجليزية، أو مهارات القراءة المحدودة، أو ضعف السمع، أو أولئك الذين لديهم خلفيات ثقافية وعرقية متنوعة. ويجب أن نخبرك أيضًا عن مزايا خطتنا وحقوقك بطريقة يمكنك فهمها. ويجب أن نخبرك بحقوقك كل عام كونك في خطتنا.

- للحصول على معلومات بطريقة يمكنك فهمها، اتصل بخدمات الأعضاء. تحتوي خطتنا على خدمات ترجمة مجانية متاحة للإجابة عن الأسئلة بلغات مختلفة.
- يمكن أن توفر لك خطتنا أيضًا مواد بلغات أخرى غير الإنجليزية وبتنسيقات مثل الطباعة الكبيرة أو طريقة برايل أو ملف صوتي أو قرص مضغوط للبيانات. للحصول على مواد بأحد هذه التنسيقات البديلة، يُرجى الاتصال أو الكتابة إلى خدمات الأعضاء (راجع **الفصل 2**). اتصل بخدمات الأعضاء للقيام بما يلي:
    - طلب لغة مفضلة بخلاف اللغة الإنجليزية و/أو تنسيق بديل، و

- الاحتفاظ بمعلوماتك كطلب دائم للرسائل البريدية والاتصالات المستقبلية، و
- تغيير طلب قائم للغة المفضلة و/أو التنسيق.

إذا كنت تواجه مشكلة في الحصول على معلومات من خطتنا بسبب مشكلات لغوية أو إعاقة وترغب في تقديم شكوى، فاتصل بـ:

- Medicare على الرقم 1-800-MEDICARE (1-800-633-4227). يجب على مستخدمي الهاتف النصي (TTY) الاتصال على الرقم 1-877-486-2048.
- مكتب Medi-Cal للحقوق المدنية على الرقم 916-440-7370. يجب على مستخدمي الهاتف النصي (TTY) الاتصال على الرقم 711.
- وزارة الصحة والخدمات الإنسانية الأمريكية، مكتب الحقوق المدنية على الرقم 1-800-368-1019. يجب على مستخدمي الهاتف النصي (TTY) الاتصال على الرقم 1-800-537-7697.

Ա. Ձեր կարիքներին համապատասխանող եղանակով ծառայություններ և տեղեկություններ ստանալու ձեր իրավունքը

Մենք պետք է համոզվենք, որ **բոլոր** ծառայությունները՝ թե՛ կլինիկական, և թե՛ ոչ կլինիկական, տրամադրվում են ձեզ մշակութային առումով գրագետ և մատչելի ձևով, այդ թվում՝ անգլերենի սահմանափակ իմացություն, կարդալու սահմանափակ հմտություններ, լսողության խանգարում ունեցող կամ բազմազան մշակութային և էթնիկ ծագում ունեցող անձանց համար: Մենք պետք է նաև տեղեկացնենք ձեզ մեր պլանի արտոնությունների և ձեր իրավունքների մասին այնպիսի եղանակով, որը հասկանալի է ձեզ: Մենք պարտավոր ենք ձեզ տեղեկացնել ձեր իրավունքների մասին ամեն տարի, երբ դուք բաժանորդագրվում եք մեր պլանին:

- Ձեզ հասկանալի ձևով տեղեկություններ ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն: Մեր պլանը տրամադրում է անվճար թարգմանչական ծառայություններ, որոնք հասանելի են՝ տարբեր լեզուներով հարցերին պատասխանելու համար:
- Մեր պլանը կարող է նաև ձեզ նյութեր տրամադրել անգլերենից բացի այլ լեզուներով և ձևաչափերով՝ խոշոր տառաչափով, Բրայլի գրատիպով կամ CD-ROM-ով: Այս այլընտրանքային ձևաչափերից մեկով նյութեր ստանալու համար խնդրում ենք զանգահարել կամ գրել Անդամների սպասարկման կոնտրոն (այցելեք **2-րդ Գլուխ**): Դիմեք Անդամների սպասարկման կենտրոն հետևյալ հարցերի դեպքում՝
  - Անգլերենից բացի այլ նախընտրելի լեզու և (կամ) այլ ձևաչափ պահանջելու համար
  - Հետագայում նամակագրություններ և հաղորդակցություններ ստանալու հարցումների համար, և
  - Նախընտրած լեզուն և (կամ) ձևաչափը փոխելու համար:

Եթե լեզվական խնդրի կամ հաշմանդամության պատճառով մեր պլանի կողմից տեղեկություններ ստանալու դժվարություն ունեք, և ցանկանում եք բողոք ներկայացնել, զանգահարեք.

- Medicare 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով: TTY-ից օգտվողները պետք է զանգահարեն 1-877-486-2048 հեռախոսահամարով:
- Medi-Cal-ի Քաղաքացիական իրավունքների գրասենյակ՝ 916-440-7370 հեռախոսահամարով: TTY-ից օգտվողները պետք է զանգահարեն 711:
- ԱՄՆ Առողջապահության և մարդկային ծառայությունների դեպարտամենտ, Քաղաքացիական իրավունքների գրասենյակ՝1-800-368-1019 հեռախոսահամարով: TTY-ից օգտվողները պետք է զանգահարեն 1-800-537-7697 հեռախոսահամարով:

A. សិទ្ធិរបស់អ្នកក្នុងការទទួលបានសេវាកម្ម និងព័ត៌មានតាមរបៀបដែលបំពេញទៅតាមតម្រូវការរបស់អ្នក

យើងត្រូវតែធានាថា សេវាកម្ម **ទាំងអស់** ទាំងគ្លីនិក និងមិនមែនគ្លីនិក ត្រូវបានផ្តល់ជូនអ្នកដោយមានសមត្ថភាពផ្នែករបួឆម៍ និងអាចចូលប្រើបាន រួមទាំងសម្រាប់អ្នកដែលមានកម្រិតជំនាញភាសាអង់គ្លេសកម្រិតទាប ជំនាញអានកម្រិតទាប អសមត្ថភាពក្នុងការស្តាប់ ឬអ្នកដែលមានប្រវត្តិរបួឆម៍ និងជនជាតិចម្រុះ។ យើងក៏ត្រូវតែប្រាប់អ្នកអំពីអត្ថប្រយោជន៍នៃគម្រោងរបស់យើង និងសិទ្ធិរបស់អ្នកតាមរបៀបដែលអ្នកអាចយល់បានផងដែរ។ យើងត្រូវតែប្រាប់អ្នកអំពីសិទ្ធិរបស់អ្នកជារៀងរាល់ឆ្នាំ ដែលអ្នកស្ថិតនៅក្នុងគម្រោងរបស់យើង។

- ដើម្បីទទួលបានព័ត៌មានតាមរបៀបដែលអ្នកអាចយល់បាន សូមទូរសព្ទទៅសេវាសមាជិក។ គម្រោងរបស់យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃដែលអាចឆ្លើយសំណួរជាភាសាផ្សេងៗ។
- គម្រោងរបស់យើងក៏អាចផ្តល់ឱ្យអ្នកនូវឯកសារជាភាសាផ្សេងក្រៅពីភាសាអង់គ្លេសផងដែរ និងក្នុងទម្រង់ដូចជាការពុម្ពអក្សរធំ អក្សរស្ទាប ឬអូឌីយ៉ូ។ ដើម្បីទទួលបានឯកសារជាទម្រង់ជំនួសណាមួយទាំងនេះ សូមទូរសព្ទ ឬសរសេរទៅកាន់សេវាសមាជិក (សូមមើល**ជំពូកទី 2**)។ ទាក់ទងសេវាកម្មសមាជិកដើម្បីធ្វើដូចខាងក្រោម៖
  - ស្នើសុំភាសាដែលចង់បានក្រៅពីភាសាអង់គ្លេស និង/ឬទម្រង់ជំនួស
  - រក្សាព័ត៌មានរបស់អ្នកជាសំណើជាអចិន្ត្រៃយ៍សម្រាប់ការផ្ញើសំបុត្រ និងទំនាក់ទំនងនាពេលអនាគត និង
  - ការផ្លាស់ប្តូរសំណើជាអចិន្ត្រៃយសម្រាប់ភាសា និង/ឬទម្រង់ដែលពេញចិត្ត។

ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើង ដោយសារបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់ដាក់ពាក្យបណ្តឹង សូមទូរសព្ទទៅ៖

- Medicare តាមរយៈលេខ 1-800-MEDICARE (1-800-633-4227)។ អ្នកប្រើប្រាស់ TTY គួរតែហៅទូរសព្ទទៅលេខ 1-877-486-2048។
- ការិយាល័យសិទ្ធិស៊ីវិលរបស់ Medi-Cal តាមលេខ 916-440-7370។ សម្រាប់អ្នកប្រើប្រាស់ TTY សូមទូរសព្ទទៅលេខ 711។
- ក្រសួងសុខាភិបាល និងសេវាមនុស្សជាតិសហរដ្ឋអាមេរិក ការិយាល័យសិទ្ធិស៊ីវិលតាមលេខ 1-800-368-1019។ អ្នកប្រើប្រាស់ TTY គួរហៅទូរសព្ទទៅកាន់លេខ 1-800-537-7697 ។

A. 您有權以符合您需求的方式取得服務和資訊

我們必須確保**所有**服務（臨床和非臨床），都以符合文化要求並可供取得的方式提供給您，包括英語水準或閱讀能力有限、聽力喪失，或具有不同文化和族裔背景的人。我們還必須以您能理解的方式告知您本計劃的理賠福利和您的權利。我們每年都必須告訴您有關您在本計劃中的權利。

- 若要以您可以理解的方式獲取資訊，請致電會員服務。本計劃提供免費口譯服務，可以用不同語言回覆問題。
- 本計劃還會以英語以外的其他語言和大字版、點字版、音訊檔案或資料CD的格式提供您資訊。若要取得這些其他格式的資訊，請致電或寫信給會員服務（請參閱**第2章**）。請致電會員服務以進行下列行動：
    - 要求使用英文以外的慣用語言和/或其他格式，
    - 保留您的資訊作為未來郵寄和溝通時的常規要求，以及
    - 變更慣用語言和/或格式的常規要求。

如果您因為語言問題或身心障礙而無法取得本計劃的資訊，而且您想提出投訴，請致電：

- Medicare的電話為1-800-MEDICARE (1-800-633-4227)。聽障及語障電話專線使用者，請撥打1-877-486-2048。
- Medi-Cal民權辦公室的電話為916-440-7370。聽障及語障電話專線使用者，請撥打711。
- 美國衛生與民眾服務部民權辦公室的電話為1-800-368-1019。聽障及語障電話專線使用者，請撥打1-800-537-7697。

A.حق شما برای دریافت خدمات و اطلاعات به روشی که نیازهای شما را برآورده کند

ما باید اطمینان حاصل کنیم که تمام خدمات، چه بالینی و چه غیربالینی، از لحاظ فرهنگی، به شیوه ای شایسته و قابل دسترس ارائه می شوند ازجمله برای کسانی که مهارت های محدودی در زبان انگلیسی، مهارت های خواندن محدود، ناتوانی شنوایی، یا پیشینه های فرهنگی و قومی متنوع دارند. ما همچنین باید مزایای طرحمان و حقوقتان را به صورتی که برای شما قابل درک باشد به شما اطلاع دهیم. باید هر سالی که در طرح ما هستید، حقوقتان را به شما اطلاع دهیم.

- برای دریافت اطلاعات به صورتی که برایتان قابل درک باشد، با "خدمات اعضا" تماس بگیرید. طرح ما دارای خدمات مترجم شفاهی رایگان برای پاسخ به سؤالات به زبان های متفاوت است.

- طرح ما همچنین می تواند مطالبی به سایر زبان ها غیر از انگلیسی و در قالب هایی از جمله چاپ درشت، خط بریل، فایل صوتی یا سی دی به شما ارائه دهد. برای دریافت مطالب به یکی از این فرمت های جایگزین، لطفاً با "خدمات اعضا" تماس بگیرید یا مکاتبه کنید. (به فصل 2 مراجعه کنید). برای انجام کارهای زیر با "خدمات اعضا" تماس بگیرید:
  - درخواست زبان ترجیحی غیر از انگلیسی و/یا فرمت جایگزین،
  - حفظ اطلاعاتتان جهت درخواست دائمی برای نامه ها و مکاتبات آینده، و
  - تغییر درخواست قبلی برای زبان و/یا فرمت ترجیحی.

اگر به دلیل مشکلات زبانی یا معلولیت برای دریافت اطلاعات از طرحمان دچار مشکل هستید، و قصد طرح شکایت دارید، با این شماره تماس بگیرید:

- Medicare از طریق شماره 1-800-MEDICARE (1-800-633-4227). کاربران TTY باید با شماره 1-877-486-2048 تماس بگیرند.
- دفتر حقوق مدنی Medi-Cal شماره 916-440-7370. کاربران TTY باید با شماره 711 تماس بگیرند.
- با اداره سلامت و خدمات انسانی، دفتر حقوق مدنی به شماره 1-800-368-1019 تماس بگیرید. کاربران TTYباید با شماره 1-800-537-7697 تماس بگیرند.

A. Koj muaj cai tau txais tej kev saib xyuas thiab cov ntaub ntawv uas koj xav tau ntawd

Peb yuav tsum saib xyuas **tag nrho** cov kev saib xyuas, tsis hais kho mob thiab tsis yog kho mob, uas tau muab saib xyuas rau koj ntawd kom haum raws li kab lis kev cai thiab mus cuag tau suav nrog cov neeg uas tsis paub lus Askiv zoo, nyeem ntawv tsis tau zoo, hnov lus tsis zoo, los sis cov uas muaj kab lis kev cais thiab kev ntseeg sib txawv tib si. Peb kuj yuav tsum qhia rau koj txog peb qhov kev npaj kho mob cov txiaj ntsig thiab koj cov cai kom koj nkag siab tau. Peb yuav tsum qhia koj txog koj cov cai hauv txhua xyoo uas koj koom rau hauv peb qhov kev npaj kho mob.

- Yuav tau txais cov ntaub ntawv uas koj nkag siab tau, ces hu rau Lub Chaw Pab Tswv Cuab. Peb qhov kev npaj kho mob yeej muaj cov kws txhais lus pub dawb uas khoom los teb cov lus nug ua ntau hom lus rau sawv daws.

- Peb qhov kev npaj kho mob kuj yuav muab cov ntaub ntawv sau ua lwm hom lus uas tsis yog lus Askiv thiab muab luam tawm kom loj, sau ua ntawv rau neeg dig muag xua, tso ua suab lus, los sis tso rau hauv CD rau koj thiab. Yuav tau txais cov ntaub ntawv sau ua ib hom ntawm cov no, thov hu los sis sau ntawv mus rau Lub Chaw Pab Tswv Cuab (saib **Tshooj ntawv 2**). Hu Rau Lub Chaw Pab Tswv Cuab los mus ua raws li nram qab no:

    - Thov ib hom lus uas koj nyiam uas tsis yog lus Askiv thiab/los sis lwm hom ntawv,

    - Khaws koj cov ntaub ntawv tseg cia siv rau kev thov rau kev xa ntawv thiab kev sib txuas lus yav tom ntej, thiab

    - Kev hloov pauv ib qho kev thov rau hom lus uas nyiam thiab/los sis lwm hom ntawv.

Yog tias koj tau txais cov ntaub ntawv los ntawm peb qhov kev npaj kho ob tau nyuaj vim yog qhov tsis paub lus los sis qhov tsis taus thiab koj xav hais ib qho kev tsis txaus siab, ces hu rau:

- Medicare rau ntawm tus xov toooj 1-800-MEDICARE (1-800-633-4227). Cov neeg siv TTY yuav tsum hu rau1-877-486-2048.

- Medi-Cal Lub Chaw Lis Hauj Lwm txog Pej Xeem Cov Cai rau ntawm 916-440-7370. Cov neeg siv TTY yuav tsum hu rau 711.

- Tsoom Fwv Meskas Lub Chaw Ua Hauj Lwm ntsig txog Kev Noj Qab Haus Huv thiab Kev Pab Cuam Tib Neeg, Lub Chaw Ua Hauj Lwm rau Pej Xeem Cov Cai ntawm 1-800-368-1019. Cov neeg siv TTY yuav tsum hu rau 1-800-537-7697.

A. 가입자의 요구에 부합하는 방식으로 서비스와 정보를 제공받을 권리

저희는 영어 유창성, 읽기 능력, 듣기 능력이 부족한 사람들이나 문화적, 인종적 배경이 다른 사람들을 포함하여 가입자가 문화적으로 적합하고 이용하기 쉬운 방식으로 임상 및 비임상이 포함된 **모든** 서비스를 제공해야 합니다. 저희는 또한 저희 플랜의 혜택과 가입자의 권리에 대해 가입자가 이해할 수 있는 방식으로 알려야 합니다. 저희는 저희 플랜 가입자의 권리에 대해 매년 가입자에게 알려야 합니다.

- 가입자가 이해할 수 있는 방식으로 정보를 얻으려면 가입자 서비스부로 전화하십시오. 저희 플랜은 다양한 언어로 질문에 답변할 수 있는 무료 통역 서비스를 제공하고 있습니다.
- 저희 플랜은 영어 이외의 언어로 된 자료와 큰 활자, 점자 또는 오디오 파일이나 데이터 CD 등의 형식으로 된 자료도 제공할 수 있습니다. 이와 같은 대체 형식 중 하나로 된 자료를 얻으려면 가입자 서비스부로 전화하거나 서신을 보내주시기 바랍니다(**제2장** 참조). 다음과 관련하여 도움을 받으려면 가입자 서비스에 문의하십시오.
    - 영어 이외 선호하는 언어로 번역된 통지서 및/또는 대체 형태로 된 통지서 요청
    - 정보를 향후 서신 및 통신문에 대한 상시 요청으로 보관
    - 선호하는 언어 및/또는 형태에 대한 상시 요청 변경.

언어 문제 또는 장애로 인해 저희 플랜에서 정보를 얻는 데 문제가 있어 불만 사항을 접수하려면 다음 연락처로 전화하시기 바랍니다.

- Medicare 전화번호 1-800-MEDICARE(1-800-633-4227). TTY 사용자께서는 1-877-486-2048번으로 전화해 주십시오.
- Medi-Cal 민권사무소 전화번호 916-440-7370. TTY 사용자께서는 711번으로 전화해 주십시오.
- 미 보건복지부 민권사무소 전화번호 1-800-368-1019번으로 전화하시기 바랍니다. TTY 사용자께서는 1-800-537-7697번으로 전화해 주십시오.

A. Ваше право на получение услуг и информации таким способом, который отвечает вашим потребностям

Мы должны гарантировать, что **все** услуги, как клинические, так и неклинические, предоставляются с соблюдением принципов культурной компетентности и в такой форме, которая доступна, в том числе, людям с ограниченным знанием английского языка, ограниченными навыками чтения, нарушениями слуха или людям с различным культурным и этническим происхождением. Мы должны также рассказать вам о льготах плана и ваших правах таким образом, чтобы вы могли их понять. Мы должны рассказывать вам о правах каждый год, когда вы принимаете участие в нашем плане.

- Чтобы получить информацию таким образом, чтобы вы ее понимали, позвоните в отдел обслуживания участников. Наш план предусматривает услуги устного перевода, в рамках которых вы получите ответы на разных языках.

- В рамках нашего плана мы также можем предоставить материалы на разных языках, кроме английского, и в таких форматах, как крупный шрифт, шрифт Брайля, аудиофайл или компакт-диск с данными. Чтобы получить материалы в одном из этих альтернативных форматов, позвоните в отдел обслуживания участников или напишите его сотрудникам (см. **главу 2**). Обратитесь в отдел обслуживания участников, чтобы выполнить следующее:

  - отправить запрос на предпочтительный язык, кроме английского, и (или) альтернативный формат;

  - сохранить вашу информацию в качестве долгосрочного запроса для будущих рассылок и сообщений; а также

  - изменить долгосрочный запрос относительно предпочтительного языка и (или) формата.

Если у вас возникли трудности при получении информации из нашего плана из-за проблем с языком или нетрудоспособности и вы хотите подать жалобу, звоните на указанные ниже телефоны.

- Программа Medicare, телефон: 1-800-MEDICARE (1-800-633-4227). Пользователям линии TTY следует звонить по телефону 1-877-486-2048.

- Управление по гражданским правам программы Medi-Cal, телефон: 916-440-7370. Пользователям линии TTY следует звонить по телефону 711.

- Министерство здравоохранения и социального обеспечения США, Управление по гражданским правам, телефон: 1-800-368-1019. Пользователям линии TTY следует звонить по телефону 1-800-537-7697.

A. Su derecho a obtener servicios e información de una manera que satisfaga sus necesidades

Debemos garantizar que **todos** los servicios, clínicos y no clínicos, se le brinden de manera culturalmente competente y sean accesibles, incluidos aquellos con habilidades de lectura y dominio del inglés limitadas, discapacidad auditiva o a los miembros de diversos orígenes étnicos y culturales. También debemos informarle, de manera que pueda entender, sobre los beneficios de nuestro plan y sus derechos. Debemos informarle sobre sus derechos cada año que esté en nuestro plan.

- Para obtener información de una manera que pueda entender, llame a Servicio a los Miembros. Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder preguntas en diferentes idiomas.
- Además, nuestro plan puede entregarle materiales en otros idiomas y en formatos como letra grande, braille, archivo de audio o CD de datos. Para obtener materiales en alguno de estos formatos alternativos, llame o escriba a Servicio a los Miembros (consulte el **Capítulo 2**). Comuníquese con Servicio a los Miembros para:
    - pedir el idioma que prefiere además de inglés u otro formato;
    - mantener su información como una solicitud abierta, para que sea considerada en las futuras listas de correo y comunicaciones, y
    - cambiar una solicitud abierta por un idioma preferido o formato.

Si tiene problemas para obtener información sobre nuestro plan debido al idioma o a una discapacidad y desea presentar una queja, llame al:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Los usuarios de la línea TTY deben llamar al 1-877-486-2048.
- Oficina de Derechos Civiles de Medi-Cal al 916-440-7370. Los usuarios de la línea TTY deben llamar al 711.
- Llame al Departamento de Salud y Servicios Humanos de EE. UU., Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de la línea TTY deben llamar al 1-800-537-7697.

A. Ang iyong karapatang makakuha ng mga serbisyo at impormasyon sa paraang nakakatugon sa iyong mga pangangailangan

Dapat naming tiyakin na ang **lahat** ng serbisyo, klinikal at hindi klinikal, ay ibinibigay sa iyo sa paraang suportado ng kaalaman sa kultura at naa-access kabilang ang para sa mga taong may limitadong kasanayan sa Ingles, limitadong kasanayan sa pagbabasa, may problema sa pandinig, o mayroong iba't ibang kultura at etnikong pinagmulan. Dapat din naming sabihin sa iyo ang tungkol sa mga benepisyo ng aming plano at iyong mga karapatan sa paraang nauunawaan mo. Dapat naming sabihin sa iyo ang tungkol sa iyong mga karapatan sa bawat taong kabilang ka sa aming plano.

- Upang makakuha ng impormasyon sa paraang nauunawaan mo, tumawag sa Mga Serbisyo sa Miyembro. Ang aming plano ay mayroong mga libreng serbisyo ng interpreter na available upang sagutin ang mga tanong sa iba't ibang wika.
- Maaari ka ring bigyan ng aming plano ng mga materyal na nasa mga wikang bukod sa Ingles at nasa mga format na gaya ng malaking titik, braille, audio file, o data CD. Para kumuha ng mga materyal na nasa isa sa mga alternatibong format na ito, mangyaring tumawag o sumulat sa Mga Serbisyo sa Miyembro (sumangguni sa **Kabanata 2**). Makipag-ugnayan sa mga serbisyo sa Miyembro upang gawin ang mga sumusunod:
  - Humiling ng gustong wika maliban sa English at/o alternatibong format,
  - Panatilihin ang iyong impormasyon bilang patuloy na kahilingan para sa mga sulat at komunikasyon sa hinaharap, at
  - Baguhin ang isang patuloy na kahilingan para sa mas gustong wika at/o format.

Kung nagkakaproblema ka sa pagkuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at gusto mong maghain ng reklamo, tumawag sa:

- Medicare sa 1-800-MEDICARE (1-800-633-4227). Dapat tumawag ang mga gumagamit ng TTY sa 1-877-486-2048.
- Medi-Cal Office of Civil Rights sa 916-440-7370. Dapat tumawag ang mga gumagamit ng TTY sa 711.
- U.S Department of Health and Human Services, Office for Civil Rights sa 1-800-368-1019. Dapat tumawag ang mga gumagamit ng TTY sa 1-800-537-7697.

A. Quyền nhận được các dịch vụ và thông tin theo cách đáp ứng nhu cầu của quý vị

Chúng tôi phải đảm bảo **tất cả** dịch vụ, cả lâm sàng và phi lâm sàng, được cung cấp cho quý vị theo cách phù hợp với văn hóa và có thể tiếp cận được bao gồm cả những người có trình độ tiếng Anh hạn chế, kỹ năng đọc hạn chế, khiếm thính hoặc những người có nền tảng văn hóa và nguồn gốc dân tộc đa dạng. Chúng tôi cũng có nghĩa vụ phải thông báo cho quý vị biết về các quyền lợi thuộc chương trình của chúng tôi cùng các quyền của quý vị theo cách mà quý vị có thể hiểu được. Chúng tôi cũng sẽ cho quý vị biết về các quyền của quý vị mỗi năm trong trường hợp quý vị vẫn tham gia chương trình của chúng tôi.

- Để nhận thông tin theo cách mà quý vị có thể hiểu được, hãy gọi cho Dịch Vụ Hội Viên. Chương trình của chúng tôi có sẵn dịch vụ thông dịch viên miễn phí để trả lời nhiều câu hỏi bằng các ngôn ngữ khác nhau.

- Chương trình của chúng tôi cũng có thể cung cấp cho quý vị tài liệu bằng các ngôn ngữ khác ngoài tiếng Anh và ở các định dạng như chữ in lớn, chữ nổi braille, tệp âm thanh hoặc CD dữ liệu. Để nhận tài liệu có tuỳ chọn định dạng thay thế này, vui lòng gọi hoặc làm đơn gửi đến Dịch Vụ Hội Viên (tham khảo **Chương 2**). Hãy liên hệ với Dịch Vụ Hội Viên để thực hiện những việc sau:

    - Yêu cầu ngôn ngữ ưu tiên khác với tiếng Anh và/hoặc định dạng thay thế,

    - Lưu thông tin thường xuyên sử dụng của quý vị để phục vụ cho việc gửi thư tín hay liên lạc trong tương lai và

    - Thay đổi yêu cầu về ngôn ngữ và/hoặc định dạng ưa thích mà quý vị thường xuyên sử dụng.

Nếu quý vị gặp khó khăn trong việc nhận thông tin từ chương trình của chúng tôi vì vấn đề ngôn ngữ hoặc tình trạng khuyết tật và muốn nộp đơn than phiền, hãy gọi:

- Medicare theo số 1-800-MEDICARE (1-800-633-4227). Người dùng TTY hãy gọi số 1-877-486-2048.

- Văn Phòng Dân Quyền Medi-Cal theo số 916-440-7370. Người dùng TTY hãy gọi số 711.

- Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ theo số 1-800-368-1019. Người dùng TTY hãy gọi số 1-800-537-7697.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what

types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Member Handbook*.

  - Call Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.

- You have the right to a women's health specialist without getting a referral as well as other providers described in **Chapter 3** of this *Member Handbook*. A referral is approval from your PCP to use a provider that isn't your PCP.

- You have the right to get covered services from network providers within a reasonable amount of time.

  - This includes the right to get timely services from specialists.

  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.

- You have the right to get emergency services or care that's urgently needed without prior authorization (PA).

- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.

- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Member Handbook*.

- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to **Chapter 1** of this *Member Handbook*.

- You have the right to make your own healthcare decisions with help from your care team and care coordinator.

Chapter 9 of this *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We provide you with a written notice that advises you about these rights and explains how we protect the privacy of your PHI. The notice is called the “Notice of Privacy Practice.”

Members who may consent to receive sensitive services aren’t required to get any other member’s authorization to receive sensitive services or to submit a claim for sensitive services. Kaiser Permanente will direct communications regarding sensitive services to a member’s alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. Kaiser Permanente won’t disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Kaiser Permanente will accommodate requests for confidential communication in the form and format requested, if it’s readily producible in the requested form and format, or at alternative locations. A member’s request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

Members may request confidential communication by completing a confidential communication request form, which is available on kp.org under “Request for confidential communications forms.

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don’t give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don’t need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan’s quality of care.
- We may release PHI if ordered by a court, but only if it’s allowed by California law.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Member Services.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. This document is available in Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Spanish, Tagalog, and Vietnamese, by calling Member Services. We can also give you information in large print, braille, audio file, or data file.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:

- services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by our plan
- limits to your coverage and drugs
- rules you must follow to get covered services and drugs

- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Member Handbook*:
  - For more information about when you can join a new MA or drug benefit plan.
  - For information about how you'll get your Medi-Cal benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.

- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people can't make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever can't make decisions for yourself.
- Give **your doctors written instructions** about how to handle your health care if you can't make decisions for yourself, including care you don't want.

The legal document you use to give your directions is called an "advance directive". There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.

- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Kaiser Permanente Dual Complete will tell you about changes to the state law no later than 90 days after the change.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Quality Improvement Organization listed in **Chapter 2, Section F** of this *Member Handbook.*

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* – or you want more information about your rights, you can call:

- Member Services.

- The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. For more details about HICAP, refer to **Chapter 2**, **Section E** of this *Member Handbook*.
- The Medi-Cal Ombudsman at 1-888-452-8609. For more details about this program, refer to **Chapter 2** of this *Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read this *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this *Member Handbook*.
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment.

- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - Medicare Part A and Medicare Part B premiums. For most Kaiser Permanente Dual Complete members, Medi-Cal pays for your Medicare Part A premium and for your Medicare Part B premium.
    - For some of your drugs covered by our plan, you must pay your share of the cost when you get the service or drug. **Chapter 6** tells what you must pay for your drugs.
    - If **you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
    - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* advises you about our service area.
    - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.
    - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Medi-Cal.
    - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
    - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Tell us if you have a new phone number** or a better way to contact you.
- **Call Member Services for help if you have questions or concerns.**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about our plan.
- You need a service, item, or medication that our plan said it won't pay for.
- You disagree with a decision our plan made about your care.
- You think your covered services are ending too soon.
- You have a problem or complaint with your long-term services and supports, which include Community-Based Adult Services (CBAS) and Nursing Facility (NF) services.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you have a problem with your care, you can call the Medicare Medi-Cal Ombudsman Program at 1-855-501-3077 for help**. This chapter explains different options you have for different problems and complaints, but you can always call the Ombudsman Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** of this *Member Handbook*.

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A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from our plan

You can call our plan at 1-800-443-0815 (TTY 711) to help deal with a problem or answer questions.

Help from the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. You can also review their website at https://www.aging.ca.gov/HICAP/. HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP isn’t connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free.

Help from the Medicare Medi-Cal Ombudsman Program

You can call the Medicare Medi-Cal Ombudsman Program and speak with an advocate about your health coverage questions. They may be able to offer free legal help. The Ombudsman Program isn't connected with us or with any insurance company or health plan. Their phone number is 1-855-501-3077, and their website is www.healthconsumer.org.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help from the California Department of Health Care Services

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

Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care (DMHC) for free help. The DMHC is responsible for overseeing health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is **1-888-466-2219**. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free **TDD number**, **1-877-688-9891**. You can also visit DMHC's website at **www.dmhc.ca.gov**.

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 **1-800-443-0815 (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.

C. Understanding Medicare and Medi-Cal complaints and appeals in our plan

You have Medicare and Medi-Cal. Information in this chapter applies to all your Medicare and Medi-Cal managed care benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes can’t be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they’re covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** “Coverage decisions and appeals.”	**No.** My problem isn’t about benefits or coverage. Refer to **Section K,** “How to make a complaint.”

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Part B drugs as medical care. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may

refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision when we review a request for service or a claim. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or Medi-Cal. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

In most cases, you must start your appeal at Level 1. If your health problem is urgent or involves an immediate and serious threat to your health, or if you're in severe pain and need a faster decision, you may ask for an IMR Medical Review from the Department of Managed Health Care at www.dmhc.ca.gov. Refer to **Section F4** for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **Medicare Medi-Cal Ombudsman Program at 1-855-501-3077.**
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **The Help Center at the Department of Managed Health Care** (DMHC) for free help. The DMHC helps people with appeals regarding Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891. You can also visit DMHC's website at www.dmhc.ca.gov. While the DMHC can help people in Managed Medi-Cal plans, it can't help people in Medicare plans only and in the following County Organized Health Systems (COHS):

Partnership Health Plan, Gold Coast Health Plan, CenCal Health, Central California Alliance for Health, and CalOptima. The federal government regulates Medicare plans, and the Department of Health Care Services regulates COHS plans.

- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
    - Ask for a legal aid attorney from the Medicare Medi-Cal Ombudsperson Program at 1-855-501-3077.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page. You can also get help or information from government organizations such as your Health Insurance Counseling and Advocacy Program (**Chapter 2, Section C,** of this *Member Handbook* has the phone numbers for this program).

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care. For information about requesting a longer hospital stay, please refer to **Section H**.

This section is about your benefits for medical care that's described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the following situations:

1. You think we cover medical care you need but aren't getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2.**

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4.**

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

6. You're experiencing delays in care or you can't find a doctor.

   What you can do: You can file a complaint. Refer to **Section K2.**

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **integrated organization determination.**

You, your doctor, or your representative can ask us for a coverage decision by:

- calling: 1-800-443-0815 (TTY 711), 7 days a week, 8 a.m. to 8 p.m. If your coverage decision, appeal, or complaint qualifies for a fast decision, call the Expedited Review Unit at 1-888-987-7247, 8:30 a.m. to 5 p.m., 7 days a week.
- faxing: 1-888-987-2252.
- writing:
    - For a standard coverage decision or complaint, write to your local Member Services office (see the *Provider and Pharmacy Directory* for locations).
    - For a standard appeal, write to the address shown on the denial notice we send you. If your coverage decision, appeal, or complaint qualifies for a fast decision, write to:

      Kaiser Permanente
      Expedited Review Unit
      P.O. Box 1809
      Pleasanton, CA 94566

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within:

- **5 business days** after we get your request for a medical service or item that's subject to our prior authorization rules.
- **5 business days**, and no later than **14 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request for a **Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

> **The legal term** for fast coverage decision is **expedited determination.**

When you ask us to make a coverage decision about your medical care that requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get.** You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so, and we use the standard deadlines instead. The letter tells you:
- We automatically give you a fast coverage decision if your doctor asks for it.
- How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances, we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal related to a denied service or item, or to continue a service or item you're already receiving, you, your doctor, or your authorized representative must contact us. Call Member Services at 1-800-443-0815 (TTY 711).

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-800-443-0815 (TTY 711).

- If your doctor or other provider asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
    - We dismiss your request, and
    - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care, you and/or your doctor can request a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
- We automatically give you a fast appeal if your doctor asks for it.
- How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K.**

If we tell you we're stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within ten calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
- You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
- If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal, or sooner if your health requires a quicker response.** If we deny a fast appeal we'll give you, your doctor, prescriber, or representative verbal confirmation of the denial.

- If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about a service or item that Medi-Cal usually covers, you can file a Level 2 Appeal yourself. We include more information later in this chapter. We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal, or sooner if your health requires it.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within seven calendar days** after we get your appeal or sooner if your health requires it.
    - If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about a service or item that Medi-Cal usually covers, you can file a Level 2 Appeal yourself. We include more information later in this chapter. We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days of the date we got your appeal request, or as fast as your health condition requires and within 72 hours of the date we change our decision, or within seven calendar days of the date we got your appeal if your request is for a Medicare Part B drug.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we'll send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the IRO. In addition to the automatic Level 2 Appeal, you can also ask for a State Hearing and an Independent Medical Review with the state. However, an Independent Medical Review isn't available if you have already presented evidence in a State Hearing.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within ten calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity,** sometimes called the **IRE.**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within seven calendar days** of getting your appeal.

If the IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service**, we must promptly implement the decision:
    - Authorize the medical care coverage **within 72 hours, or**
    - Provide the service within **14 working days** after we get the IRO's decision for **standard requests, or**
    - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
    - **Within 72 hours** after we get the IRO's decision for **standard requests**, **or**
    - **Within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
- If your case meets the requirements, you choose whether you want to take your appeal further.
- There are three additional levels in the appeals process after Level 2, for a total of five levels.
- If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.

- An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medi-Cal usually covers

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

(1) Department of Managed Health Care (DMHC)

You can file a complaint with or apply for an Independent Medical Review (IMR) from the Help Center at the DMHC. By filing a complaint, the DMHC will review our decision. The DMHC will do their own investigation of your complaint or decide whether the case qualifies for IMR. An IMR may be available for any Medi-Cal covered service or item that's medical in nature. An IMR is a review of your case by experts who aren't part of our plan or a part of the DMHC. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it's not medically necessary.
- Won't cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Disputes whether a surgical service or procedure was cosmetic or reconstructive in nature.
- Won't pay for emergency or urgent Medi-Cal services that you already received.
- Hasn't resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours, or sooner, if your health requires it, for a fast appeal.

In most cases, you must file an appeal with us before requesting an IMR. Refer to **Section G5** for information about our Level 1 appeal process. If you disagree with our decision, you can submit an IMR Application/Complaint Form with the DMHC.

NOTE: If your provider filed an appeal for you, but we don't get your Appointment of Representative form, you'll need to refile your appeal with us before you can file for a Level 2 IMR with the DMHC unless your appeal involves an imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

You may request for an IMR and a State Hearing, but you aren't allowed to go to IMR if you have already presented evidence in a State Hearing or had a State Hearing on the same issue.

If your treatment was denied because it was experimental or investigational, you don't have to take part in our appeal process before you apply for an IMR.

If your problem is urgent or involves an immediate and serious threat to your health or if you're in severe pain, you may bring it immediately to the DMHC's attention without first going through our appeal process.

You must **apply for an IMR within six months** after we send you a written decision about your appeal. The DMHC may accept your application after six months for good reason, such as you had a medical condition that prevented you from asking for the IMR within six months, or you didn't get adequate notice from us of the IMR process.

To file a complaint or ask for an IMR:

- Fill out the IMR/Complaint Form available at: www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the DMHC Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center can't return any documents.
- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the Department's Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- Submit the IMR/Complaint Form and any attachments to the DMHC online at: www.dmhc.ca.gov/FileaComplaint
- Submit by mail or fax:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, CA 95814-2725
  FAX: 1-916-255-5241

Within seven days, DMHC will review your application and send you an acknowledgement of receipt letter. If DMHC determines the case qualifies for IMR, then an IMR decision will be made within 45 days after the receipt of all required documentation.

If your case is urgent and you qualify for IMR, an IMR decision will usually be made within seven days after the receipt of all required documentation.

If you're not satisfied with the result of the IMR, you can still ask for a State Hearing

An IMR can take longer if the DMHC doesn't receive all of the medical records needed from you or your treating doctor. If you're using a doctor who isn't in your health plan's network, it's important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

If the DMHC decides that your case isn't eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

(2) State Hearing

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we won't approve, or we won't continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the "Appeal Decision Letter" notice is mailed to you.

NOTE: If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Refer to **Section F4** for more information about whether benefits continue during Level 2 appeals.

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov.
- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.
- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:
- Mail: California Department of Social Services State Hearings Division P.O. Box 944243, Mail Station 9-17-433 Sacramento, CA 94244-2430
- Fax: (916) 309-3487 or toll-free at 1-833-281-0903
- You may complete the "Request for State Hearing" on the back of the notice of action. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, 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 the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

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

You're 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. Medi-Cal Rx pharmacy benefit decisions are not subject to the IMR process.

The sections below will provide you with more information on how to ask for a State Hearing or an IMR.

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by Kaiser Permanente. 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 5 or 711). However, complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing.

Note: Items and services you receive under the Community Supports Program do not qualify for IMR.

The State Hearings Division gives you their decision in writing and explains the reasons.

- If the State Hearings Division says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Hearings Division says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or State Hearing decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the State Hearings Division describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill. The only amount you should be asked to pay is the cost sharing described in the Benefits Chart in **Chapter 4** (if you lose full-scope Medi-Cal) or in **Chapter 6** (for your drugs).

If you get a bill that's more than your copay for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or items.

For more information, refer to **Chapter 7** of this *Member Handbook.* It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you our share of the cost for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.

- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal.** Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Medi-Cal usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
    - Cover a Medicare Part D drug that isn't on our plan's *Drug List* or

  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)

- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?

You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section G2,** then refer to **Sections G3 and G4**.	**You can ask us for a coverage decision.** Refer to **Section G4**.	**You can ask us to pay you back.** (This is a type of coverage decision.) Refer to **Section G4**.	**You can make an appeal.** (This means you ask us to reconsider.) Refer to **Section G5**.

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our *Drug List* or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**
>
> Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception**.

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a drug that isn't on our *Drug List*

- If we agree to make an exception and cover a drug that's not on our *Drug List*, you pay the copay that applies to all of our drugs.
- You can't get an exception to the required copay amount for the drug.

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
    - Being required to use the generic version of a drug instead of the brand name drug.
    - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called “prior authorization (PA)”.
    - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you’re required to pay.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our *Drug List* is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

- Our *Drug List* often includes more than one drug for treating a specific condition. These are called “alternative” drugs.
- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
    - If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
    - If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
    - If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- You can’t ask us to change the cost-sharing tier for any drug in Tier 5 (specialty tier drugs).
- If we approve your tiering exception request and there‘s more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No.**

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling Member Services at 1-800-443-0815 (TTY 711), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll review your request under the fast coverage decision timeline. We'll send you a letter with this information.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we'll decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we'll use the standard deadlines instead.
    - We send you a letter that tells you we'll use the standard deadline. The letter also tells you how to make an appeal about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard or fast appeal** by calling 1-866-206-2973, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within seven calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
    - If we don't give you a decision within seven calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than seven calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
    - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity,"** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**. If you need help requesting a free copy of your case file, call Member Services at 1-800-443-0815.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within seven calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

- An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Member Handbook*.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Notwithstanding the appeals discussed in this **Section H**, you may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
    - Be a part of any decisions about the length of your hospital stay.
    - Know where to report any concerns you have about the quality of your hospital care.
    - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.

- You or someone acting on your behalf can sign the notice.
- Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.

- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In California, the QIO is Commence Health. Call them at 1-877-588-1123. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization won't hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you're in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section E4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
    - Call Member Services at the numbers at the bottom of the page.
    - Call the HICAP at 1-800-434-0222.
- **Contact the QIO.**
    - Refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook* for more information about the QIO and how to contact them.
    - Ask them to review your appeal and decide whether to change our plan's decision.
    - **Act quickly and ask for a "fast-track appeal".** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.
- If the Quality Improvement Organization won't hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and

serious threat to your health or if you're in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

> The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers provide their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123.

You must ask for this review **within 60 calendar days** after the day the QIO said No to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to **Section F4** to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
- If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No.** This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the State Hearings Division will tell you what to do if you want to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.

- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No.** This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Member Services at 1-800-443-0815 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Services at 1-800-443-0815 (TTY 711). You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there's anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.

We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with Kaiser Permanente Dual Complete before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

Medi-Cal

You can file a complaint with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8 a.m. and 5 p.m.

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. For non-urgent matters, you may file a complaint with the DMHC if you disagree with the decision in your Level 1 appeal or if the plan hasn't resolved your complaint after 30 calendar days. However, you may contact the DMHC without filing a Level 1 appeal if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you're in severe pain, if you disagree with our plan's decision about your complaint, or if our plan hasn't resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TTY number, 1-877-688-9891. The call is free.
- Visit the Department of Managed Health Care's website (www.dmhc.ca.gov).

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Customer Response Center: 1-800-368-1019
Fax: 1-202-619-3818
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act (ADA).

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook*.

In California, the QIO is called Commence Health. The phone number for Commence Health is 1-877-588-1123.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and Medi-Cal programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you have some choices to end your membership with our plan including any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Medi-Cal or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to leave our plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. If you enroll in another plan, your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medi-Cal options and services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434-0222, Monday through Friday from 8 a.m. to 5 p.m., TTY users should

call 711. For more information or to find a local HICAP office in your area, please visit https://www.aging.ca.gov/HICAP.

- Health Care Options at 1-800-430-4263, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-800-430-7077.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8 a.m. to 5 p.m. or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Member Handbook* for information about drug management programs.

B. How to end membership in our plan

If you decide to end your membership you can do so by enrolling in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart **Section C1**.
- Call Health Care Options at 1-800-430-4263, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-800-430-7077.
- **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Medi-Cal services separately

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It's for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.** **Note:** The term Medi-Medi Plan is the name for integrated dual eligible special needs plans (D-SNPs) in California	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8 a.m. to 5 p.m., TTY users should call 711. For more information or to find a local HICAP office in your area, please visit https://www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medi-Medi Plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal plan will change to match your Medi-Medi Plan.
2. You can change to: **Original Medicare with a separate Medicare drug plan, and a Medi-Cal Plan.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8 a.m.

	to 5 p.m. TTY users should call 711. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll remain enrolled in your Medi-Cal Plan unless you choose a different plan.
3. You can change to: **Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason** **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8 a.m. to 5 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8 a.m. to 5 p.m. TTY users should call 711. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll remain enrolled in your Medi-Cal Plan unless you choose a different plan.

4. You can change to: **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8 a.m. to 5 p.m. TTY users should call 711. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our plan when your new plan's coverage begins. Your Medi-Cal Plan may change.

C2. Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-800-430-4263, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-800-430-7077. Or visit www.healthcareoptions.dhcs.ca.gov/en. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in Kaiser Permanente Dual Complete ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is for people who qualify for both Medicare and Medi-Cal. Note: If you no longer qualify for Medi-Cal, you can temporarily continue in our plan with Medicare benefits, please see information below on deeming period. If you're no longer eligible for Medi-Cal, we will tell you in writing that you have a four-month grace period to regain Medi-Cal eligibility before you're required to leave the Kaiser Permanente Dual Complete plan. Prior to termination of your Kaiser Permanente Dual Complete plan, we will contact you to give you the opportunity to enroll in one of our other Medicare Advantage plans. The benefits and out-of-pocket costs in these plans may differ from the Kaiser Permanente Dual Complete
- If you move out of our service area.
- If you're away from our service area for more than six months.
    - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or national, or an eligible non-citizen.
    - You must be a United States citizen or national, or an eligible non-citizen to be a member of our plan.

- The Centers for Medicare & Medicaid Services (CMS) will notify us if you're not eligible to remain a member on this basis.
- We must disenroll you if you don't meet this requirement.

If you lose your Medi-Cal eligibility but can be expected to regain it within four month(s), we'll continue to provide all Medicare benefits covered by Kaiser Permanente Dual Complete. When your Medi-Cal coverage ends, we won't pay for your Medi-Cal benefits. Your cost-sharing for benefits covered by Kaiser Permanente Dual Complete will change as described in the Benefits Chart in this *Member Handbook*. You may also lose Extra Help from Medicare to help pay for your Medicare Part D drugs.

If your Medi-Cal eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your Medi-Cal benefits and your enrollment with us will continue. If you can't regain Medi-Cal within four month(s), we'll disenroll you from Kaiser Permanente Dual Complete. If you regain Medi-Cal eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1 800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *Member Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of *this Member Handbook*.

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Member Handbook*. The main laws that apply are federal and state laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

B. Federal notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit hhs.gov/ocr/index.html for more information.

C. Notice about nondiscrimination for Medi-Cal

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. In addition, we don't unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health Care Services, Office for Civil Rights at 916-440-7370. TTY users can call 711 (Telecommunications Relay Service). If you believe that you've been discriminated against and want to file a discrimination grievance, contact:
- By phone: Call Member Services, 24 hours a day, 7 days a week (except closed holidays).
- By mail: Call Member Services and ask to have a form sent to you.
- In person: Fill out a Complaint or Benefit Claim/Request form at a Member Services office located at a plan facility (go to your *Provider and Pharmacy Directory* or kp.org/facilities for addresses).
- Online: Use the online form on our website at kp.org.

- You may also contact the Kaiser Permanente Civil Rights Coordinators directly at the addresses below:

  Attn: Kaiser Permanente Civil Rights Coordinator
  Member Relations Grievance Operations
  P.O. Box 939001
  San Diego CA 92193

If your grievance is about discrimination in the Medi-Cal program, you can also file a complaint with the Department of Health Care Services, Office of Civil Rights, by phone, in writing, or electronically:

- By phone: Call 916-440-7370. If you can't speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

D. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.

Medi-Cal members must utilize all other health coverage (OHC) prior to Medi-Cal when the same service is available under your health coverage since Medi-Cal is the payer of last resort. This means that in most cases, Medi-Cal will be the secondary payer to the Medicare OHC, covering allowable costs not paid by our plan or other OHC up to the Medi-Cal rate.

E. Notice about Medi-Cal 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 and managed care premiums/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 can't exceed the value of a member's probated estate.

To learn more, go to the Department of Health Care Services' estate recovery website at **dhcs.ca.gov** or call 916-650-0590.

F. Administration of this *Member Handbook*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *Member Handbook***.**

G. Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *Member Handbook***.**

H. Assignment

You may not assign this *Member Handbook* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

I. Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses, except as otherwise required by law.

J. Coordination of benefits

If you have other insurance, you are required to use your other coverage in combination with your coverage as a Kaiser Permanente Dual Complete Plan member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about

primary payments in third party liability situations, see **Section S** in this chapter, and for primary payments in workers' compensation cases, see **Section U** in this chapter.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

K. Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services, we may recover the value of the services from the employer.

L. *Member Handbook* binding on members

By electing coverage or accepting benefits under this *Member Handbook*, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this *Member Handbook*.

M. Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

N. Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

O. No waiver

Our failure to enforce any provision of this *Member Handbook* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

P. Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this booklet) and Social Security at 1-800-772-1213 (TTY 1-800-325-0778) as soon as possible to report your address change.

Q. Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

R. Third party liability

Third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services.

Note: This “Third party liability” section does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers’ compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount. Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 1-502-753-7064

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party’s liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

S. U.S. Department of Veterans Affairs

For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

T. Workers' compensation or employer's liability benefits

Workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

U. Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

V. Binding arbitration

The following description of binding arbitration applies to the following members:

- All members enrolled in a Kaiser Permanente Medicare Advantage Individual Plan with an effective date prior to January 1, 2008; and
- All members enrolled in a Kaiser Permanente Medicare Advantage Individual Plan with an effective date of January 1, 2008 or after who have not expressly opted out of the binding arbitration process within 60 calendar days of the enrollment effective date.

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *Member Handbook***.** Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Member Handbook* or a member Party's relationship to Kaiser Foundation Health Plan, Inc., including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted.
- The claim is asserted by one or more member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more member Parties.
- Governing law does not prevent the use of binding arbitration to resolve the claim.

Members enrolled under this *Member Handbook* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court.
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Dual Complete Plan members (see **Chapter 9** for Medicare appeal information).
- Claims that cannot be subject to binding arbitration under governing law.

As referred to in this "Binding arbitration" section, "member Parties" include:

- A member.
- A member's heir, relative, or personal representative.
- Any person claiming that a duty to him or her arises from a member's relationship to one or more Kaiser Permanente Parties.

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc
- Kaiser Foundation Hospitals.
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group.
- The Permanente Federation, LLC.
- The Permanente Company, LLC.

- Any Southern California Permanente Medical Group or The Permanente Medical Group physician.
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more member Parties.
- Any employee or agent of any of the foregoing.

“Claimant” refers to a member Party or a Kaiser Permanente Party who asserts a claim as described above. “Respondent” refers to a member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the **Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator** (“Rules of Procedure”) developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, KP Cal, LLC, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

- **South Plans:** Kaiser Foundation Health Plan, Inc.
  Legal Department, Professional & Public Liability
  373 E. Walnut Street
  Pasadena, CA 91188
- **North Plans:** Kaiser Foundation Health Plan, Inc.
  Legal Department, Professional & Public Liability
  1 Kaiser Plaza, 19th Floor
  Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to “Arbitration Account” regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator’s fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants’ responsibility for paying the neutral arbitrator’s fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two-party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators’ fees and expenses

Kaiser Foundation Health Plan, Inc., will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this “Binding arbitration” section, each party shall bear the party’s own attorneys’ fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the

applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding arbitration" section, **Section 2** of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding arbitration" section. In accord with the rule that applies under **Sections 3** and **4** of the Federal Arbitration Act, the right to arbitration under this "Binding arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: An Administrative Law Judge (ALJ) is a judge who hears and decides cases involving government agencies. A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Allowance: A specified credit amount that you can use toward the cost of an item or service. If the cost of the item(s) or service(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the maximum out-of-pocket amount.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Member Handbook* explains appeals, including how to make an appeal.

Balance billing: The practice where a provider bills a patient for the difference between the provider's full billed charges and the amount paid by the patient's health plan.

Behavioral health: Refers to our emotional, psychological, and social well-being. In simpler terms: It's about how we think, feel, and interact with others. It's an all-inclusive term referring to mental health and substance use disorder services.

Benefit period: The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original biological product" and "Biosimilar").

Biosimilar: A biological drug that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized care plan."

Care team: Refer to "Interdisciplinary care team."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $2,400 for Part D covered drugs during the year.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 of this *Member Handbook* explains how to contact CMS.

Community-Based Adult Services (CBAS): Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get certain services or drugs. For example, you might pay $2 or $5 for a service or a drug.

Cost-sharing: Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. (This is in addition to our plan's monthly premium.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is gotten. **Note:** In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the

cost-sharing. For example, if you receive non-preventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the non-preventive care. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the List of Covered Drugs (also known as the *Drug List*) is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. Chapter 9 of this *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Creditable Prescription Drug Coverage: Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care: Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Department of Health Care Services (DHCS): The state department in California that administers the Medicaid Program (known as Medi-Cal).

Department of Managed Health Care (DMHC): The state department in California responsible for regulating most health plans. DMHC helps people with appeals and complaints about Medi-Cal services. DMHC also conducts Independent Medical Reviews (IMR).

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Management Program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or specialty drugs are examples of drug tiers. Every drug on the Drug List is in one of six tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Emergency Medical Condition: A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded drug: A drug that's not a covered Part D drug, as defined under 42 U.S.C. Section 1395w-102(e).

Excluded services: Services that aren't covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy", or "LIS."

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health Insurance Counseling and Advocacy Program (HICAP): A program that provides free and objective information and counseling about Medicare. **Chapter 2** of this *Member Handbook* explains how to contact HICAP.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of six months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand.

As a plan member, you only pay our plan's cost-sharing amounts when you get services we cover. We **don't** allow providers to bill you more than this amount.

In-Home Supportive Services (IHSS): The IHSS Program will help pay enrolled care providers for services provided to you so that you can remain safely in your own home. IHSS is an alternative to out-of-home care, such as nursing homes or board and care facilities. To receive services, an assessment is conducted to determine which types of services may be authorized for each participant based on their needs. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. County social service agencies administer IHSS.

Independent Medical Review (IMR): If we deny your request for medical services or treatment, you can make an appeal. If you disagree with our decision and your problem is about a Medi-Cal service, including DME supplies and drugs, you can ask the California Department of Managed Health Care for an IMR. An IMR is a review of your case by experts who aren't part of our plan. If the IMR

decision is in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized care plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach **$2,400.** This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. **You begin in this stage when you fill your first prescription of the year.** During this stage, we pay part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan or affiliated health plans for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Interdisciplinary care team (ICT or care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Kaiser Foundation Health Plan (Health Plan): Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions, is a nonprofit corporation and a Medicare Advantage organization. This *Member Handbook* sometimes refers to Health Plan as "we" or "us."

Kaiser Foundation Hospital: A network hospital owned and operated by Kaiser Foundation Hospitals.

Kaiser Permanente: Health Plan, Medical Group, and Kaiser Foundation Hospitals.

Kaiser Permanente Region (Region): A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you're outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente Region's service area. For more information, please refer to **Chapter 3**, **Section D4**.

List of Covered Drugs (*Drug List*): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells

you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS covered by our plan include Community-Based Adult Services (CBAS), also known as adult day health care, Nursing Facilities (NF), and Community Supports. IHSS and 1915(c) waiver programs are Medi-Cal LTSS provided outside our plan.

Low-income subsidy (LIS): Refer to "Extra Help".

Mail-order program: Some plans may offer a mail-order program that allows you to get up to a three-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. Medi-Cal is the Medicaid program for the State of California.

Medical Group: It is the network of plan providers that our plan contracts with to provide covered services to you. The names of our medical groups are The Permanente Medical Group, Inc., a for-profit professional corporation and Southern California Permanente Medical Group, a for-profit professional partnership.

Medi-Cal: This is the name of California's Medicaid program. Medi-Cal is managed by the state and is paid for by the state and the federal government.

- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medi-Cal.

Medi-Cal plans: Plans that cover only Medi-Cal benefits, such as long-term services and supports, medical equipment, and transportation. Medicare benefits are separate.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare Diabetes Prevention Program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medi-Cal enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this *Member Handbook* for more information.

Medi-Medi Plan: A Medi-Medi Plan is a type of Medicare Advantage plan. It’s for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services.

Member (member of our plan, or plan member): A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and disclosure information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network Physician: Any licensed physician who is a partner or an employee of Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network provider: Are providers who work with our plan. These providers agree to accept our payment as full payment. “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They’re licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and don’t charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers”.

Nursing home or facility: A facility that provides care for people who can’t get their care at home but don’t need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2 and 9** of this *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9** of this *Member Handbook* explains coverage decisions.

Original biological product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It’s also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this *Member Handbook* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Plan charges: Plan Charges means the following:

- For services provided by Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to members.

- For services for which a provider (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

Post-stabilization care: Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You're considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you're safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Providers: Are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost-sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) or our approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy. Refer to **Chapter 4** of this *Member Handbook* to learn more about rehabilitation services.

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.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

The service area is described in **Chapter 1** for the purposes of cost-sharing, enrollment, and disenrollment. For the purposes of obtaining covered services, you get care from network providers anywhere inside your Regions' service area (refer to our *Provider and Pharmacy Directory*).

Services: Health care services, supplies, or items.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Special Enrollment Period: A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Specialist: 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, a member will need a referral from their PCP to go to a specialist.

Specialized pharmacy: Refer to **Chapter 5** of this *Member Handbook* to learn more about specialized pharmacies.

Specialty-Tier Drugs: Very high-cost drugs approved by the FDA that are on our formulary.

State hearing: If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to get services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

Kaiser Permanente Dual Complete Member Services

CALL	1-800-443-0815 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Your local Member Services office (see the *Provider and Pharmacy Directory* for locations).
WEBSITE	kp.org

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1444. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850*

Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, 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, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

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

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office for Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** 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

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**