Important Information Inside

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

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KAISER PERMANENTE®

Medi-Cal Plan Member Handbook

What you need to know about your benefits

2025 Combined Evidence of Coverage and Disclosure Form ("EOC/DF")

Effective January 1, 2025
Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

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Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages for free. We provide written translations from qualified translators. Call our Member Services department at **1-855-839-7613** (TTY 711). The call is free. Read this Member Handbook to learn more about healthcare language assistance services such as interpreter and translation services.

Other formats

You can get this information in other formats such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call Member Services at **1-855-839-7613** (TTY **711**). The call is free.

Interpreter services

We provide oral interpretation services, including sign language, from a qualified interpreter, on a 24-hour basis,

at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters unless it is an emergency. Interpreter, linguistic, and cultural services are available for free. Help is 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 **1-855-839-7613** (TTY **711**). The call is free.

English: Attention: If you need help in your language, call **1-855-839-7613** (TTY **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. You can also ask for materials translated into your language, or in alternative formats. Call **1-855-839-7613** (TTY **711**). These services are free.

Arabic: تنبيه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على الرقم **1-855-839-7613** (TTY **711**). كما وتتوفر مساعدات وخدمات للأشخاص الذين يعانون من إعاقات مثل وثائق بلغة برايل والطباعة بخط كبير. يمكنك أيضاً طلب وثائق مترجمة بلغتك أو بصيغ بديلة. اتصل على الرقم **1-855-839-7613** (TTY **711**). هذه الخدمات مجانية.

Armenian: Ուշադրություն. եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք **1-855-839-7613** (TTY **711**): Մատչելի են նաև աջակցություններ և ծառայություններ հաշմանդամություն ունեցող անձանց համար, ինչպես օրինակ՝ փաստաթղթեր բրեյլով կամ մեծ տառատեսակով: Կարող եք նաև հայցել ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափերով նյութեր: Զանգահարեք **1-855-839-7613** (TTY **711**): Այս ծառայություններն անվճար են:

Chinese：请注意：如果您需要语言协助，请致电 **1-800-757-7585** (TTY **711**)。我们也为残障人士提供援助和服务，例如盲文和大字版文件。您还可以索要翻译为您所用语言或其他格式的材料。请致电 **1-800-757-7585** (TTY **711**)。这些服务免费。

Farsi: توجه: اگر نیاز به کمک به زبان خودتان دارید با شماره **1-855-839-7613** (TTY **711**) تماس بگیرید. کمک‌ها و خدمات برای افراد دچار معلولیت، مانند اسناد با خط بریل و چاپ بزرگ نیز در دسترس است. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین درخواست کنید. با شماره **1-855-839-7613** (TTY **711**) تماس بگیرید. این خدمات رایگان است.

Hindi: ध्यान दें: अगर आपको अपनी भाषा में सहायता चाहिए, तो **1-855-839-7613** (TTY **711**) पर कॉल करें। विकलांग व्यक्तियों के लिए सहायताएँ और सेवाएँ, जैसे कि ब्रेल और बड़े प्रिंट में दस्तावेज़, उपलब्ध हैं। आप सामग्रियों को अपनी भाषा, या वैकल्पिक प्रारूप में अनुवाद करवाने के लिए भी कह सकते हैं। **1-855-839-7613** (TTY **711**) पर कॉल करें। ये सेवाएँ मुफ़्त होती हैं।

Hmong: Ceeb toom: Yog koj yuav tau muaj kev pab ua koj yam lus, hu rau **1-855-839-7613** (TTY **711**). Kuj muaj cov kev pab cuam rau cov neeg uas muaj qhov kev tsis ua taus, xws li cov ntaub ntawv ua pob su rau cov dig muag thiab cov tsiaj ntawv loj. Koj kuj thov kom tau ntaub ntawv txhais ua koj yam lus, lossis ua lwm yam los tau. Hu **1-855-839-7613** (TTY **711**). Cov kev pab no muab pub dawb.

Japanese: 注意：言語でサポートが必要な場合は、 **1-855-839-7613** (TTY **711**) までお電話ください。点字や大きな活字で書かれたなど、障害者のための補助やサービスも用意されている。また、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることもできます。 **1-855-839-7613** (TTY **711**) までお電話ください。これらのサービスは無料です。

Khmer: **យកចិត្តទុកដាក់៖**
ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក
សូមទូរស័ព្ទទៅ **1-855-839-7613** (TTY **711**)។ ជំនួយ
និងសេវាកម្មសម្រាប់ជនពិការ
ដូចជាឯកសារជាអក្សរស្ទាប និងអក្សរធំៗក៏មានផងដែរ។
អ្នកក៏អាចស្នើសុំឯកសារដែលបានបកប្រែជាភាសារបស់
អ្នក ឬក្នុងទម្រង់ផ្សេង។ សូមទូរស័ព្ទទៅ **1-855-839-7613**
(TTY **711**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ។

Korean: 주의: 귀하의 언어로 도움이 필요하시면
1-855-839-7613 (TTY **711**)번으로 전화하십시오.
점자 및 큰 활자로 된 문서 등 장애인을 위한 지원 및
서비스도 제공됩니다. 또한 귀하의 언어로 번역된
자료 또는 대체 형식의 자료를 요청할 수
있습니다. **1-855-839-7613** (TTY **711**)번으로
전화하십시오. 이러한 서비스는 무료입니다.

Laotian: ຊຶ່ນຊາບ:
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໂທຫາເບີ **1-855-839-7613** (TTY **711**). ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສໍາລັບຄົນພິການແມ່ນມີໃຫ້ຊຶ່ນ: ເອກະສານເປັນຕົວໜັງສືນູນ ແລະ ສື່ສິ່ງພິມໃຫຍ່. ທ່ານຍັງສາມາດຂໍເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໆໄດ້. ໂທຫາເບີ **1-855-839-7613** (TTY **711**). ການບໍລິການນີ້ແມ່ນບໍ່ເສຍຄ່າ.

Mien: Cau fim jangx longx oc: Beiv hnangv meih qiemx zuqc longc mienh tengx faan benx meih nyei waac bun muangx nor, douc waac lorx **1-855-839-7613** (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. Meih corc haih tov heuc dorh naaiv deix jaa-sic mingh zoux benx meih nyei waac, a'fai zoux benx da'nyeic nyungc guv bun. Douc waac lorx **1-855-839-7613** (TTY **711**). Naaiv deix gong-bou jauv-louc se wangv henh tengx hnangv oc.

Navajo: Ńt'éé': Hadiilnéhgo shizaad k'ehjí shíká ahił halne'go, bił hane' **1-855-839-7613** (TTY **711**) Ałch'į' ádaats'íísígíí dóó ał'ąą ał'ąą ak'e'edzáhígíí baa hane'go, naaltsoos Braille dóó ch'įįh naaltsoos, éí kódahat'e'. Níigo éí yiká azhígíí shí bizaad bee yit'éého éí díí bidáhálne'go, doodago léechąąí bíla'ashdla'ii bíká'go éí dabikáá'go, yeidooleeł. Bił hane' **1-855-839-7613** (TTY **711**). Éí ał'ąą ał'ąą ak'éadzáhígíí díí bílaashdladi bee hahoodzo da.

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ **1-855-839-7613** (TTY **711**) 'ਤੇ ਕਾੱਲ ਕਰੋ। ਵਿਕਲਾਂਗ ਵਿਅਕਤੀਆਂ ਲਈ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਵੀ ਉਪਲਬਧ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। **1-855-839-7613** (TTY **711**) 'ਤੇ ਕਾੱਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

Russian: Внимание: Если вам нужна помощь на вашем языке, позвоните **1-855-839-7613** (kbybz TTY **711**). Также доступны вспомогательные средства и услуги для людей с инвалидностью, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах. Звоните **1-855-839-7613** (линия TTY **711**). Эти услуги бесплатны.

Spanish: Atención: Si necesita ayuda en su idioma, llame al **1-800-788-0616** (TTY **711**). Se encuentran disponibles ayudas y servicios para personas con discapacidad, como documentos en braille y letra grande. También puede solicitar materiales traducidos a su idioma o en formatos alternativos. Llame al **1-800-788-0616** (TTY **711**). Estos servicios no tienen costo.

Tagalog: Paunawa: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-855-839-7613** (TTY **711**). Available din ang mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumento sa braille at malaking letra. Maaari ka ring humiling ng mga babasahin na isinalin sa iyong wika, o sa mga alternatibong format. Tumawag sa **1-855-839-7613** (TTY **711**). Libre ang mga serbisyong ito.

Thai: ข้อควรพิจารณา:
หากคุณต้องการความช่วยเหลือในด้านภาษา กรุณาโทร **1-855-839-7613** (TTY **711**) นอกจากนี้ ยังมีการให้ความช่วยเหลือและบริการแก่คนพิการ เช่น เอกสารอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่อีกด้วย คุณยังสามารถขอเอกสารที่แปลเป็นภาษาของคุณหรือในรูปแบบอื่นได้ โทร **1-855-839-7613** (TTY **711**) บริการเหล่านี้ไม่มีค่าใช้จ่าย

Ukrainian: Увага! Якщо вам потрібна допомога вашою мовою, телефонуйте за номером **1-855-839-7613** (телетайп **711**). Також доступні допоміжні засоби й послуги для людей з інвалідністю, наприклад документи, надруковані шрифтом Брайля чи великим шрифтом.
Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах. Телефонуйте за номером **1-855-839-7613** (телетайп **711**).
Ці послуги безплатні.

Vietnamese: Chú ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số **1-855-839-7613** (TTY **711**). Cũng có hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn. Quý vị cũng có thể yêu cầu các tài liệu được dịch sang ngôn ngữ của quý vị hoặc ở các định dạng khác. Hãy gọi **1-855-839-7613** (TTY **711**). Các dịch vụ này miễn phí.

Welcome to Kaiser Permanente!

Thank you for joining the Kaiser Foundation Health Plan, Inc. Medi-Cal Plan. We work with the State of California to help you get the health care you need.

Member Handbook

This Member Handbook tells you about your coverage under our Medi-Cal Plan. You are enrolled in one of our California Regions (either Northern California or Southern California). The Region where you are enrolled is called your Home Region. Your Home Region is also printed on your Health Plan ID Card. The coverage information in this Member Handbook applies when you obtain care in your Home Region. Please read it carefully and completely. It will help you understand your benefits, the services available to you, and how to get the care you need. It also explains your rights and responsibilities as a member of the Health Plan. If you have special health needs, be sure to read all sections that apply to you.

This Member Handbook is also called the Combined Evidence of Coverage and Disclosure Form ("EOC/DF"). This EOC and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. To learn more, call our Member Services at **1-855-839-7613** (TTY **711**).

In this Member Handbook, Kaiser Foundation Health Plan, Inc. is sometimes referred to as "we", "our" or "us." Members are sometimes called "you." Some capitalized words have special meaning in this Member Handbook. See Chapter 8, "Important numbers and words to know", of this Member Handbook for terms you should know.

To ask for a copy of the contract between Kaiser Foundation Health Plan, Inc. and The California Department of Health Care Services ("DHCS"), call Member Services at **1-855-839-7613** (TTY **711**). You may ask for another copy of the Member Handbook for free. You can also find the Member Handbook on the website at **kp.org/medi-cal/documents.**

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

You can also ask for a free copy of our non-proprietary clinical and administrative policies and procedures. They are also on our website.

Contact us

We are here to help. If you have questions, call our Member Services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free.

You can also visit online at any time at **kp.org** or visit the Member Services department at a Plan Facility (refer to the facility locations on our website at **kp.org/finddoctors** for addresses). For more information on our providers and locations, call our Member Services at **1-855-839-7613** (TTY **711**) or go to **kp.org/finddoctors**.

Thank you,
Kaiser Foundation Health Plan, Inc.

1. Getting started as a member

How to get help

We want you to be happy with your health care. If you have questions or concerns about your care, we want to hear from you!

Kaiser Permanente Member Services

Kaiser Permanente member services is here to help you. We can:

- Answer questions about our Medi-Cal plan and services covered by us
- Help you choose or change a primary care provider ("PCP")
- Tell you where to get the care you need
- Help you get interpreter services if you do not speak English
- Help you get information in other languages and formats

If you need help, call Member Services as follows:

- English (and more than 150 languages using interpreter services) **1-855-839-7613**
- Spanish **1-800-788-0616**
- Chinese dialects **1-800-757-7585**
- TTY **711**

We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. We must make sure you wait less than 10 minutes when calling. You can also visit Member Services online at any time at kp.org

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

Who can become a Member

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

You qualify for our Medi-Cal Plan because you live in the Kaiser Permanente Medi-Cal Plan Service Area and meet the qualifying criteria. Our Medi-Cal Plan Service Area is described in Chapter 8, “Important phone numbers and words to know”, of this Member Handbook.

You might also qualify for Medi-Cal through Social Security because you are getting SSI or SSP. For questions about enrollment, call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077** or **711**). Or go to http://www.healthcareoptions.dhcs.ca.gov/

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

Transitional Medi-Cal

You may be able to get Transitional Medi-Cal if you start earning more money and you no longer qualify for Medi-Cal.

You can ask questions about qualifying for Transitional Medi-Cal at your local county office at: http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

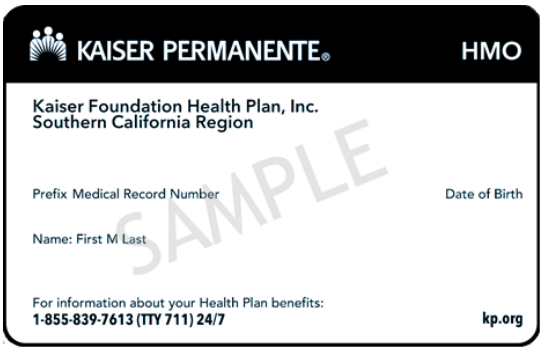
Or call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077** or **711**).

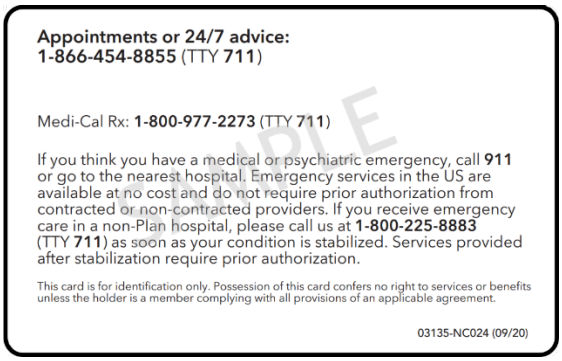
Identification (“ID”) cards

As a member of the Health Plan, you will get our Kaiser Permanente Identification (“ID”) card. You must show your Kaiser Permanente ID card **and** a photo ID when you get Covered Services from Kaiser Permanente Medi-Cal Providers. You should also have a Medi-Cal Benefits Identification Card (“BIC”) that the State of California sent to you. Your Medi-Cal BIC card is the benefits identification card. You may be required to show your BIC when you get Covered Services from providers who are outside of Kaiser Permanente. You should always carry all health cards with you.

Your Medi-Cal BIC look similar to the samples below:

Your Kaiser Permanente ID cards look similar to the cards below:





If you do not get your Kaiser Permanente ID card within a few weeks after your enrollment date, or if your Kaiser Permanente ID card is damaged, lost, or stolen, call member services right away. We will send you a new card for free. Call our Member Services at **1-855-839-7613** (TTY **711**).

If you do not have a Medi-Cal BIC card or if your card is damaged, lost, or stolen, call the local county office. To find your local county office, go to http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

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Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

2. About your health plan

Health plan overview

The Kaiser Foundation Health Plan, Inc., Medi-Cal Plan is a health plan for people who have Medi-Cal and live in our Medi-Cal Plan Service Area. Our Medi-Cal Plan Service Area is described in Chapter 8, “Important phone numbers and words to know”, of this Member Handbook. We work with the State of California to help you get the health care you need. You are enrolled in one of our California Regions (either the Northern California Region or Southern California Region). The Kaiser Permanente Region where you are enrolled is called your Home Region.

You may talk with one of Kaiser Permanente’s member services representatives to learn more about our Medi-Cal Plan and how to make it work for you. Call our Member Services at **1-855-839-7613** (TTY **711**).

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 work together to provide quality care to our members. Our medical care program gives you access to Covered Services you may need in your Home Region Service Area, such as routine care, hospital care, laboratory services, and other benefits described in this Member Handbook. Plus, our health education programs offer you great ways to protect and improve your health.

When your coverage starts and ends

When you enroll in our Medi-Cal Plan we will send you a Kaiser Permanente Identification (“ID”) card within two weeks of your enrollment date. You must show both your Kaiser Permanente ID card and a photo ID when you get Covered Services from Kaiser Permanente Providers.

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

You may be required to show your BIC when you get Covered Services from providers who are outside of Kaiser Permanente. You should always carry all health cards with you.

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

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

To find your local county office, go to http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Your Kaiser Permanente Medi-Cal coverage may end if any of the following is true:

- You move out of our Medi-Cal Plan Service Area
- You no longer have Medi-Cal
- You become eligible for a waiver program that requires you to be enrolled in Fee-for-Service ("FFS") Medi-Cal
- You are in jail or prison

If you lose your Kaiser Permanente Medi-Cal coverage, you may still qualify for FFS Medi-Cal coverage. If you are not sure if you are still covered by us, call our Member Services at **1-855-839-7613** (TTY **711**).

Special considerations for American Indians in managed care

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

If you are an American Indian, you have the right to get health care services at an Indian Health Care Provider ("IHCP"). You can also stay with or disenroll (drop) from our Medi-Cal Plan while getting health care services from these locations. To learn more about enrollment and disenrollment, call our Member Services at **1-855-839-7613** (TTY **711**).

We must provide care coordination for you, including out-of-network case management. If you ask to get Covered Services from an IHCP and there is no available in-network IHCP in our Medi-Cal network, we must help you find an out-of-network IHCP. To learn more, read “Provider Network” in Chapter 3, “How to get care”, of this Member Handbook.

How your plan works

Kaiser Foundation Health Plan, Inc. is a managed care health plan contracted with the California Department of Health Care Services (“DHCS”) for Medi-Cal.

Kaiser Permanente provides health care services directly to Members through an integrated medical care program. Our medical care program gives you access to most of the Covered Services you may need in your Home Region Service Area, such as routine care, hospital care, laboratory services, and other benefits described in this Member Handbook. Plus, our health education programs offer you great ways to protect and improve your health.

As a Member of Kaiser Permanente, you may qualify for some services provided through FFS Medi-Cal. These include outpatient prescription drugs, over-the-counter drugs, some medical supplies, and supplements that are available through Medi-Cal Rx.

Kaiser Permanente Member Services

Kaiser Permanente Member Services can:

- Answer questions about services covered by us, including transportation services
- Help you choose or change a primary care provider (“PCP”)
- Tell you where to get the care you need
- Tell you how to schedule appointments
- Help you get interpreter services if you do not speak English
- Help you get information in other languages and formats

To learn more, call our Member Services at **1-855-839-7613** (TTY **711**). You can also find member service information online at **kp.org.**

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

Changing health plans

You can leave our Medi-Cal Plan and join another Medi-Cal managed care plan in your county of residence at any time if another health plan is available. How many health plan choices you have depends on where you live. To choose a new plan, call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077** or **711**).

You can call Monday through Friday between 8 a.m. and 6 p.m. Or go to **https://www.healthcareoptions.dhcs.ca.gov**.

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

If you want to leave our Medi-Cal Plan sooner, you can call Health Care Options to ask for an expedited (fast) disenrollment.

Members who can request expedited disenrollment include, but are not limited to:

- Children getting services under the Foster Care or Adoption Assistance programs
- Members with special health care needs
- Members already enrolled in Medicare, another Medi-Cal, or commercial managed care plan.

You can ask to leave our Medi-Cal Plan in person at your local county office. Find your local county office at:

http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Or call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077** or **711**).

Students who move to a new county or out of California

You can get emergency care and urgent care anywhere in the United States, including the United States Territories. Routine Care, including preventive care, is covered only in your Home Region Service Area.

The table below describes what actions you need to take if you leave your home county

to attend school either in another California county or outside California.

Situation	Actions you need to take and what your coverage is
You move temporarily to a new county **inside your Home Region** to attend school or an institute for higher education	Tell your eligibility worker you are moving temporarily to attend school. The county will update your case record with your new address and county code in the State's database. This will ensure you are covered for any FFS Medi-Cal services you may need. If you remain enrolled in the Kaiser Permanente Medi-Cal Plan, you will continue to be covered for Routine Care, including preventive care, in your new county.
You move temporarily to a new county **outside your Home Region** to attend school or an institute for higher education and **do not** need coverage for Routine Care in your new county.	Tell your eligibility worker you are moving temporarily to attend school. The county will update the case records with your new address and county code in the State's database. This will ensure you are covered for any FFS Medi-Cal services you may need. Routine Care, including preventive care, is covered only inside your Home Region.
You move temporarily to a new county **outside your Home Region** to attend school or an institute for higher education and **want** coverage for Routine Care in your new county.	Tell your eligibility worker you are moving to a new county. You will need to transfer your Medi-Cal enrollment to the new county to continue coverage for Routine Care, including preventive care. If Kaiser Permanente does not have a Medi-Cal Plan in your new county, you will need to change your Medi-Cal plan.

Situation	Actions you need to take and what your coverage is
You move temporarily to another state to attend school or an institute for higher education	Tell your eligibility worker you are temporarily moving to a new state and want to keep your Medi-Cal coverage. As long as you are eligible, Medi-Cal will cover Emergency Care and Urgent Care in another state. Medi-Cal does not cover Emergency Care, Urgent Care, or any other health care services outside of the United States, except for Canada and Mexico as noted in Chapter 3, “How to get care”, of this Member Handbook. Medi-Cal Rx does not cover outpatient prescription drugs outside of California, except for prescriptions that are given to you as part of covered Emergency Care or covered Urgent Care. If you want to get Routine Care, including preventive care, in another state, you will need to apply for Medicaid in that state. If you sign up for Medicaid in another state, you will no longer be eligible for Medi-Cal in California, and we will not pay for your health care.

Continuity of care

Standard Continuity of Care for New Members

As a new Member of our Medi-Cal Plan, you might have providers from your prior health

plan who are not part of our Medi-Cal provider network. You may be able to keep going to your Out-of-Network Provider for up to 12 months or longer if all the following are true:

- DHCS required you to change your Medi-Cal managed care plan and did not have the option to continue with your previous health plan or DHCS required you to transition from Fee-for-Service Medi-Cal to Medi-Cal managed care
- You did not have the option to choose another health plan that would cover the services of your current Out-of-Network Provider
- Your prior health plan's coverage of the provider's services has ended or will end on your enrollment date into our Medi-Cal Plan
- Your situation is one of the cases listed in the “Continuity of Care scenarios” section below

Continuity of Care when a Provider leaves our Medi-Cal network

If your provider stops working with Kaiser Permanente, you may be able to keep getting services from that provider. This is another form of Continuity of Care.

If you are assigned to a provider group whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible). We will also give you written notice at least 60 days before we terminate a contract with a hospital that is within 15 miles of where you live. You may be able to continue to see a provider in that provider group or at that hospital for up to 12 months or longer in certain situations.

Your situation must meet the criteria listed below under the heading “Continuity of Care qualifying conditions” to qualify for Continuity of Care coverage. In addition, you must be receiving Covered Services from the terminated Medi-Cal Network Provider on the provider's termination date.

Continuity of Care qualifying conditions

Qualifying condition	**Coverage under Continuity of Care**
You are a new member under the standard Continuity of Care	Covered Services for up to 12 months
You have an acute condition (a medical issue that needs fast attention)	Covered Services for as long as your acute condition lasts

You have serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time)	Covered Services until the earlier of: (1) 12 months from the date the provider's contract ended; or (2) the first day after a course of treatment is complete when it would be safe to transfer your care to a Network Provider, as determined by Kaiser Permanente after working with the Member and Out-of-Network Medi-Cal Provider. The decision will be made consistent with good professional practice.
You need maternity care	Covered Services while you are pregnant and through the postpartum (after birth) period of 12 months
You have a mental health condition while pregnant or right after birth	Covered Services for up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later
You are a child under the age of 3	Covered Services until the earlier of: (1) 12 months from the date the provider's contract ended; or (2) the child's third birthday
You have a terminal illness (a life-threatening medical issue)	Covered Services for as long as your illness lasts. Terminal illnesses are illnesses that cannot be cured or reversed and are likely to cause death within a year or less in most cases.
You are scheduled for surgery or other medical procedure as long as it is covered, medically necessary, and authorized as part of a documented course of treatment and recommended and documented by	Covered Services related to your surgery or procedure: • If you are a new Member, the surgery or procedure must be recommended and documented by the provider to

the provider	occur within 180 days of your effective date of coverage. • If your provider's contract with Kaiser Permanente ends, the surgery or procedure must be recommended and documented by the provider to occur within 180 days of the end date of the contract between Kaiser Permanente and the provider

Additional requirements for Continuity of Care

In addition to the criteria listed above, the following must be true for you to get Continuity of Care:

- Your Medi-Cal coverage is in effect on the date you receive the services
- You have an existing relationship with the provider
  - For behavioral health treatment for children under 21, this means you saw the provider within the past 12 months for a non-emergency visit.
  - For all other services, this means you saw the provider within the past 12 months for a non-emergency visit.
- The provider agrees to our standard contractual terms and conditions
- The services are Medically Necessary and are covered by Medi-Cal managed care

Kaiser Permanente does not have a documented quality of care concern with the Out-of-Network Provider

We do **not** cover Continuity of Care from Out-of-Network Medi-Cal Providers if either of the following is true:

- The services are not covered by Medi-Cal managed care
- Your Out-of-Network Medi-Cal Provider won't work with us. You will need to find a new Medi-Cal Network Provider

Not all services are eligible for coverage under Continuity of Care. For more information about Continuity of Care, or to request the services or a copy of our "Completion of

Covered Services" policy, please call our Member Services at **1-855-839-7613** (TTY **711**).

Costs

Member costs

Our Medi-Cal Plan serves people who qualify for Medi-Cal. In most cases, Kaiser Permanente Medi-Cal members do not have to pay for covered services, premiums, or deductibles. For a list of Covered Services, see Chapter 4, "Benefits and services", of this Member Handbook.

If you are an American Indian, you do not have to pay enrollment fees, premiums, deductibles, co-pays, cost sharing, or other similar charges. We must not charge any American Indian member who gets an item or service directly from an IHCP or through a referral to an IHCP or reduce payments due to an IHCP by the amount of any enrollment fee, premium, deductible, copayment, cost sharing, or similar charge.

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

If you get services from Out-of-Network Medi-Cal Providers, they may not be covered if you did not get pre-approval (prior authorization). In cases where the services are not covered, you may have to pay for the services.

You can go to Out-of-Network Medi-Cal Providers for some Sensitive Care without pre-approval. For information on what Sensitive Care is, go to the heading "Sensitive Care" in Chapter 3, "How to get care" of this Member Handbook.

You do not need pre-approval for Emergency Care, even when you go to Out-of-Network Medi-Cal Providers. If you are outside the United States other than in Canada or Mexico and need Emergency Care, Kaiser Permanente will **not** cover your care.

When you are inside the United States, we cover Urgent Care services. If you are inside your Home Region Service Area, you must have pre-approval to go to an Out-of-Network Urgent Care provider. You do not need pre-approval for Urgent Care if you are outside

your Home Region Service Area. If you are outside of the United States, Urgent Care services are **not** covered, and you will have to pay for your care. Your Home Region is either the Kaiser Permanente Northern California Region or the Kaiser Permanente Southern California Region. Your Kaiser Permanente ID Card has the name of your Home Region on the front.

For Members with Long-Term Care and a Share of Cost

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

How a provider gets paid

Kaiser Permanente pays providers in these ways:

- Capitation payments
    - We pay some providers a set amount of money every month for each Member. This is called a capitation payment. Kaiser Permanente and providers work together to decide on the payment amount.
- FFS payments
    - Some providers give care to Medi-Cal members and send us a bill for the services they provide. This is called an FFS payment. Kaiser Permanente and providers work together to decide how much each service costs.

To learn more about how we pay providers, call our Member Services at **1-855-839-7613** (TTY **711**).

If you get a bill from a health care provider

Covered services are health care services that we must pay for. If you get a bill for any Medi-Cal covered services, do not pay the bill. Call our member services right away at **1-855-839-7613** (TTY **711**).

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

Asking us to pay you back for expenses

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

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

If you do not meet one of the above conditions, we will not pay you back. We will also not pay you back if:

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

Part D plan

We will tell you if we will pay you back in a letter. We must reimburse you within 45 working days of receipt of the claim. If we decide that you do not qualify for reimbursement, we will tell you in a letter called a Notice of Action (“NOA”). that will include information about your appeal rights.

How to file a claim

If you paid for services that you already got, you can file a claim. Use a claim form and tell us in writing why you had to pay. Call our Member Services at **1-855-839-7613** (TTY **711**) to ask for a claim form. We will review your claim to see if you can get your money back.

You may file a claim (request for payment/reimbursement):

- By visiting kp.org, completing an electronic form, and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting kp.org or calling Member Services at **1-855-839-7613** (TTY **711**); or
- If you are unable to access the electronic form (or obtain the paper form), mail the minimum amount of information we need to process your claim:
    - 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
    - A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

Mailing address to submit your claim to Kaiser Permanente in Northern California:

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Mailing address to submit your claim to Kaiser Permanente in Southern California:

Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

3. How to get care

Getting health care services

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

The coverage information in this Member Handbook applies when you get health care services in your Home Region Service Area. Your Home Region is the Kaiser Permanente Region where you are enrolled. It is either our Northern California Region or the Southern California Region. The name of your Home Region is printed on your Kaiser Permanente ID Card. If you visit the other California Region, you are covered only for Emergency Care, Urgent Care, and Family Planning Services, unless we pre-approve the services for you. If you visit a Kaiser Permanente Region outside California, you are covered only for Emergency Care or Urgent Care, unless we pre-approve the services for you. For more information on how to find Medi-Cal Network Providers in your Home Region Service Area, go to our provider listings on kp.org/finddoctors or call our Member Services at **1-855-839-7613** (TTY **711**)**.**

We provide services to our Members through our Medi-Cal Network Providers. They work together to provide you with quality care. When you choose Kaiser Foundation Health Plan, Inc. as your managed care plan, you are choosing to get your care through our medical care program. To find where our Medi-Cal Network Providers are located, visit our website at kp.org/finddoctors**.** For more information, call our Member Services at **1-855-839-7613** (TTY **711**)**.**

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

New members with only Medi-Cal coverage must choose a primary care provider (“PCP”) in the Medi-Cal provider network. New members with both Medi-Cal and comprehensive

other health coverage do not have to choose a PCP. However, we encourage all Members to choose a PCP.

The Kaiser Permanente Medi-Cal provider network is a group of doctors, hospitals, and other providers who work with us. You must choose a PCP within 30 days from the time you become a member with us. If you do not choose a PCP, we will choose one for you.

You can choose the same PCP or different PCPs for all family members in the Kaiser Permanente Medi-Cal Plan, as long as the PCP is available.

If you have a doctor you want to keep, or you want to find a new PCP, go to your Kaiser Permanente Medi-Cal Provider Directory for a list of all PCPs and other providers in our Medi-Cal provider network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call our Member Services at **1-855-839-7613** (TTY **711**). You can find our searchable provider directory at kp.org/finddoctors. You can also download a Medi-Cal Provider Directory from our website at kp.org/Medi-Cal/documents**.** For more information, call our Member Services at **1-855-839-7613** (TTY **711**).

- In Northern California, if you cannot get the care you need from a Kaiser Permanente Medi-Cal provider network, your PCP will ask The Permanente Medical Group for approval to send you to an Out-of-Network Medi-Cal Provider. This is called an Out-of-Network Referral. You do not need approval to go to an Out-of-Network Medi-Cal provider to get Sensitive Care, which is described under the heading “Sensitive care” later in this chapter of this Member Handbook
- In Southern California, if you cannot get the care you need from a Kaiser Permanente Medi-Cal provider network, your PCP will ask the Southern California Permanente Medical Group for approval to send you to an Out-of-Network Medi-Cal Provider. This is called an Out-of-Network Referral. You do not need approval to go to an Out-of-Network Medi-Cal Provider to get Sensitive Care, which is described under the heading “Sensitive Care” later in this chapter of this Member Handbook.

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

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

Primary care provider ("PCP")

Your primary care provider ("PCP") is the licensed provider you go to for most of your health care. Your PCP also helps you get other types of care you need. You must choose a PCP within 30 days of enrolling in our Medi-Cal Plan.

To help you find a doctor who is right for you, you can browse our online doctor profiles at kp.org/finddoctors. You can find out which doctors are taking new patients and choose one who matches your needs.

Adults can choose a PCP from the following:

- Adult medicine/internal medicine
- Family medicine
- Specialists in OB/GYN whom The Permanente Medical Group or the Southern California Permanente Medical Group designates as PCPs

For children up to age 18, you can choose a doctor from Pediatrics/adolescent medicine or Family medicine to be your child's PCP. Each covered family member can choose their own personal doctor. Depending on the type of provider, you may be able to choose one PCP for your entire family who are Members of Kaiser Permanente. If you are in both Medicare and Medi-Cal or if you have comprehensive other health care insurance, you do not have to choose a PCP. However, we encourage you to do so.

You can also choose your primary health care at a Federally Qualified Health Center ("FQHC"), an Indian Health Care Provider ("IHCP"), or a Rural Health Clinic ("RHC") in our network. Depending on the type of provider, you might be able to choose one PCP for yourself and your other family members who are members of Kaiser Permanente, as long as the PCP is available.

Note: American Indians can choose an IHCP as their PCP, even if the IHCP is not in our

Medi-Cal Network Providers.

If you do not choose a PCP within 30 days of enrollment, we will assign you to a PCP.

You can change to another available doctor in our Medi-Cal provider network at any time, for any reason. You can change your doctor online anytime at kp.org or you can call our Member Services at **1-855-839-7613** (TTY **711**). If you choose your PCP from The Permanente Medical Group or the Southern California Permanente Medical Group, your choice will become your PCP immediately. If you choose your PCP from another site, such as an FQHC, your change happens on the first day of the next month.

Your PCP will:

- Get to know your health history and needs
- Keep your health records
- Give you the preventive and routine health care you need
- Refer (send) you to a specialist if you need one
- Arrange for hospital care if you need it. In some cases, a specialist can also arrange for hospital care if you need it

You can look in your Medi-Cal Provider Directory to find a PCP in the Kaiser Permanente Medi-Cal provider network. The Medi-Cal Provider Directory has a list of providers that work with Kaiser Permanente to provide Covered Services, including IHCPs, FQHCs, and RHCs.

You can find the searchable Kaiser Permanente Medi-Cal Provider Directory online at **kp.org/finddoctors.** You can also request a Medi-Cal Provider Directory to be mailed to you by calling our Member Services at **1-855-839-7613** (TTY **711**). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

It is best if you choose your PCP.

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

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

If you choose your PCP from The Permanente Medical Group or the Southern California Permanente Medical Group, your choice will become your PCP immediately. If you choose your PCP from another site, such as an FQHC, your choice will be effective on the first day of the next month after you make the change. To learn how to select or change your PCP, call our Member Services at **1-855-839-7613** (TTY **711**).

We may change your PCP if the PCP is not taking new patients, has left our Medi-Cal provider network, does not give care to patients your age, or if there are quality concerns with the PCP that are not resolved. We or your PCP might also ask you to change to a new PCP if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If we need to change your PCP, we will tell you in writing.

Some things to think about when picking a PCP

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

Initial Health Appointment ("IHA")

For Medi-Cal Members who are new to Kaiser Permanente

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

If your PCP is at a facility that is not part of The Permanente Medical Group or the Southern California Permanente Medical Group:

- When you call to schedule your first health appointment, tell the person who answers the phone that you are a Kaiser Permanente Medi-Cal Member. Give them your Kaiser Permanente ID number.

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

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

For Medi-Cal Members with prior Kaiser Permanente coverage

If you are new to Medi-Cal and your previous health coverage was also with Kaiser Permanente, please contact your PCP to see if you need an Initial health appointment ("IHA"). If your medical record is current, you may be able to wait until your next scheduled Routine Care visit to make any additional updates to your medical record.

Home Region	**Phone number to schedule an appointment**
Northern California	If you have questions about your first health appointment, call our Member Services at **1-833-721-6012** (TTY **711**), Monday through Friday, 8:30 a.m. to 1 p.m. and 2 p.m. to 5 p.m.
Southern California	If you have questions about your first health appointment, call our Member Services at **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week (except closed holidays).

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or

well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular check-ups, screenings, immunizations, health education, and counseling.

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

Routine care also includes care when you are sick. We cover routine care from your Medi-Cal provider network.

Your PCP will:

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

Home Region	**Phone number to schedule an appointment**
Northern California	**1-866-454-8855** (TTY **711**), 24 hours a day, 7 days a week or go to kp.org
Southern California	**1-833-574-2273** (TTY **711**), 24 hours a day, 7 days a week or go to kp.org

For Emergency Care, call **911** or go to the nearest hospital.

To learn more about health care and services we cover and what it does not cover, read

Chapter 4, “Benefits and services” and Chapter 5, “Child and youth well care”, of this Member Handbook.

All Medi-Cal Provider Network can use aids and services to communicate with people with disabilities. They can also communicate with you in another language or format. Tell your provider or call us to tell us what you need.

Medi-Cal Provider Network

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

Kaiser Foundation Health Plan, Inc. is a managed care health plan. When you choose our Medi-Cal Plan, you are choosing to get your care through our medical care program. You must get most of your covered services from our Medi-Cal network providers. You can go to an Out-of-Network Provider without a referral or pre-approval for Emergency Care. You can also go to an Out-of-Network Medi-Cal Provider for family planning services without a referral or pre-approval. You can also go to an Out-of-Network provider for out-of-area Urgent Care when you are outside your Home Region Service Area. Except for these instances, you must have a referral or pre-approval for all other out-of-network services, or they will not be covered.

Note: American Indians can choose an Indian Health Care Provider (“IHCP”) as their PCP, even if the IHCP is not in our Medi-Cal provider network.

Your PCP, hospital, or other provider has a moral objection to providing you with a covered service, such as family planning or abortion, they can help you find another Medi-Cal network provider who will give you the services you need. You can also call our Member Services at **1-855-839-7613** (TTY **711**) to ask for help finding another Medi-Cal Network Provider. For more about moral objections, read the “Moral objection” section later in this chapter.

Medi-Cal Network Providers

You will use providers in the Kaiser Permanente Medi-Cal provider network for most of your health care needs. You will get preventive and routine care from our Medi-Cal Network Providers. You will also use specialists, hospitals, and other providers in the Kaiser Permanente Medi-Cal provider network.

To get a copy of the Medi-Cal Provider Directory for your area, call our Member Services at **1-855-839-7613** (TTY **711**). You can also find Kaiser Permanente Medi-Cal Network Providers and locations online at kp.org/finddoctors.

To get a copy of the Medi-Cal Rx Contract Drugs List, call Medi-Cal Rx at **1-800-977-2273** (TTY **1-800-977-2273**) and press **7** or **711**. Or go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

You must get pre-approval (prior authorization) from us before you go to a provider outside the Kaiser Permanente Medi-Cal provider network, even inside your Home Region Service Area, except in these cases:

- If you need Emergency Care, call 911 or go to the nearest hospital.
- If you are outside your Home Region Service Area and need urgent care, go to any urgent care facility.
- If you need family planning services, go to any Medi-Cal provider without pre-approval (prior authorization).
- If you need mental health services, go to an in-network provider or a county mental health plan provider, without pre-approval (prior authorization).

If you are not in one of the cases listed above and you do not get pre-approval (prior authorization) before getting care from an Out-of-Network Provider, you might be responsible for paying for any care you got from that Out-of-Network Provider. Kaiser Permanente providers who are outside your Home Region Service Area are Out-of-Network Providers.

Out-of-Network Providers inside your Home Region Service Area

Out-of-network providers are providers that do not have an agreement to work with Kaiser Permanente.

We must give you approval before you go to an Out-of-Network Provider inside the Home Region Service Area, except for:

- Emergency Care
- Sensitive care, as described under the “Sensitive Care” heading in this chapter

If you need medically necessary health care services that are not available in the Kaiser Permanente Medi-Cal provider network, you might be able to get them from an out-of-network provider for free. We will approve and refer you to an Out-of-Network Medi-Cal Provider to get those services. If we give you a referral to an Out-of-Network Medi-Cal Provider, we will pay for your care.

For urgent care inside the Home Region Service Area, you must go to a Kaiser Permanente Medi-Cal Network Provider. You do not need pre-approval (prior authorization) to get urgent care from one of our Medi-Cal Network Providers.

You must get our approval (prior authorization) to get Urgent Care from an Out-of-Network Medi-Cal Provider inside your Home Region Service Area. If you do not get pre-approval, you may have to pay for Urgent Care you get from an Out-of-Network Medi-Cal provider inside your Home Region Service Area. You can read more about Emergency Care, Urgent Care, and Sensitive Care services in this chapter.

Your Urgent Care provider might give you medication as part of your Urgent Care visit. If you get medications as part of your visit, we will cover the medications as part of your covered Urgent Care. If your urgent care provider gives you a prescription that you need to take to a pharmacy, Medi-Cal Rx will decide if it is covered. For more information on Medi-Cal Rx, go to the “Medi-Cal Rx” heading in the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” in Chapter 4, “Benefits and services”, of this Member Handbook.

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

If you need help with Out-of-Network services, call our Member Services at **1-855-839-7613** (TTY **711**).

Providers Outside your Home Region Service Area

Most Routine Care, including preventive care, is not covered outside your Home Region Service Area. Family planning services are covered outside your Home Region Service Area when obtained from a qualified Medi-Cal provider in California. For more information on family planning services, go to the heading “Sensitive Care” in Chapter 4, “Benefits and services”, of this Member Handbook.

If you are outside of your Home Region Service Area and need care that is **not** Emergency Care or Urgent Care, call our advice line phone number on the back of your Kaiser Permanente ID card, and talk to a licensed health care professional, 24 hours a day, 7 days a week.

Your Urgent Care provider might give you medication as part of your Urgent Care visit. If you get medications as part of your visit, we will cover the medications as part of your covered Urgent Care. If your urgent care provider gives you a prescription that you need to take to a pharmacy, Medi-Cal Rx will decide if it is covered. For more information on Medi-Cal Rx, go to the “Medi-Cal Rx” heading in the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” in Chapter 4, “Benefits and services”, of this Member Handbook.

If you need urgent care outside of your Home Region Service Area, go to the nearest urgent care facility. Medi-Cal does not cover Urgent Care services outside of the United States. If you are traveling outside of the United States and need Urgent Care, we will not pay for your care. For more on urgent care, read “Urgent care” later in this chapter.

For emergency care, call **911** or go to the nearest hospital. Kaiser Permanente covers Out-of-Network Emergency Care. If you travel to Canada or Mexico and need Emergency Care requiring hospitalization, Kaiser Permanente will cover your care. We do not cover other services in Canada or Mexico. If you are traveling abroad outside of Canada or Mexico and need Emergency Care, Urgent Care, or any health care services we will **not** cover your care.

If you paid for emergency care requiring hospitalization in Canada or Mexico, you can ask us to pay you back. Submit a claim form and we will review your request. For more information on filing a claim, see the “Ask us to pay a bill” section in Chapter 2, “About your health plan”, of this handbook.

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

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

If you are outside of California and have an emergency need to fill outpatient prescription drugs, have the pharmacy call Medi-Cal Rx at **1-800-977-2273**, 24 hours a day, 7 days a week.

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

Out-of-Network Providers for CCS-Eligible Conditions

The California Children's Services ("CCS") program is a state program that treats children under 21 years of age who have certain health conditions, diseases, or chronic health problems and meet the CCS program rules. If you need health care services for a CCS-eligible medical condition and we do not have a CCS-paneled specialist in our Medi-Cal provider network who can provide the care you need, you may be able to go to a provider outside of the provider network for free. To learn more about the CCS program, read Chapter 4, "Benefits and services", of this Member handbook.

If you have questions about services available from Out-of-Network Medi-Cal Providers or outside your Home Region Service Area, call our Member Services at **1-855-839-7613** (TTY **711**).

How Managed Care Works

Kaiser Permanente provides health care services directly to Members through an integrated medical care program. Our medical care program gives you access to most of the Covered Services you may need, such as routine care, hospital care, laboratory and 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.

Sometimes, you might need a service that is not available from a provider in our Medi-

Cal provider network. In that case, The Permanente Medical Group (Northern California) or the Southern California Permanente Medical Group (Southern California) will authorize a referral to an Out-of-Network Medi-Cal Provider. You do not need pre-approval (prior authorization) for emergency services, family planning services, or in-network mental health services.

Members who have both Medicare and Medi-Cal

Beneficiaries with both Medicare and Medi-Cal coverage are Dually Eligible beneficiaries. If you have both Medicare and Medi-Cal coverage, your Medicare coverage will always pay first for covered services. Medi-Cal is always the payor of last resort.

Our Medi-Cal plan does not cover routine care services or transportation to routine care services outside of your Home Region Service Area. Medi-Cal covers only Emergency Care, including emergency transportation, Urgent Care, and some Sensitive Care services when you are outside of your Home Region Service Area.

If your Medicare coverage is with Kaiser Permanente

When you are away from home, your Kaiser Permanente Medicare plan will be the primary payor for services you receive. Please see your Kaiser Permanente Medicare Evidence of Coverage for coverage details. Medi-Cal coverage outside of your Home Region Service Area is limited, as described above.

In most cases, your Medicare Part D prescription drug coverage requires you to get your prescriptions filled at pharmacies in the Kaiser Permanente Medicare network. If you go to a Medi-Cal Rx pharmacy outside of the Kaiser Permanente network, your Medicare plan may not cover your prescriptions. Since Medicare pays first, we encourage you to use our Plan Pharmacies for your prescriptions. See your Medicare pharmacy directory for information on network pharmacies.

If you already have a Kaiser Permanente PCP, you do not need to choose another PCP for your Medi-Cal coverage.

If your Medicare coverage is not with Kaiser Permanente

For information on your Medicare drug coverage, see your Medicare coverage documents from your FFS Medicare coverage or your Medicare plan. Remember that Medicare pays first, so you may be required to obtain your Part D drugs through your Medicare plan and

not through us. We will work with your Medicare plan or your Medicare providers to help coordinate your care.

You will need to choose a Kaiser Permanente PCP for your Medi-Cal coverage.

Doctors

You will choose a doctor or other provider from the Kaiser Permanente Medi-Cal Provider Directory as your PCP. The PCP you choose must be a Medi-Cal Network Provider. To find a PCP near you, you can look on our website at kp.org/finddoctors. You can download a copy of your Medi-Cal Provider Directory at kp.org/Medi-Cal/documents. You can also call our Member Services at **1-855-839-7613** (TTY **711**).

You can call our Member Services or check our online provider directory at kp.org/finddoctors to be sure the PCP you want is taking new patients.

If you had a doctor before you were a member of Kaiser Permanente, and that doctor is not part of our Medi-Cal provider network, you might be able to keep that doctor for a limited time. This is called Continuity of Care. You can read more about continuity of care in this handbook. To learn more, call our Member Services at **1-855-839-7613** (TTY **711**).

If you need a specialist, your PCP will refer you to a specialist in the Kaiser Permanente Medi-Cal provider network. Some specialists do not require a referral. For more on referrals, read “Referrals” later in this chapter.

Remember, if you do not choose a PCP, we will choose one for you, unless you have other comprehensive health coverage in addition to Medi-Cal. You know your health care needs best, so it is best if you choose.

If you want to change your PCP, you must choose a PCP from the Kaiser Permanente Medi-Cal provider network. You can access our searchable online Medi-Cal Provider Directory at **kp.org/finddoctors**. Be sure the PCP is taking new patients. To learn how to select or change to a different PCP, please visit our website at **kp.org** or call our Member Services at **1-855-839-7613** (TTY **711**)

Hospitals

For Emergency Care, call **911** or go to the nearest hospital.

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in our Medi-Cal provider network. To find our

Medi-Cal network hospitals you can look on our website at kp.org/facilities. You can also call our Member Services at **1-855-839-7613** (TTY **711**).

Women's health specialists

You can go to a women's health specialist within the Kaiser Permanente Medi-Cal provider network for covered care necessary to provide women's preventative and routine care services. You do not need a referral or authorization from your PCP to get these services. For help finding a women's health specialist, you can call our Member Services at **1-855-839-7613** (TTY **711**). You may also call **1-866-454-8855** (TTY **711**) and talk to a licensed health care professional,24 hours a day, 7 days a week.

For family planning services, your provider does not have to be in the Kaiser Permanente Medi-Cal provider network. You can choose any Medi-Cal provider and go to them without a referral or pre-approval (prior authorization). For help finding a Medi-Cal provider outside our Medi-Cal provider network, call our Member Services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays)

Medi-Cal Provider Directories

Kaiser Permanente Medi-Cal Provider Directories lists providers in the Kaiser Permanente Medi-Cal provider network. The network is the group of providers that work with Kaiser Permanente to provide Medi-Cal Covered Services.

There are six Medi-Cal Provider Directories in the Northern California Region and six Medi-Cal Provider Directories in the Southern California Region. Each Provider Directory is for the specific area that we serve. For example, if you live in Santa Clara County, the South Bay and Peninsula directory lists the Medi-Cal Network Providers in your county.

The table below can help you decide which Provider Directory will have the providers closest to you. You may see any Kaiser Permanente Medi-Cal Network Provider in your Home Region Service Area.

Where You Live in Northern California	**Medi-Cal Provider Directory that may be most helpful to you**
Sacramento, Amadaor, El Dorado, Placer, Sutter and Yuba Counties	Sacramento Area

San Francisco, Marin, and Sonoma counties; and ZIP Codes 94515 and 95476 in Napa County	San Francisco, Marin, and Sonoma Areas
Eastern Contra Costa County, and Solano and Yolo counties; ZIP Codes 94505, 94514, 94550, 94551, 94566, 94568, 94586, and 94588 in Alameda County; and Napa County excluding ZIP Codes 94515 and 95476	Diablo, Napa, Solano and Yolo Areas
San Mateo, Santa Clara, and Santa Cruz Counties	South Bay and Peninsula Areas
Fresno, Kings, Madera, Mariposa, San Joaquin, Stanislaus, and Northern Tulare counties, and ZIP Codes 95377 and 95391 in Alameda County	Central California Area

Where You Live in Southern California	**Medi-Cal Provider Directory that may be most helpful to you**
Riverside and San Bernardino counties; and ZIP Codes 91711, 91759, 91766, and 91767 in Los Angeles County	Inland Empire and Coachella Valley Areas

Kern, Northern Los Angeles, Southern Tulare, and Ventura Counties	Kern County, Valleys, and WVC Areas
Central Los Angeles County	Los Angeles Area
Eastern and Southern Los Angeles County	Baldwin Park, Bellflower, and South Bay Areas
Orange County; and ZIP Codes 90623, 90630, 90631, 90637, 90638, and 90639 in Los Angeles County	Orange County Area
San Diego and Imperial counties	San Diego and Imperial Areas

The Kaiser Permanente Medi-Cal Provider Directory includes the following types of providers that are in our Medi-Cal provider network:

- Hospitals
- PCPs
- Specialists
- Nurse practitioners, and Nurse midwives
- Physician assistants
- Family planning providers
- Federally Qualified Health Centers (" FQHCs"), where available
- Outpatient mental health providers
- Freestanding Birth Centers ("FBCs")
- Indian Health Care Providers ("IHCPs"),
- Long-term services and supports ("LTSS")
- Rural Health Clinics ("RHCs"), where available
- Enhanced Care Management Providers ("ECM")
- Community Supports Providers ("CS")

The Medi-Cal Provider Directories have Kaiser Permanente Medi-Cal Network provider names, specialties, addresses, phone numbers, business hours, and languages spoken. They also tell you if the provider is taking new patients. The Medi-Cal Provider Directories give the level of physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars.

If you want information about a doctor's education, professional qualifications, residency completion, training, and board certification, call our Member Services at **1-855-839-7613** (TTY **711**).

You can find the online, searchable, Provider Directory at **kp.org/finddoctors**. On the website, go to the Advanced Search link, and select "Medi-Cal Managed Care" in the Health Plan field to make sure you get the listing of Medi-Cal providers. You can download a copy of any of our Medi-Cal directories at **kp.org/Medi-Cal/documents**

If you need a printed Provider Directory or want to request an alternate format, call our Member Services at **1-855-839-7613** (TTY **711**).

You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at https://medi-calrx.dhcs.ca.gov/home/. You can also find a participating pharmacy near you by calling Medi-Cal Rx Customer Service at **1-800-977-2273,** 24 hours a day, 7 days a week. TTY users can call **1-800-977-2273** and press **7** or **711,** Monday through Friday, 8 a.m. to 5 p.m.

Timely access to care

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

Appointment type	**You should be able to get an appointment within:**
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours

Appointment type	You should be able to get an appointment within:
Urgent care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent (routine) primary care appointments	10 business days
Non-urgent (routine) specialist care appointments	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days
Non-urgent (routine) mental health provider (non-doctor) follow-up care appointments	10 business days of the last appointment
Non-urgent (routine) appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness, or other health condition	15 business days

Other wait time standards	You should be able to get connected within:
Telephone wait times for Member Services during normal business hours	10 minutes
Telephone wait times for the Appointment and Advice Line	30 minutes (to connect to a nurse for advice)

Sometimes waiting longer for an appointment is not a problem. Your provider might give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health. You can choose to wait for a later appointment or call Kaiser Permanente to go to another provider of your choice. Your provider should respect your wish.

Your doctor may recommend a specific schedule for preventive services, follow-up care

for ongoing conditions, or standing referrals to specialists, depending on your needs.

Interpreter services

Tell us if you need interpreter services, including sign language, when you call us or when you get covered services, please let us know. Interpreter services are available for free. We highly discourage the use of minors or family members as interpreters. To learn more about the interpreter services we offer, call our Member Services at **1-855-839-7613** (TTY **711**).

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

Travel time or distance to care

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

If we are not able to arrange for a Medi-Cal Network Provider within these travel time or distance standards, DHCS may allow a different standard, called an alternative access standard. For our time or distance standards for where you live, visit our website: **kp.org/Medi-Cal/documents.** Or call our Member Services at **1-855-839-7613** (TTY **711**).

It is considered far if you cannot get to that Medi-Cal Provider within the travel time and distance standards for your county, regardless of any alternative access standard that we might use for your ZIP Code.

If you need care from a provider located far from where you live, call our Member Services at **1-855-839-7613** (TTY **711**). They can help you find a Medi-Cal provider located closer to you. If we cannot find care for you from a closer Medi-Cal provider, you can ask to arrange transportation for you to go to your provider, even if that provider is located far from where you live.

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

Appointments

When you need health care:

- In Northern California, call **1-866-454-8855** (TTY **711**), 24 hours a day, 7 days a week to schedule an appointment.
- In Southern California, call **1-833-574-2273** (TTY **711**), 24 hours a day, 7 days a week. You can also schedule some types of appointments online at **kp.org.**
- Have your Kaiser Permanente medical record number (located on your Kaiser Permanente ID card) ready when you call.
- Take your Medi-Cal BIC card, Kaiser Permanente ID card, and photo ID to your appointment.
- Ask for transportation to your appointment, if needed.
- Ask for language assistance or interpreter services if needed when you schedule your appointment.
- Be on time for your appointment, arriving a few minutes early to sign in, fill out forms, and answer any questions your provider may have
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

For Emergency Care, call 911 or go to the nearest hospital.

Getting to your appointment

If you don't have a way to get to and from your appointments for covered services, we can help arrange transportation for you. Depending on your situation, you may qualify for either Medical Transportation or Non-Medical Transportation. These transportation services are not for emergencies and may be available for free.

If you are having a medical emergency, call **911** or go to the nearest hospital.

Go to the section "Transportation services for situations that are not emergencies" in Chapter 4, "Benefits and services", of this Member Handbook for more information about

transportation services that are available to you.

Canceling and rescheduling

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

Telehealth services

Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider by phone, video, or other means. Or telehealth may involve sharing information with your provider without a live conversation. You can get many services through telehealth. Telehealth visits are intended to make it more convenient for you to receive Covered Services, when a Medi-Cal Network Provider determines it is medically appropriate for your medical condition. Telehealth may not be available for all Covered Services. You are not required to use telehealth. Some Medi-Cal Network Providers offer services only through a telehealth and have no physical location at which you can receive Covered Services. You can choose to receive in-person Services from a Medi-Cal Network Provider instead.

Payment

You do **not** have to pay for covered services unless you have a share of cost for long-term care. To learn more, read "For members with long-term care and a share of cost" in Chapter 2, "About your health plan", of this Member Handbook.

In most cases, you will not get a bill from a provider. You must show your Kaiser Permanente ID card, your Medi-Cal BIC card, and your photo ID when you get any health care services or prescriptions. Your ID Card will tell your doctors where to send the bill. You might get an Explanation of Benefits ("EOB") from us or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call our Member Services at **1-855-839-7613** (TTY **711**).

If you get a bill for prescriptions, call Medi-Cal Rx at **1-800-977-2273** (TTY 1**-800-977-2273**) and press **7** or **711**. Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Tell us the amount charged, the date of service, and the reason for the bill. We will help you figure out if the bill was for a covered service or not. You do not need to pay providers for any amount owed by Kaiser Permanente for any covered service.

You must get pre-approval (prior authorization) before you go to an Out-of-Network Medi-Cal Provider except when you need:

- Emergency Care
- Urgent Care outside your Home Region Service Area
  - Inside your Home Region Service Area, you need pre-approval (prior authorization) to see an Out-of-Network Medi-Cal Provider for Urgent Care
- Some Sensitive Care as described later in this chapter

If you do not get pre-approval, you may have to pay for care from providers who are outside our Medi-Cal provider network. For more information on emergency care, urgent care, and sensitive care services, go to those headings in this chapter.

If you need to get Medically Necessary Services that are covered by Medi-Cal and are not available in the Kaiser Permanente Medi-Cal provider network, we will approve and refer you to an out-of-network provider to get those services. To learn more about emergency care, urgent care, and sensitive services, go to those headings in this chapter.

If you get a bill or are asked to pay a copay that you think did not have to pay, you can also file a claim form. You will need to tell us in writing about the item or service you paid for. We will read your claim and decide if you can get money back.

You can get a claim form online at kp.org. You can also call our Member Services at **1-855-839-7613** (TTY **711**). We will be happy to help you if you need help completing our claim form.

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

Referrals

If you need to see a specialist that requires a referral, your PCP or another specialist will give you a referral to one. A specialist is a provider who focuses on one type of health care service. The doctor who refers you will work with you to choose a specialist. To help make sure you can go to a specialist in a timely way, DHCS sets timeframes for members to get appointments. These timeframes are listed in the "Timely access to care" section in this Member Handbook. Your doctor's office can help you set up an appointment with a specialist.

Other services that might need a referral include in-office procedures, X-rays or other imaging, and lab work.

If you have a health problem that needs special medical care for a long time, you might need a standing referral. Having a standing referral means you can go to the same specialist more than once without getting a referral each time.

If you have trouble getting a standing referral or want a copy of our referral policy, call our Member Services at **1-855-839-7613** (TTY **711**).

You do **not** need a referral for:

- PCP visits
- Obstetrics/Gynecology ("OB/GYN") visits
- Specialists in Optometry
- Mental Health Services for mild to moderate conditions, including initial mental health assessments
- Urgent Care from a Medi-Cal Network Provider
- Emergency Care visits
- Adult sensitive services, such as sexual assault care
- Family planning services (to learn more, call the Office of Family Planning Information and Referral Service at **1-800-942-1054**)
- HIV testing and counseling (12 years or older)

- Services for Sexually transmitted infection services (12 years or older)
- Chiropractic services (a referral may be required when provided by out-of-network FQHCs, RHCs, and IHCPs)

Minors can also get certain outpatient mental health services, sensitive care services, and substance use disorder treatment services without their parents' or guardian's consent.

To learn more information, read "Minor consent services" later in this chapter and "Substance use disorder treatment services" in Chapter 4, "Benefits and services", of this Member Handbook.

California Cancer Equity Act referrals

Effective treatment of complex cancers depends on many factors. These include getting the right diagnosis and getting timely treatment from cancer experts. If you are diagnosed with a complex cancer, the new California Cancer Care Equity Act allows you to ask for a referral from your doctor to get cancer treatment specifically from an in-network National Cancer Institute ("NCI")-designated cancer center, NCI Community Oncology Research Program ("NCORP")-affiliated site, or a qualifying academic cancer center.

If we do not have an NCI-designated cancer center or NCORP-affiliated site, or qualified academic cancer center in our Medi-Cal provider network in your county, you can ask for a referral to a qualified Out-of-Network cancer center in California. For services to be covered at an Out-of-Network cancer center all of the following must apply:

- The requested services must be Medically Necessary
- The Medically Necessary services must be available at the cancer center
- The cancer center must agree to our payment terms

You can also request a referral to another qualified cancer center in our network.

If you have been diagnosed with cancer, talk with your doctor to find out if you qualify for services from one of these cancer centers.

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

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

Pre-approval (prior authorization)

Prior authorization in Northern California

For the services listed under the heading "Services that need Pre-Approval (Prior Authorization)" later in this chapter, your PCP or specialist will need to ask The Permanente Medical Group for permission before you get the care. This is called asking for pre-approval or prior authorization. It means that The Permanente Medical Group must make sure the care is medically necessary (needed).

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

Under Health and Safety Code Section 1367.01(h)(1), The Permanente Medical Group has 5 business days from when they get the information reasonably needed to decide (approve or deny) pre-approval (prior authorization) requests.

For requests in which a provider indicates, or the applicable The Permanente Medical Group designee determines that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, The Permanente Medical Group will make an expedited (fast) authorization decision in no longer than 72 hours. We will give you notice as quickly as your health condition requires and no later than 72 hours after getting the request for services.

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

We do not influence the reviewers' decision to deny or approve coverage or services in any way. If The Permanente Medical Group does not approve the request, we will send you a Notice of Action ("NOA") letter. The NOA will tell you how to file an appeal if you do

not agree with the decision.

We will contact you if The Permanente Medical Group needs more information or more time to review your request.

Prior authorization in Southern California

For the services listed under the heading “Services that need Pre-Approval (Prior Authorization)” later in this chapter, your PCP or specialist will need to ask the Southern California Permanente Medical Group for permission before you get the care. This is called asking for prior authorization, prior approval, or pre-approval. It means that the Southern California Permanente Medical Group must make sure that the care is Medically Necessary or needed.

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

Under Health and Safety Code Section 1367.01(h)(1), the Southern California Permanente Medical Group has 5 business days from when they get the information reasonably needed to decide (approve or deny) pre-approval (prior authorization) requests.

For requests in which a provider indicates, or the applicable Southern California Permanente Medical Group designee determines, that following the standard timeframe could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, Southern California Permanente Medical Group will make an expedited (fast) authorization decision. We will give notice as quickly as your health condition requires and no later than 72 hours after getting the request for services.

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

We do not influence the reviewers’ decisions to deny or approve coverage or services in any way. If the Southern California Permanente Medical Group does not approve your request, we will send you a Notice of Action (“NOA”) letter. The NOA will tell you how to

file an appeal if you do not agree with the decision.

We will contact you if the Southern California Permanente Medical Group needs more information or more time to review your request.

Services that need Pre-Approval (Prior authorization)

The following are examples of services that always need pre-approval:

- Acupuncture services when you need more than two visits per month
- Community-Based Adult Services (“CBAS”)
- Dental anesthesia
- Durable medical equipment
- Home health care
- Ostomy and urological supplies
- Prosthetics and orthotics
- Services not available from Medi-Cal Network Providers
- Transplants
- Medical Transportation when it is not an emergency

Emergency Care, including emergency ambulance services, does not require pre-approval (prior authorization).

You never need pre-approval (prior authorization) for emergency care, even if it is Out-of-Network or outside your Home Region Service Area. This includes labor and delivery if you are pregnant. You do not need pre-approval for most Sensitive Care services. For more information on Sensitive Care, go to the section “Sensitive Care” later in this chapter.

For the complete list of services that require pre-approval, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Services at **1-855-839-7613** (TTY **711**).

Second opinions

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

We will pay for a second opinion if you or your Medi-Cal Network Providers ask for it, and you get the second opinion from Medi-Cal Network Provider. You do not need permission from us to get a second opinion from a Medi-Cal Network Provider. Your Medi-Cal Network Provider can help you get a referral for a second opinion if you need one.

To get a second opinion, call your PCP. Your PCP can refer you to a Medi-Cal Network Provider who is an appropriately qualified medical professional for your medical condition for a second opinion. You may also call our Member Services at **1-855-839-7613** (TTY **711**) to help you arrange one with a Medi-Cal Network Provider.

If there is no qualified Medi-Cal Network Provider to give you a second opinion, our Member Services will help you get a second opinion with an out-of-network provider. If we refer you to an Out-of-Network Provider for a second opinion, we will pay for the second opinion. We will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic, severe, or serious illness, or face an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, we will decide within 72 hours.

If we deny your request for a second opinion, you can file a grievance. To learn more about grievances, read “Complaints” in Chapter 6, “Reporting and solving problems”, of this Member Handbook.

Sensitive care

Minor consent services

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

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

- Services for rape and other sexual assaults
- Pregnancy testing and counseling
- Contraception services such as birth control (excludes sterilization)
- Abortion services

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

- Outpatient mental health services and counseling, or residential shelter services, based on your maturity and ability to participate in your own health care
- HIV/AIDS counseling, prevention, testing, and treatment
- Sexually transmitted infection prevention, testing, and treatment which may include sexually transmitted diseases like syphilis, gonorrhea, chlamydia, and herpes simplex
- Substance use disorder treatment for drug and alcohol abuse including screening, assessment, intervention, and referral services
    - To learn more, read "Substance Use Disorder Treatment Services" in Chapter 4, "Benefits and services", of this Member Handbook.

For pregnancy testing, contraception services, or services for sexually transmitted infections the doctor or clinic does not have to be in the Kaiser Permanente Medi-Cal provider network. You can choose any Medi-Cal provider and go to them for these services without a referral or pre-approval (prior authorization). For more information related to family planning services, go to the "Preventive and Wellness Services and Chronic Disease Management" in Chapter 4, "Benefits and services", of this Member Handbook. Services from an out-of-network provider that are not related to Sensitive Care may not be covered. To find a Medi-Cal provider who is outside the Kaiser Permanente Medi-Cal network, or to ask for transportation help to get to a provider, call our Member Services at **1-855-839-7613** (TTY **711**).

For minor consent services that are outpatient mental health services, you can go to a Medi-Cal Provider Network or Out-of-Network Medi-Cal Provider without a referral and without pre-approval (prior authorization). Your PCP does not have to refer you, and you

do not need to get pre-approval (prior authorization) from us to get covered minor consent services.

We do not cover minor consent services that are Specialty Mental Health Services. The County Mental Health Plan for the county where you live covers minor consent services that are Specialty Mental Health Services. For specialty mental health services, call your county mental health plan 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, go to: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Minors can talk to a representative in private about their health concerns by calling the Advice line for your Home Region:

Home Region	**Advice Number**
Northern California	**1-866-454-8855** (TTY **711**), 24 hours a day, 7 days a week
Southern California	**1-833-574-2273** (TTY **711)**, 24 hours a day, 7 days a week

If you are able to consent to your own care without the consent of a parent or guardian under the law, we will not give information on your sensitive care services to your plan non-policyholder or primary subscriber or to any Kaiser Permanente enrollees without your written permission. You can also ask to get private information about your medical services in a certain form or format, if available, and have it sent to you at another location.

To learn more about how to ask for confidential communications related to sensitive services, read "Notice of privacy practices" in Chapter 7, "Rights and responsibilities", of this Member Handbook.

Adult sensitive care services

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

- Family planning/birth control (including sterilization services for adults 21 and

older)

- Pregnancy testing and counseling and other pregnancy-related services
- HIV/AIDS prevention/testing/treatment
- Sexually transmitted infections prevention/testing/treatment
- Sexual assault care
- Outpatient abortion services

For adult sensitive care, services, your provider does not have to be a Kaiser Permanente Medi-Cal Network Provider. You can choose to go to any Medi-Cal provider for these services without a referral or pre-approval (prior authorization) from us. If you get care not listed here as sensitive care from an Out-of-Network Medi-Cal provider, you might have to pay for it if you do not have a referral or prior authorization.

If you need help finding a doctor or clinic for these services or if you need help getting to these services (including transportation), call our Member Services at **1-855-839-7613** (TTY **711**). You may also call the advice line on your Health Plan ID Card and talk to a licensed health care professional, 24 hours a day, 7 days a week.

We will not give information on your sensitive care services to your Kaiser Permanente plan policyholder or primary subscriber, or to any Kaiser Permanente enrollees, without your written permission. You can get private information about your medical services in a certain form or format, if available, and have it sent to you at another location.

To learn more about how to request confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7, “Rights and responsibilities”, of this Member Handbook.

Moral objection

Some providers have a moral objection to some covered services. They have a right to **not** offer some covered services if they morally disagree with the services. These services are still available to you from another provider. If your provider has a moral objection, they will help you find another provider for the needed services. Kaiser Permanente can also help you find a provider. If you need help getting a referral to a different provider, call our Member Services at **1-855-839-7613** (TTY **711**).

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

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

To make sure you choose a provider who can give you the care you and your family need, call the doctor, medical group, independent practice association, or clinic you want. Ask if the provider can and will provide the services you need. Or call our Member Services at **1-855-839-7613** (TTY **711**).

These services are available to you, and we will make sure you and your family members can see providers (doctors, hospitals, and clinics) who will give you the care you need for the Covered Services. If you have questions or need help finding a provider, call our Member Services at **1-855-839-7613** (TTY **711**).

Urgent care

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

For Urgent Care, call the Appointment and Advice Line for your Home Region:

Home Region	**Appointment and Advice Number**
Northern California	**1-866-454-8855** (TTY **711**), 24 hours a

	day, 7 days a week
Southern California	**1-833-574-2273** (TTY **711)**, 24 hours a day, 7 days a week

Urgent Care needs could be:

- A Cold
- Sore throat
- Fever
- Ear pain
- Sprained muscle
- Maternity services

When you are inside your Home Region Service Area and need Urgent Care, you must get Urgent Care Services from a Medi-Cal Network Provider. You do not need pre-approval (prior authorization) for Urgent Care from Medi-Cal Network Providers inside your Home Region Service Area.

If you are outside your Home Region Service Area, but inside the United States, you do not need pre-approval (prior authorization) to get Urgent Care. Go to the nearest Urgent Care facility.

Medi-Cal does not cover Urgent Care services outside the United States. If you are traveling outside the United States and need Urgent Care, we will **not** cover your care.

If you need mental health urgent care, call your county mental health plan or our Member Services at **1-855-839-7613** (TTY **711**). Call your County Mental Health Plan 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, go to: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

If you get medicines as part of your Urgent Care visit while you are there, we will cover them as part of your covered visit. If your urgent care provider gives you a prescription that you need to take to a pharmacy, Medi-Cal Rx will decide if it is covered. To learn more about Medi-Cal Rx, read "Prescription drugs covered by Medi-Cal Rx" in "Other

Medi-Cal programs and services not covered by Kaiser Permanente" in Chapter 4, "Benefits and services", of this Member Handbook.

We do not cover follow-up care from Out-of-Network Medi-Cal Providers after you no longer need Urgent Care, except for covered durable medical equipment. After your Urgent Care issue has been resolved, you must visit a Medi-Cal Network Provider for any needed follow-up care. If you need durable medical equipment related to your Urgent Care, your Out-of-Network Medi-Cal Provider must obtain pre-approval (prior authorization) from us.

Emergency care

For emergency care, call **911** or go to the nearest emergency room ("ER"). For emergency care, you do **not** need pre-approval (prior authorization) from us.

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

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

Emergency Care is for life-threatening medical conditions. This care is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you do not get care right away, you would place your health (or your unborn baby's health) in serious danger. This includes risking serious harm to your bodily functions, body organs, or body parts.

Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain
- Trouble breathing

- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts

Do **not** go to the ER for Routine Care or care that is not needed right away. You should get Routine Care from your PCP, who knows you best. You do not need to ask your PCP or us before you go to the ER. However, if you are not sure if you have an emergency, call your PCP. You can also call the advice line on the back of your Health Plan ID Card and talk to a licensed health care professional, 24 hours a day, 7 days a week.

If you need Emergency Care outside the Kaiser Permanente Home Region Service Area, go to the nearest ER hospital even if it is not in the Kaiser Permanente Medi-Cal Provider Network. If you go to an ER, ask them to call us. You or the hospital that admitted you should call Kaiser Permanente within 24 hours after you get emergency care. If you are traveling outside the United States other than to Canada or Mexico and need Emergency Care, Kaiser Permanente will **not** cover your care.

If you need emergency transportation, call **911**.

If you need care in an Out-of-Network hospital after your emergency (post-stabilization care), the hospital will call Kaiser Permanente.

If you or someone you know is in crisis, please contact the 988 Suicide and Crisis Lifeline: **Call or text 988** or **chat online at 988lifeline.org/chat**. The 988 Suicide and Crisis Lifeline offers free and confidential support for anyone in crisis. That includes people who are in emotional distress and those who need support for a suicidal, mental health, and/or substance use crisis.

Remember: Do not call **911** unless you reasonably believe you have a medical emergency. Get emergency care only for an emergency, not for routine care or a minor illness like a cold or sore throat. If it is an emergency, call **911** or go to the nearest ER.

Post-Stabilization Care

Post-stabilization care is the Medically Necessary services in a hospital (including the ER) that you get after the doctor who is treating you finds that your emergency medical condition is clinically stable. Post-stabilization care also includes durable medical equipment ("DME") only when all of the following conditions are met:

- The DME item is covered under this Member Handbook
- It is 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

For more information about covered durable medical equipment, go to the "Durable medical equipment" heading in Chapter 4, "Benefits and services", of this Member Handbook.

We cover Post-Stabilization Care from an Out-of-Network Provider only if we pre-approve it or if otherwise required by applicable law. The provider treating you must get authorization from us before we will pay for post-stabilization care.

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**). You 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 will talk to the doctor who is treating you about your health issue. If we determine you need Post-Stabilization Care, we will authorize the Covered Services. In some cases, we may arrange to have a Medi-Cal Network Provider provide the care.

If we decide to have a network hospital, skilled nursing facility, or other provider provide the care, we may authorize transport services that are Medically Necessary to get you to the provider. This may 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 authorize. If you ask for and get

services that are not covered, we may not pay the provider for the services.

The Appointment and Advice Line gives you free medical information and advice 24 hours a day, every day of the year. In Northern California, call **1-866-454-8855** (TTY **711**). In Southern California, call **1-833-574-2273** (TTY **711**). 24 hours a day, 7 days a week.

Appointment and Advice Line

Sometimes it is difficult to know what kind 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 may be right for your condition
- Get help on what to do if you need care and a Plan Facility is closed, or you are outside your Home Region Service Area

You can reach one of the licensed health care professionals by calling the number listed below for your Home Region. When you call, a trained support person may ask you questions to help determine how to direct your call.

Home Region	**Appointment and Advice Number**
Northern California	**1-866-454-8855** (TTY **711**), 24 hours a day, 7 days a week

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

Southern California	**1-833-574-2273** (TTY **711**), 24 hours a day, 7 days a week

Advance health care directives

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

You can get an advance directive form at Kaiser Permanente Plan Facilities at no cost to you. You can also get a form at pharmacies, hospitals, law offices, and doctors' offices. You might have to pay for the form if you do not get the form from us. You can also download a free form online at **kp.org**. You can ask your family, PCP, or someone you trust to help you fill out the form.

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

You have the right to learn about changes to advance directive laws. Kaiser Permanente will tell you about changes to the state law no longer than 90 days after the change. For more information, you can call our Member Services at **1-855-839-7613** (TTY **711**).

Organ and tissue donation

You can help save lives by becoming an organ or tissue donor. If you are between 15 and 18 years old, you can become a donor with the written consent of your parent or guardian. You can change your mind about being an organ donor at any time. If you want to learn more about organ or tissue donation, talk to your PCP. You can also visit the United States Department of Health and Human Services website at www.organdonor.gov.

4. Benefits and services

What benefits and services your health plan covers

This chapter explains benefits and services covered by Kaiser Foundation Health Plan, Inc. Your covered services are free as long as they are Medically Necessary and provided according to the rules outlined in this Member Handbook. Most services must be provided by a Medi-Cal Network Provider. We may cover Medically Necessary services from an Out-of-Network Provider in some cases. You must ask us for pre-approval (prior authorization) if the care is Out-of-Network except for:

- Emergency Care
- Urgent Care outside your Home Region Service Area
- Some Sensitive Care as described in Chapter 3, “How to get care”, of this Member Handbook

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under the age of 21, Medically Necessary services include care that is needed to fix or help relieve a physical or mental illness or condition. For more information on your covered services, call our Member Services at **1-855-839-7613** (TTY **711**).

Members under 21 years old get extra benefits and services. To learn more, read Chapter 5, “Child and Youth Well Care”, in this Member Handbook.

The following are examples of the services we cover:

- Ambulatory (outpatient) services
- A limited number of outpatient prescription drugs, supplies, and supplements. Most outpatient prescription drugs, supplies, and supplements are covered under Medi-Cal Rx under Fee-for-Service Medi-Cal

- CCS-eligible services under the Whole Child Model Program in certain counties
- Emergency Care, including emergency ambulance services
- Hospice and palliative care
- Hospitalization
- Investigational services
- Laboratory and radiology services, such as X-rays
- Long-term services and supports (“LTSS”)
- Maternity and newborn care
- Mental health services for mild to moderate conditions
- Non-emergency medical transportation (“NEMT”)
- Non-medical transportation (“NMT”)
- Pediatric services
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative (therapy) services and devices
- Reconstructive surgery
- Substance use disorder screening services
- Telehealth services from Kaiser Permanente Medi-Cal Network Providers
- Vision services

Read each of the sections below to learn more about the services you can get.

The health care services provided to Members of Kaiser Permanente are subject to the terms, conditions, limitations, and exclusions of the contract between Kaiser Foundation Health Plan, Inc. and DHCS and as listed in this Member Handbook and any amendments.

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury.

Medically necessary services include those services that are necessary for age-appropriate growth and development, or to attain, maintain, or regain functional capacity.

For members under age 21, a service is medically necessary if it is necessary to correct or improve defects and physical and mental illnesses or conditions under the Medi-Cal for Kids and Teens (also known as Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") benefit. This includes care that is necessary to fix or help relieve a physical or mental illness or condition or maintain the member's condition to keep it from getting worse.

Medically necessary services do not include:

- **Treatments that are untested or still being tested**
- **Services or items not generally accepted as effective**
- **Services outside the normal course and length of treatment or services that do not have clinical guidelines**
- **Services for caregiver or provider convenience**

We will coordinate with other programs to be sure that you get all Medically Necessary services, even if those services are covered by another program and not by us.

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

- Protect life
- Prevent significant illness or significant disability
- Alleviate severe pain

- Achieve age-appropriate growth and development
- Attain, maintain, and regain functional capacity

For members younger than 21 years old, Medically Necessary services include all Covered Services listed above plus any other necessary health care, screening, immunizations, diagnostic services, treatment, and other measures to correct or improve defects and physical and mental illnesses and conditions, the Medi-Cal for Kids and Teens benefit requires. This benefit is known as the Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") benefit under federal law.

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

We will coordinate with other programs to make sure you get all medically necessary services, even if another program covers those services and we do not. Read "Other Medi-Cal Programs and Services not covered by Kaiser Permanente" later in this chapter.

Medi-Cal benefits covered by Kaiser Permanente

Outpatient (ambulatory) services

Adult immunizations (shots)

You can get adult immunizations (shots) from a Medi-Cal Network Provider without pre-approval (prior authorization) when they are a preventive service. We cover immunizations (shots) recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC") as preventive services, including immunizations (shots) you need when you travel. For information on immunizations for children, go to Chapter 5, "Child and Youth Well Care", of this Member Handbook.

You can also get some adult immunization (shots) services from a pharmacy through

Medi-Cal Rx. To learn more about Medi-Cal Rx, read “Other Medi-Cal programs and services not covered by Kaiser Permanente” later in this chapter.

Allergy care

We cover Medically Necessary allergy testing and treatment, including allergy desensitization, hypo-sensitization, or immunotherapy.

Anesthesiologist services

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

For dental procedures, we cover the following services when we authorize them:

- IV sedation or general anesthesia services administered by a medical professional
- Facility services related to the sedation or anesthesia in an outpatient surgical, Federally Qualified Health Center (“FQHC”), dental office, or hospital setting

We do not cover any other services related to dental care, such as the dentist’s services.

Chiropractic services

We cover chiropractic services, limited to the treatment of the spine by manual manipulation. Adults ages 21 and older, with an allowable diagnosis, may get up to two visits per month without prior authorization. Additional visits may be approved when Medically Necessary. Limits do not apply to Members under age 21.

Chiropractic services from American Specialty Health network providers

We work with American Specialty Health to arrange chiropractic services for members who are:

- Children under age 21
- Pregnant Members through the 60 days after the end of a pregnancy

- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility

For more information on chiropractic services, please call American Specialty Health at **1-800-678-9133** (TTY **711**).

Chiropractic services from county facilities, Federally Qualified Health Centers (FQHCs), or Rural Health Clinics (RHCs)

Medi-Cal may cover chiropractic services for Members of all ages when received at county hospital outpatient departments, county outpatient clinics FQHCs, or RHCs that are in Kaiser Permanente's network. FQHCs and RHCs may require a referral to get services. Not all county facilities, FQHCs, or RHCs offer outpatient chiropractic services. To get more information, call our Member Services at **1-855-839-7613** (TTY **711**).

Cognitive health assessments

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

Dialysis and hemodialysis services

We cover Medically Necessary dialysis treatments. We also cover hemodialysis (chronic dialysis) and peritoneal dialysis services. You must meet all medical criteria developed by us and by the facility providing the dialysis.

Medi-Cal coverage does not include:

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

Outpatient surgery and other outpatient procedures

We cover Medically Necessary outpatient surgery and other outpatient procedures.

Physician services

We cover physician services that are medically necessary. Some services may be provided as a group appointment.

Podiatry (foot) services

We cover podiatry services as Medically Necessary for diagnosis and for medical, surgical, mechanical, manipulative, and electrical treatment of the human foot. This includes treatment for the ankle and for tendons connected to the foot. It also includes nonsurgical treatment of the muscles and tendons of the leg that controls the functions of the foot.

Treatment therapies

We cover different treatment therapies, including:

- Chemotherapy
- Radiation therapy
- Administered drugs and products. These are medications and products that require administration or observation by a health care provider. We cover these items when a Medi-Cal Network Provider prescribes them for you, in accordance with our drug formulary guidelines. Items must be administered in a Plan Facility or during home visits to be covered. Examples of administered drugs we cover include, but are not limited to:
    - Whole blood, red blood cells, plasma, and platelets
    - Cancer chemotherapy drugs
    - Allergy antigens
    - Drugs and products that are administered via intravenous therapy or injection

For more information on our drug formulary, go to the heading “Outpatient prescription drug, supplies, and supplements covered by Kaiser Permanente” later in Chapter 4, “Benefits and services”, of this Member Handbook.

Maternity and newborn care

We cover these maternity and newborn care services:

Birthing center services

We cover services at birthing centers that are a Medi-Cal-approved Comprehensive Perinatal Services Program (“CPSP”) provider. Birthing center services are an alternative to hospital-based maternity care for women with low-risk pregnancies. If you want to have your baby at one of these centers and to find out if you qualify, ask your doctor.

Breast pumps and supplies

We will provide one retail-grade breast pump per pregnancy and one set of supplies to go with the pump. If it is Medically Necessary for you to use a hospital-grade breast pump, we will cover the rental or purchase of one. Hospital-grade breast pumps are Durable Medical Equipment (“DME”) and must be pre-approved for you. We will choose the vendor, and you must return the hospital-grade breast pump after you no longer need it.

Breastfeeding education and aids

We cover comprehensive lactation support.

Care coordination

We provide care coordination services during maternity and newborn care.

Certified Nurse Midwife (“CNM”)

We cover Medically Necessary services provided by certified nurse midwives who act within their scope of practice.

Counseling

We provide counseling services to pregnant, and postpartum persons before, during, and after childbirth by certified healthcare professionals.

Delivery and postpartum care

We cover services in the hospital and postpartum care.

Diagnosis of fetal genetic disorders and counseling

We cover diagnostic tests and counseling related to fetal genetic disorders.

Doula services

We cover doula services provided by Medi-Cal network doula providers during a member's pregnancy; during labor and delivery, including stillbirth, miscarriage, and abortion; and within one year of the end of a member's pregnancy. Medi-Cal does not cover all doula services.

Doula providers are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during, stillbirth, miscarriage, and abortion.

As a preventive benefit, doula services require a written recommendation from a physician or other licensed practitioner of the healing arts within their scope of practice. DHCS issued a standing recommendation for doula services that fulfills the requirement for an initial recommendation. The initial recommendation for doula services includes the following authorizations:

- One initial visit
- Up to 8 additional visits that can be a mix of prenatal and postpartum visits
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage
- Up to 2 extended 3-hour postpartum visits after the end of a pregnancy
- Members may receive up to nine additional postpartum visits with an additional written recommendation from a physician or other licensed practitioner.

We must coordinate for Out-of-Network access to doula services for Medi-Cal members if a Medi-Cal provider is not available. Additional visits are subject to pre-approval.

Licensed Midwife ("LM")

We cover Medically Necessary services provided by licensed nurse midwives who act

within their scope of practice.

Maternal mental health services

If you develop a mental health condition during your pregnancy or during the postpartum period, we will cover the mental health services you need, as described in the “Mental health services” section in this chapter.

Newborn care

Newborns are babies from 0 to 2 months old. If the mother is a Medi-Cal member at the time of the birth, we cover Medically Necessary services under the mother’s Medi-Cal coverage for newborns. It is important to enroll your newborn in Medi-Cal so that your newborn can have their own Medi-Cal coverage. For more information on how to enroll your newborn in Medi-Cal, call your county office.

Nutrition education

We provide nutrition education to mothers by certified healthcare professionals.

Prenatal care

We cover a series of prenatal care exams.

Social and mental health assessments and referrals

We provide social and mental health assessments without needing pre-approval. To learn more about mental health services read “Mental Health Services” in Chapter 4, “Benefits and Services”, of this Member Handbook.

Vitamin and mineral supplements

Outpatient prescription drugs, supplies, and supplements related to maternity and newborn care services are covered under Medi-Cal Rx. For more information on Medi-Cal Rx, go to the “Medi-Cal Rx” heading in the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” in Chapter 4, “Benefits and services”, of this Member Handbook.

Mental health services

Mental health assessments

You do not need a referral or pre-approval to get an initial mental health assessment from a Medi-Cal Network Provider or from a county mental health plan provider. You may get a mental health assessment at any time from a licensed mental health provider who is a qualified Medi-Cal provider. You can look at our online provider listings at **kp.org/finddoctors** to find a mental health provider in our network or call our Member Services at **1-855-839-7613** (TTY **711**).

We will cover prevention, screening, assessment, and treatment services for mild-to-moderate mental health conditions that may be provided to you before you receive a formal diagnosis related to your mental health.

Outpatient mental health services for mild to moderate conditions

Your PCP or mental health provider might make a referral for more mental health screening to a specialist in the Medi-Cal Provider Network to decide the level of care you need. If your mental health screening results find you are in mild or moderate distress or have impaired mental, emotional, or behavioral functioning, we cover mental health services such as:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory, and problem-solving
- Outpatient services for the purposes of monitoring drug therapy
- Imaging and laboratory services related to the treatment of your mental health condition. Go to “Laboratory and radiology services” later in this chapter.
- Outpatient medicines that are not already covered under the Medi-Cal Rx Contract Drugs List (https://medi-calrx.dhcs.ca.gov/home/), supplies and supplements
- Psychiatric consultation
- Family therapy when Medically Necessary and includes at least two family members. Examples of family therapy include, but are not limited to:
    - Child-parent psychotherapy (ages 0 through 5)

- Parent child interactive therapy (ages 2 through 12)
- Cognitive-behavioral couple therapy (adults)

If the treatment you need for a mental health disorder is not available in our Medi-Cal Provider network or your PCP or mental health provider cannot give the care you need in the time listed above in "Timely access to care," we will cover and help you get out-of-network services.

If your mental health screening shows that you may have a higher level of impairment and need specialty mental health services ("SMHS"), your PCP or your mental health provider can refer you to the County Mental Health Plan to get the care you need. We will help you coordinate your first appointment with a county mental health plan provider to choose the right care for you. To learn more, read Chapter 4, "Other Medi-Cal programs and services" under "Specialty Mental Health Services", of this Member Handbook.

Outpatient prescription drugs, supplies, and supplements related to mental health services are covered under Medi-Cal Rx. For more information on Medi-Cal Rx, go to the "Medi-Cal Rx" heading in the section "Other Medi-Cal programs and services not covered by Kaiser Permanente" in Chapter 4, "Benefits and services", of this Member Handbook.

For help finding more information on mental health services provided by Kaiser Permanente you can call our Member Services at **1-855-839-7613** (TTY **711**).

Dyadic services

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

Dyadic care services include:

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

Emergency Care services

Inpatient and outpatient services needed to treat a medical emergency

We cover all services needed to treat a medical emergency that happens in the United States (including territories such as Puerto Rico, United States Virgin Islands, etc.). We also cover emergency care that requires hospitalization in Canada or Mexico.

A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent (reasonable) layperson (not a health care professional) could expect it to result in any of the following:

- Serious risk to your health
- Serious harm to bodily functions
- Serious dysfunction of any bodily organ or part

Serious risk in cases of a pregnant person in active labor, meaning labor at a time when either of the following would occur:

- There is not enough time to safely transfer you to another hospital before delivery
- The transfer might pose a threat to your health or safety or to that of your unborn child

If an emergency department provider in the United States gives you up to a 72-hour supply of an outpatient prescription as part of your treatment, we will cover the prescription drug as part of your covered Emergency Care.

If a hospital emergency department provider gives you a prescription that you have to take to an outpatient pharmacy to be filled, Medi-Cal Rx will cover that prescription.

If a pharmacist at an outpatient pharmacy gives you an emergency supply of medication from an outpatient pharmacy while traveling, Medi-Cal Rx will be responsible for covering the medication, and not us. If the pharmacy needs help giving you an emergency medication supply, have them call Medi-Cal Rx at Customer Service at **1-800-977-2273**, 24 hours a day, 7 days a week.

Emergency transportation services

We cover ambulance services to help you get to the nearest place of care in an

emergency. This means your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside the United States except for Emergency Care that requires hospitalization in Canada or Mexico. If you get emergency ambulance services in Canada or Mexico and you are not hospitalized during that care episode, we will not cover your ambulance services.

Health education

We cover a variety of health education counseling, programs, and materials that your PCP or other providers provide during an appointment or visit.

We also 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 tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma).

For more information about our health education counseling, programs, and materials, please contact the health education department at your local Plan Facility. You can also call our Member Services at **1-855-839-7613** (TTY **711**) or go to our website at **kp.org**.

Health education services from community health workers ("CHWs")

We cover preventive health education and health navigation services provided by community health workers ("CHWs"). A doctor or licensed provider must recommend these services for you. We do not cover all the services that CHWs provide. Covered CHW services include the following:

- Health education to promote your health or address barriers to health care, such as:
    - How to control and prevent chronic conditions, infectious diseases, behavioral health conditions, perinatal, sexual and reproductive, and oral health conditions
    - Child health and development
    - Violence and injury prevention

- Health navigation, including information, training, referrals, and support to access health care services and connect to community resources.

- Health promotion and coaching, including goal setting and the creation of action plans to address disease prevention and management

Diabetes Prevention Program ("DPP")

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

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

Members must meet certain rules to join DPP. Ask your doctor if you qualify for the program.

Hospice and palliative care

We cover hospice and palliative care for children and adults, which help reduce physical, emotional, social, and spiritual discomforts. Adults ages 21 or older may not get hospice care and curative (healing) care at the same time. If you are getting palliative care and meet the eligibility for hospice care, you can ask to change to hospice care at any time.

Hospice care

Hospice care is a benefit for terminally ill members. It is an intervention that focuses mainly on pain and symptom management rather than on a cure to prolong life.

We cover Hospice care only if all of the following requirements are met:

- A doctor in our Medi-Cal Provider Network has diagnosed you with a terminal illness and determines that your life expectancy is 6 months or less. The services are provided in your Home Region Service Area. The services are provided by a licensed hospice agency that is a Medi-Cal Network Provider

- A network doctor determines that the services are necessary for the palliation and management of your terminal illness and related conditions

With hospice care:

- Adults ages 21 years or older can get care to relieve pain and other symptoms of their terminal illness, but not to cure the illness. Adults may not receive both hospice care and palliative care services at the same time

- Children under the age of 21 get care to relieve pain and other symptoms of their terminal illness and can choose to continue to get treatment for their illness

You can change your choice to get hospice care at any time. Your choice to start or stop hospice care must be in writing and follow Medi-Cal rules.

If all of the above requirements are met, we cover the following hospice services:

- Services of Medi-Cal Network Providers
- Skilled nursing care, including evaluation and case management of nursing needs, treatment for pain and symptom control, emotional support for you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for symptom control or to help maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and help with eating, bathing, and dressing
- Drugs for pain control and to help with other symptoms of your terminal illness.
  - We cover administered drugs in accordance with our drug formulary guidelines
  - We cover outpatient drugs that are directly related to your covered hospice services. You must obtain these drugs from a Kaiser Permanente network

pharmacy. For some drugs, we cover a 30-day supply in any 30-day period

- Outpatient prescription drugs that are not part of your hospice care, Medi-Cal Rx will decide if it is covered. You can learn more about Medi-Cal Rx by going to the heading "Medi-Cal Rx" under the section "Other benefits and programs not covered by Kaiser Permanente" later in Chapter 4.

- Durable medical equipment
- Inpatient respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five days in a row at one time
- Counseling to help with loss
- Advice about diet

We also cover the following hospice services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient care required at a level that cannot be provided at home

Palliative care

Palliative care is patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative care does not require the member to have a life expectancy of six months or less. Palliative care may be provided at the same time as curative care. We cover palliative care for Members who meet the Medi-Cal eligibility criteria for these services.

Palliative care includes the following:

- Advance care planning
- Palliative care assessment and consultation
- A Plan of care including all authorized palliative and curative care

Palliative care team including, but not limited to the following:

- Doctor of medicine or osteopathy

- Physician assistant
- Registered nurse
- Licensed vocational nurse or nurse practitioner
- Social worker
- Chaplain
- Care coordination
- Pain and symptom management
- Mental health and medical social services

Hospitalization

Anesthesiologist services

We cover Medically Necessary anesthesiologist services during covered hospital stays. An anesthesiologist is a provider who specializes in giving patients anesthesia. Anesthesia is a type of medicine used during some medical or dental procedures.

Inpatient hospital services

We cover medically necessary inpatient hospital care when you are admitted to an in-network hospital. Services include room and board, drugs, equipment, imaging and laboratory services, and other services that the hospital ordinarily provides. If you are admitted to an out-of-network hospital, you must get approval from us for the care you receive after your condition is stabilized. If you do not get approval from us, your hospital stay will not be covered.

Rapid Whole Genome Sequencing

Rapid Whole Genome Sequencing (“RWGS”) is a covered benefit for any Medi-Cal member who is 1 year of age or younger and is getting inpatient hospital services in an intensive care unit (“ICU”). It includes individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing.

RWGS is a new way to diagnose conditions in time to affect Intensive Care Unit (“ICU”)

care of children 1 year of age or younger.

- ***Coverage in Counties with the Whole Child Model (Mariposa, Marin, Napa, Orange, Placer, San Mateo, Santa Cruz, Solano, Sonoma, Sutter, Yolo and Yuba)***

  If your child qualifies for the California Children's Services ("CCS") program, we will cover the hospital stay and the RWGS under the Whole Child Model Program.

- ***Coverage in Counties with California Children's Services (all other counties in the Medi-Cal Plan Service Area)***

  If your child is eligible for California Children's Services ("CCS"), CCS may cover the hospital stay and the RWGS.

Surgical services

We cover medically necessary surgeries performed in a hospital.

Outpatient prescription drugs covered by Kaiser Permanente

Most outpatient prescription drugs are covered by Medi-Cal Rx as a service through Fee-for-Service Medi-Cal. You can learn more about Medi-Cal Rx by going to the heading "Outpatient prescription drugs covered by Medi-Cal Rx" under the section "Other Medi-Cal programs and services not covered by Kaiser Permanente" later in this Chapter 4.

There are some prescription drugs and items that are still covered by us because state law requires us to cover them. This section describes the prescription drugs and items that we still cover under state law.

Enteral and parenteral nutrition

These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. We cover enteral and parenteral nutrition products when Medically Necessary. Enteral nutrition formulas and parenteral nutrition products may also be covered through Medi-Cal Rx.

Contraceptive drugs and devices

We cover contraceptive drugs and devices when prescribed by a Medi-Cal Network Provider. If you receive contraceptive drugs or devices from an Out-of-Network Medi-Cal Provider, the provider will ask Medi-Cal Rx to pay for your items. You do not have to pay for covered contraception. Over-the-counter contraceptive drugs and devices are covered by Medi-Cal Rx.

Diabetic Testing Supplies

State law requires that we cover diabetic testing supplies when prescribed by a Medi-Cal Network Provider. If you get your diabetic testing supplies at a pharmacy outside of the Kaiser Permanente network, your pharmacy will ask Medi-Cal Rx to pay for your supplies.

Other prescription drug items we cover

We also cover items prescribed by the following Out-of-Network Medi-Cal Providers:

- Out-of-Network doctors, if The Permanente Medical Group authorizes a written referral to the out-of-network doctor and the item is covered as part of that referral
- Out-of-Network doctors, if the item is covered as part of covered Emergency Care or covered Urgent Care
- An Out-of-Network pharmacist or hospital emergency room gives you up to a 72-hour emergency supply

You can learn more about Medi-Cal Rx by going to the heading “Medi-Cal Rx” under the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” later in Chapter 4, “Benefits and services”, of this Member Handbook.

Day supply limit

There is a limit to the amount of a drug or other item that can be dispensed at one time.

- ***Hormonal contraceptives***

  The prescribing doctor determines how much of a contraceptive drug or item to prescribe. For purposes of day supply coverage limits, Medi-Cal Network Providers determine what is the Medically Necessary supply for you for 30 days, 100 days, or 365 days. The most you may get at one time for hormonal contraceptives is a 365-day supply.

- ***All other items***

    - The prescribing doctor or dentist determines how much of a drug, supply, or supplement to prescribe. Medi-Cal Network doctors decide what is the Medically Necessary supply for you for 30 days or 100 days

    - The most you may get at one time of a covered item is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. Amounts of drugs or items over the day supply limit are not covered.

    - The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy finds that the item is in limited supply in the market or for specific drugs (your network pharmacy can tell you if a drug you take is one of these drugs).

Drug formulary for prescription items covered by Kaiser Permanente

We cover certain Medically Necessary items that require a prescription and certain items that are available over the counter ("OTC"). We cover these items when you receive them as part of a covered hospital stay or when you receive them as part of a medical visit. We also cover certain items required under state law when those items are dispensed from a network outpatient pharmacy. We cover items prescribed by Medi-Cal Network Providers, within the scope of their license and practice, and in accordance with our drug formulary guidelines.

Our drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our members. Our Pharmacy and Therapeutics Committee is a group of network doctors and pharmacists who review drugs for their safety and effectiveness. The Pharmacy and Therapeutics Committee decides which drugs will be on the Kaiser Permanente drug formulary. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available.

To find out if a drug is on the formulary or to get a copy of the formulary, call our Member Services at **1-855-839-7613** (TTY **711**).

Note: The fact that a drug is on the list does not necessarily mean that your doctor will prescribe it for a particular medical condition.

Contract Drugs List for outpatient drugs covered by Medi-Cal Rx

You can learn more about Medi-Cal Rx by going to the heading “Medi-Cal Rx” under the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” later in Chapter 4, “Benefits and services”, of this Member Handbook.

Pharmacies

You can fill your prescriptions at a Kaiser Permanente network pharmacy, or you can go to a Medi-Cal Rx pharmacy for most of your Medi-Cal prescriptions. If your prescription is part of an investigational treatment or covered hospice services, you must get your prescription filled at a Kaiser Permanente network pharmacy.

- ***Getting prescriptions at a Kaiser Permanente pharmacy***

  You can find locations for our pharmacies on our website at **kp.org/finddoctors** or call our Member Services at **1-855-839-7613** (TTY **711**) for locations and hours of network pharmacies in your area.

  Once you choose a pharmacy, take your prescription to the pharmacy. Give the pharmacy your prescription with your Kaiser Permanente ID card. Make sure the pharmacy knows about all medications you are taking and any allergies you have. If you have any questions about your prescription, make sure you ask the pharmacist.

  When you need a refill, you may phone ahead, order by mail, or order online. A few pharmacies do not dispense covered refills, and not all items can be mailed through our mail-order service. Check with your pharmacy if you have a question about whether your prescribed drug can be mailed or obtained at a network pharmacy. Items available through our mail order service are subject to change at any time without notice.

- ***Getting prescriptions at a Medi-Cal Rx pharmacy***

  Go to the heading “Medi-Cal Rx” in the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” for information on finding a Medi-Cal Rx pharmacy outside of the Kaiser Permanente network.

Medicare Part D

If you are covered by Medi-Cal and eligible for or enrolled in Medicare with Part D

coverage, Medicare Part D pays first. Sometimes a drug covered by Medi-Cal may not be covered by Medicare Part D. If Medicare does not cover a drug that was covered by Medi-Cal, it may still be covered under your Medi-Cal coverage. If you are a Kaiser Permanente Senior Advantage member and want to know more about your Medicare Part D drug coverage, see your Senior Advantage Evidence of Coverage. You can also learn how to get extra help to pay for your out-of-pocket expenses.

To learn more about Medicare Part D (including how to enroll in Part D), please call our Member Services at **1-800-443-0815** (TTY **711**). You can also call Medicare free at **1-800-MEDICARE** (**1-800-633-4227**) (TTY **1-877-486-2048**) or visit their website at **www.medicare.gov.**

Extended postpartum coverage

We cover full-scope coverage for up to 12 months after the end of the pregnancy regardless of citizenship, immigration status, changes in income, or how the pregnancy ends.

Rehabilitative and habilitative (therapy) services and devices

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

We cover rehabilitative and habilitative services described in this section if all of the following requirements are met:

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

Kaiser Permanente covers these rehabilitative/habilitative services:

Acupuncture

We cover Medically Necessary acupuncture services to prevent, change, or relieve the perception of severe, ongoing chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services do not require a referral or pre-approval.

Outpatient acupuncture services, with or without electric stimulation of needles, are covered when obtained through our Medi-Cal Network Providers or American Specialty Health Network Providers. For more information on acupuncture services, please call American Specialty Health at **1-800-678-9133** (TTY **711**).

Audiology (hearing)

We cover medically necessary audiology services.

Behavioral health treatments

We cover behavioral health treatment ("BHT") services for members under 21 years old through the Medi-Cal for Kids and Teens benefit. BHT includes services and treatment programs such as applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a member under 21 years old.

BHT services teach skills using behavioral observation and reinforcement or through prompting to teach each step of a targeted behavior. BHT services are based on reliable evidence. They are not experimental. Examples of BHT services include behavioral interventions, cognitive behavioral intervention packages, comprehensive behavioral treatment, and applied behavioral analysis.

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

The behavioral health treatment plan must meet the following criteria:

- Must be developed by a Medi-Cal Network Provider who is a qualified BHT provider and may be administered by a qualified BHT provider, qualified BHT service professional, or qualified BHT service paraprofessional
- Has measurable individualized goals over a specific timeline that are developed and approved by the qualified autism service provider for the Member being treated

- Is reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate
- Ensures that interventions are consistent with evidence-based BHT techniques
- Includes care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable
- Includes parent/caregiver training, support, and participation
- Describes the Member's behavioral health impairments to be treated and the outcome measurement assessment criteria used to measure achievement of behavior objectives
- Includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
- Utilizes evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism

Medi-Cal coverage does not include:

- BHT provided when continued clinical benefit is not expected
- Services that are primarily respite, daycare, or educational
- Reimbursement for parent participation in a treatment program
- Treatment when the purpose is vocational or recreational
- Custodial care that is provided primarily (i) to assist in the activities of daily living (like bathing, dressing, eating, and maintaining personal hygiene), (ii) to maintain safety of the Member or others, and (iii) could be provided by persons without professional skills or training
- Services, supplies, or procedures performed in a non-conventional setting including, but not limited to, resorts, spas, and camps
- Services rendered by a parent, legal guardian, or legally responsible person

If you have any questions call our Member Services at **1-855-839-7613** (TTY **711**).

Cardiac rehabilitation

We cover Medically Necessary inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment ("DME")

Durable medical equipment ("DME") includes items that meet all 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 or injury
- The item is appropriate for use in the home
- The item is needed to help you with activities of daily living ("ADLs")

Durable medical equipment requires pre-approval. We cover the purchase or rental of medical supplies, equipment, and other services with a prescription from a licensed provider if the item is Medically Necessary and has been pre-approved for you. 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.

Generally, we do not cover:

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described earlier in this chapter under "Breast pumps and supplies" in "Maternity and newborn care"
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment, except when medically necessary for a member under age 21
- Nonmedical items such as sauna baths or elevators
- Modifications to your home or car, except for stair lifts that do not require permanent changes to your home. For information on modifications that may be covered under Community Supports, go to that heading later in chapter 4, "Benefits and services", of this Member Handbook. Devices for testing blood or other body substances except for diabetic testing supplies. Diabetes blood glucose monitors including continuous glucose monitors, test strips, and lancets are covered. See the section "Diabetic testing supplies" earlier in this chapter for more information.
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse, except when Medically Necessary for a member under age 21

- Other items that are generally not used mainly for a health care purpose

Hearing aid coverage in Counties with Whole Child Model

The Whole Child Model Program is a Medi-Cal program in the following counties: Marin, Mariposa, Napa, Orange, Placer, San Mateo, Santa Cruz, Solano, Sonoma, Sutter, Yolo, and Yuba Counties. In these counties, we cover hearing aids for all Members if:

- You are tested for hearing loss
- The hearing aids are Medically Necessary
- You receive a prescription from your doctor

Coverage is limited to the lowest-cost hearing aid that meets your medical needs. We will choose who will supply the hearing aid. We will cover one hearing aid unless a hearing aid for each ear is needed for better results than what you can get with one hearing aid.

Under Medi-Cal, we will cover the following for each covered hearing aid:

- Ear molds needed for fitting
- One standard battery pack
- Visits to make sure the hearing aid is working right
- Visits for cleaning and fitting your hearing aid
- Repair of your hearing aid
- Hearing aid accessories and rentals

Under Medi-Cal, we will cover a replacement hearing aid if:

- Your hearing loss is such that your current hearing aid is not able to correct it
- Your hearing aid is lost, stolen, or broken (and cannot be fixed), and it was not your fault. You must give us a note that tells us how this happened

- For adults ages 21 and older, Medi-Cal does **not** cover:
    - Replacement hearing aid batteries

Hearing aid coverage in Counties with California Children's Services

- ***Hearing aids for Members under the age of 21***

  State law requires children who need hearing aids to be referred to the California Children's Services ("CCS") program to determine if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for Medically Necessary hearing aids. If the child is not eligible for CCS, we will cover Medically Necessary hearing aids as part of Medi-Cal coverage.

- ***Hearing aids for Members ages 21 and older***

  Under Medi-Cal, we cover the following for each covered hearing aid:

  - Ear molds needed for fitting
  - One standard battery package
  - Visits to make sure the aid is working right
  - Visits for cleaning and fitting your hearing aid
  - Repair of your hearing aid.

  Under Medi-Cal, we will cover a replacement hearing aid if:

  - Your hearing loss is such that your current hearing aid is not able to correct it
  - Your hearing aid is lost, stolen, or broken (and cannot be fixed), and it was not your fault. You must give us a note that tells us how this happened

  For adults ages 21 and older, Medi-Cal coverage does not include:

  - Replacement hearing aid batteries

Home health services

We cover Medically Necessary health services given in your home prescribed by a qualified Medi-Cal Network Provider if all of the following are true:

- You are housebound (substantially confined to your home or a friend's or family member's home)
- Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist
- A network doctor finds that it is possible to monitor and control your care in your home
- A network doctor finds that the services can be provided in a safe and effective way in your home
- You get the services from Medi-Cal Network Providers

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

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

Medical supplies, equipment, and appliances

We cover Medically Necessary medical equipment, appliances, and supplies that are prescribed by a Medi-Cal Network Provider, including implanted hearing devices. Some medical supplies are covered through Medi-Cal Rx, part of Fee-for-Service ("FFS") Medi-Cal, and not by us.

You can ask your pharmacy for more information about what supplies are covered by Medi-Cal Rx. To learn more about Medi-Cal Rx, see the Medi-Cal Rx heading under the "Other benefits and programs not covered by Kaiser Permanente" later in Chapter 4, "Benefits and services", of this Member Handbook. Note: Incontinence supplies are covered only as specified in the DHCS Provider Manual.

Medi-Cal does **not** cover:

- Common household items including, but not limited to:

  - Adhesive tape (all types)
  - Rubbing alcohol
  - Cosmetics
  - Cotton balls and swabs
  - Q-tips, dusting powders
  - Tissue wipes
  - Witch hazel
- Common household remedies including, but not limited to:
  - White petrolatum
  - Dry skin oils and lotions
  - Talc and talc combination products
  - Oxidizing agents such as hydrogen peroxide
  - Carbamide peroxide and sodium perborate
  - Non-prescription shampoos

Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid, and zinc oxide paste

Other items not generally used primarily for health care, and that are regularly and primarily used by persons who do not have a specific medical need for them

Occupational therapy

We cover Medically Necessary occupational therapy services including occupational therapy evaluation, treatment planning, treatment, instruction, and consultative services.

Orthotics/prostheses

We cover orthotic and prosthetic 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

Items must be pre-approved for you. They include implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments, and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part. Coverage is limited to the lowest-cost item of equipment that adequately meets your medical needs. We select the vendor.

Ostomy and urological supplies

Ostomy and urological supplies must be pre-approved for you. We cover ostomy bags, urinary catheters, draining bags, irrigation supplies, and adhesives. This does not include supplies that are for comfort or convenience, or luxury equipment or features.

Physical therapy

We cover Medically Necessary physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medicines.

Pulmonary rehabilitation

We cover pulmonary rehabilitation that is Medically Necessary and prescribed by a Medi-Cal Network Provider.

Skilled nursing facility services

We cover skilled nursing facility services as Medically Necessary if you are disabled and need a high level of care. These services include room and board in a licensed facility with 24-hour per day skilled nursing care.

Speech therapy

We cover speech therapy that is Medically Necessary.

Transgender services

We cover transgender services (gender-affirming services) when they are medically necessary or when the services meet the criteria for reconstructive surgery.

Clinical trials

We cover Routine Care services you receive in connection with a clinical trial if all of the following are met:

- We would have covered the services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
    - A Kaiser Permanente Medi-Cal Network Provider makes this determination
    - You provide us with medical and scientific information establishing this determination
- If any Kaiser Permanente Medi-Cal Network Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Kaiser Permanente Medi-Cal Network Provider, unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of a life-threatening condition. The clinical trial must meet one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention

- The Agency for Health Care Research and Quality
- The Centers for Medicare & Medicaid Services
- A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:

  (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and

  (2) it assures an unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

We do not cover services that are provided only for data collection and analysis.

If the service related to a clinical trial involves an outpatient prescription drug, supply, or supplement that would otherwise be covered by Medi-Cal Rx, we will not cover it. You or your provider will have to request coverage for the prescription item from Medi-Cal Rx.

Laboratory and radiology services

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

Preventive and wellness services and chronic disease management

Preventive services

We cover the following preventive services:

- Advisory Committee for Immunization Practices (“ACIP”) recommended

vaccines

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

Family planning services

Family planning services are provided to members of childbearing age to allow them to choose the number and spacing of children. These services include all methods of birth control approved by the Food and Drug Administration ("FDA"). Kaiser Permanente's PCPs PCP and OB/GYN specialists are available for family planning services.

For family planning services, you may choose any Medi-Cal doctor or clinic, not in-network with Kaiser Permanente without having to get a referral or pre-approval (prior authorization) from us. We will pay that doctor or clinic for the family planning services you get. If you get services not related to family planning from an Out-of-Network Medi-Cal Provider, those services might not be covered. To learn more, call our Member Services at **1-855-839-7613** (TTY **711**).

Chronic disease management

We also cover chronic disease management programs focused on the following conditions:

- Diabetes
- Cardiovascular disease
- Asthma

- Depression

For preventive care information for members under age 21, read Chapter 5, “Child and Youth Well Care”, of this Member Handbook.

Reconstructive Surgery

We cover:

- Surgery when there is a problem with a part of your body. This problem could be caused by congenital defects, a developmental abnormality, trauma, infection, tumors, disease, or injury. We also cover surgery when treatment of disease results in the loss of body structure, such as mastectomy. We cover surgery to correct or repair abnormal structures of the body to create a normal appearance to the extent possible.

- After Medically Necessary removal of all or part of a breast, we cover reconstructive surgery of the breast and reconstructive surgery of the other breast for a more similar look. We cover services for swelling after lymph nodes have been removed

We do not cover surgery that will result only in a minimum change in your appearance.

Substance use disorder screening services

We cover Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (“SABIRT”). We do not cover substance use disorder treatment services.

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

Vision benefits

Routine eye exams

We cover a Routine eye exam once every 24 months; more frequent eye exams are covered if medically necessary for members, such as for Members with diabetes.

Eyeglasses

We cover the following:

- ***Complete eyeglasses (frame and lenses)***

  We cover 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

Low vision devices

Low-vision devices are covered by 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 is not correctable by standard eyeglasses, contact lenses, medicine, or surgery
- The condition interferes with a person's ability to perform every day activities, as in the case of macular degeneration.

- 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.

Medically Necessary Contact Lenses

If you have a medical condition where a Medi-Cal network doctor or optometrist decides that it is Medically Necessary for you to wear contact lenses, we will cover the contact lenses. Medical conditions that qualify for special contact lenses include but are not limited to, aniridia, aphakia, and keratoconus.

We will replace your Medically Necessary contact lenses if your contact lenses are lost or stolen. You must give us a note that tells us how your contact lenses were lost or stolen.

Transportation benefits for situations that are not emergencies

For information on emergency transportation services, see the heading "Emergency Care" earlier in Chapter 4, "Benefits and services", of this Member Handbook.

Medical Transportation for situations that are not emergencies

You can get medical transportation in non-emergency situations if you have medical needs that do not allow you to use a car, bus, train, or taxi to get to your appointments for Medi-Cal appointments. You can get Medical Transportation for Covered Services and Medi-Cal-covered pharmacy appointments. You can request Medical Transportation by asking a Medi-Cal Network Provider, dentist, or substance use disorder provider for it. Your provider will decide the correct type of transportation to meet your needs.

Medical transportation is transportation in an ambulance, litter van, wheelchair van, or air transport.

Medical Transportation must be used when:

- You are not able to physically or medically able to use a car, bus, train, or taxi 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
- It is requested by a network doctor and authorized in advance

If your doctor decides you need Medical Transportation, they will prescribe it for you. We will call you to schedule your Medical Transportation.

Limits of Medical Transportation

For non-emergencies, we cover the lowest cost medical transportation for your medical needs to the closest provider where an appointment is available. That means, for example, if you can physically or medically be transported by a wheelchair van, we will not pay for an ambulance. You are covered for air transport only if your medical condition makes any form of ground transportation impossible. You cannot get medical transportation if Medi-Cal does not cover the service you are getting, or it is not a Medi-Cal-covered pharmacy appointment.

If Medi-Cal covers the appointment type but not through the health plan, we will not cover the Medical Transportation. However, we can help you schedule the transportation you need. If you need Medical Transportation outside of your Home Region Service Area or to go to an Out-of-Network Provider, we will cover Medical Transportation only if we have authorized it for you.

Cost to Member for Medical Transportation

There is no cost to you when we arrange Medical Transportation.

Non-Medical Transportation

Your Medi-Cal benefits include getting a ride to your appointments or to the pharmacy for Medi-Cal Covered Services when you do not have any access to transportation. You can get a ride, for free, when you have tried all other ways to get transportation and are:

- Traveling to and from an appointment for a Medi-Cal service
- Picking up prescriptions and medical supplies
- Inside your Home Region Service Area

- Outside your Home Region Service Area, NMT is covered only when pre-approved by us, unless it is for Urgent Care

If think you have a medical emergency, dial 911 or go to the nearest hospital. You do not need pre-approval from us for emergency transportation or Emergency Care. For information on emergency transportation services, go to the “Emergency Care” heading in Chapter 3, “How to get care”, of this Member Handbook.

Kaiser Permanente allows you to use a car, taxi, bus, or other public/private way of getting to your medical appointment for Medi-Cal-covered services. We will cover the lowest cost of the NMT type that meets your medical needs. Sometimes, we can reimburse you (pay you back) for rides in a private vehicle that you arrange. This must be approved by us before you get the ride.

You must tell us why you cannot get a ride in other ways, such as the bus. We will not reimburse you for using a transportation broker, bus passes, taxi vouchers, or train tickets. To request authorization and the criteria used to make authorization decisions call our transportation provider at **1-844-299-6230** (TTY **711**). The representative can also answer any questions about mileage reimbursement.

Please call Kaiser Permanente’s transportation provider at **1-844-299-6230** (TTY **711**) at least three business days (Monday-Friday) before your appointment, or as soon as you can when you have an urgent appointment. 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 are going
- If you will need a return trip
- If someone will be traveling with you (for example, a parent/legal guardian or caregiver)

Note: American Indians may contact their local IHC to request NMT Services.

Limits of NMT

We cover the lowest cost Non-Medical Transportation that meets your needs to the closest provider from your home where an appointment is available. Members cannot drive themselves or be reimbursed directly for NMT.

NMT does not apply if:

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

Cost to Member for Non-Medical Transportation

There is no cost when we arrange Non-Medical Transportation.

Travel expenses for Covered Services

In some cases, if you have to travel for doctor's appointments that are not available near your home, we may cover travel expenses such as meals, hotel stays, and other related expenses, such as parking, tolls, etc. These travel expenses may also be covered for someone who is traveling with you to help you with your appointment or someone who is donating an organ to you for an organ transplant. You need to request pre-approval (prior authorization) for these services. Ask your Medi-Cal Network Provider for more information on covered travel expenses.

Other Benefits and Programs Covered by Kaiser Permanente

Long-term care services and supports ("LTSS")

We cover, for members who qualify, long-term services and supports provided in the following types of long-term care facilities or homes:

- Skilled nursing facilities
- Subacute care facilities Intermediate care facilities, including:
  - Intermediate care facilities/developmentally disabled ("ICF/DD")
  - Intermediate care facilities/developmentally disabled-habilitative ("ICF/DD-H")
  - Intermediate care facilities/developmentally disabled nursing ("ICF/DD-N")

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

LTSS information in Northern California Region

If you have questions about long-term care services, call our Member Services at **1-833-721-6012** (TTY **711**), Monday through Friday, 8:30 a.m. to 1 p.m. and 2 p.m. to 5 p.m.

LTSS information in Southern California Region

If you have questions about long-term care services, call our Member Services at **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.

Care Coordination

Basic care management

Getting care from many different providers or in different health systems is challenging. We want to make sure members get all medically necessary services, prescription

medicines, and behavioral health services. We can help coordinate and manage your health needs for free. This help is available even when another program covers the services.

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

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

Care Coordination information in Northern California Region

If you have questions or concerns about your health or the health of your child, call our Member Services at **1-833-721-6012** (TTY **711**), Monday through Friday, 8:30 a.m. to 1 p.m. and 2 p.m. to 5 p.m.

Care coordination information in Southern California Region

If you have questions or concerns about your health or the health of your child, call our Member Services at **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.

Complex Care Management ("CCM")

Members with more complex health needs may qualify for extra services focused on care coordination. We offer Complex Care Management ("CCM") services to those at high risk, defined as those with medically complex conditions or members with a medical condition and a complex social situation that affects the medical management of the member's care and requires extensive use of resources.

If you are enrolled in CCM or Enhanced Care Management (read below) Kaiser Permanente will make sure you have an Assigned Care Manager who can not only help with the basic care management described above, but also an expanded set of transitional care supports that are available if you are discharged from a hospital, skilled nursing facility, psychiatric hospital, or residential treatment.

Enhanced Care Management ("ECM")

We cover ECM services for members with highly complex needs. ECM has extra services to help you get the care you need to stay healthy. It coordinates your care from doctors

and other providers. ECM helps coordinate primary care, preventive services, acute care, behavioral health, developmental services, oral health, community-based long-term care and support, and referrals to community resources.

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

- Covered ECM services

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

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

To find out if ECM might be right for you, talk to your health care provider or Call our Member Services at **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.

- **Cost to member**

  There is no cost to you for ECM services.

Community Supports

You may be able to get certain Community Supports services under your individualized care plan. Community Supports are suitable and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for

members. You do not have to accept Community Supports. If you qualify for and agree to receive these services, Community Supports might help you live more independently. These services do not replace benefits you already get under Medi-Cal.

Community Supports include the following services. They are 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
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 and without which acute asthma episodes could result in the need for emergency services and hospitalization.	Members who: • have poorly controlled asthma • for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.
Community Transition Services/Nursing Facility Transition to a Home	This includes non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.	Members who: • are currently receiving nursing facility level or care and • have resided 60+ days in a nursing facility and • are willing to live in the community and • are able to reside safely in the community with appropriate and cost-effective supports.

Community Support	Description	Who may be eligible
Day Habilitation	These services are provided in an individual's home or an out-of-home, non- facility setting. The 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 • exited homelessness and entered housing in the last 24 months • 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.
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	Members who: • meet the Housing and Urban Development ('HUD") definition of homeless or at risk of homelessness and

Community Support	Description	Who may be eligible
	that do not constitute room and board.	other eligibility criteria • received housing transition or housing navigation services. • Members prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system are also eligible for the housing services
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 HUD definition of homeless or at risk of homelessness and other eligibility criteria • received housing transition or housing navigation services. • Members prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system are also eligible for the housing services.

Community Support	Description	Who may be eligible
Housing Transition/Navigation Services	These services assist beneficiaries with obtaining housing and include conducting a tenant screening and housing assessment, individualized housing support plan, and securing housing.	Members who: • meet the HUD definition of homeless or at risk of homelessness and other eligibility criteria • Members prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system are also eligible for the housing services
Meals/Medically Tailored Meals	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 who: • have a chronic condition • are being discharged from the hospital or a skilled nursing facility • are at high risk of hospitalization or nursing facility placement • have extensive care coordination needs.
Nursing Facility Transition/Diversion to Assisted Living Facilities	These services assist individuals to live in the community and/or avoid institutionalization, when	For Nursing Facility Transition, Members who: • have resided 60+ days

Community Support	Description	Who may be eligible
	possible, to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care.	in a nursing facility; • are willing to live in an assisted living setting as an alternative to a Nursing Facility; • are able to reside safely in an assisted living facility with appropriate and cost-effective supports. For Nursing Facility Diversion, Members who: • are interested in remaining in the community; • are willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and • are currently receiving medically necessary nursing facility level of care or meet the criteria for needing nursing facility level of care • Member is choosing to remain in the community and continue to receive medically necessary nursing facility level of care services at an

Community Support	Description	Who may be eligible
		Assisted Living Facility.
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 • have functional deficits and no other adequate support system • 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 would be exacerbated by an unstable living environment.	Members who: • live alone without formal supports • are at risk of hospitalization or are post-hospitalization • are experiencing housing insecurity • meet the HUD definition 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	Members who: • live in the community and are compromised in their Activities of Daily Living ("ADLs")

Community Support	Description	Who may be eligible
	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 are dependent upon a qualified caregiver who provides support and requires caregiver relief to keep the Member from institutional placement • Members (children) previously covered for Respite Services under Pediatrics Palliative Care Waiver; foster care program beneficiaries; Members enrolled in either CA Children's Services or Genetically Handicapped Person Program; Members with complex care needs
Short-Term Post-Hospitalization Housing	These services provide beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery post-IP discharge or other setting (recovery, correctional, recuperative care, etc.).	Members who: • meet the HUD definition of homeless or risk of homelessness and • are being discharged from recuperative care or an inpatient stay

Community Support	Description	Who may be eligible
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 • are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress • would otherwise be transported to the emergency department or a jail • presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Community Supports information in Northern California Region

If you need help or want to find out what Community Supports might be available for you, call our Member Services at **1-833-721-6012** (TTY **711**), Monday through Friday, 8:30 a.m. to 1 p.m. and 2 p.m. to 5 p.m. for information on Community Supports

Community Supports information for Southern California Region

If you need help or want to find out what Community Supports might be available for you, call our Member Services at **1-855-839-7613**, (TTY **711**), 24 hours a day, 7 days a week.

Major Organ Transplant

For details on which counties have the Whole Child Model Program, go to the section “California Children’s Services and the Whole Child Model Program” later in this chapter.

Transplants for children in Counties with Whole Child Model

We will refer a child under age 21 who qualifies for CCS to a CCS-approved Specialty Care Center ("SCC") for an evaluation within 72 hours of when the child's doctor identifies the child as a potential candidate for transplant. If the SCC confirms that a transplant is needed and would be safe for the child, we will cover the transplant and related services, as long as the child remains enrolled in our Medi-Cal Plan.

Transplants children in all other Counties

State law requires children under age 21 who need transplants to be referred to the California Children's Services ("CCS") program to see if the child qualifies for CCS. If the child qualifies for CCS, the program will cover the costs for the transplant and related services.

If the child does not qualify for CCS, we will refer the child to a qualified transplant center for an evaluation. If the transplant center confirms that a transplant is safe and needed for the child's medical condition, we will cover the transplant and other related services.

Transplants for adults 21 and older

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

Transplants covered by Medi-Cal

The major organ transplants covered by us include, but are not limited to:

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

California Children's Services ("CCS") and Whole Child Model Program ("WCM")

California Children's Services ("CCS") is a state program that treats children under 21 years of age with certain health conditions, diseases, or chronic health problems and who meet the CCS program rules. If your doctor believes you might qualify for CCS, they will refer you to your county CCS program for an eligibility assessment.

Under the Whole Child Model ("WCM") program, we cover CCS services for our Members who qualify. The Whole Child Model program is available only in certain counties. You can check the table below to find out if the Whole Child Model is in your county.

Eligibility for CCS or Whole Child Model

County CCS program staff will decide if you qualify for CCS or WCM. We do not decide CCS eligibility. If your child qualifies to get this type of care, CCS providers will treat your child for the CCS-qualifying condition.

CCS does not cover all health conditions. CCS covers most health conditions that physically disable or that need to be treated with medicines, surgery or rehabilitation (rehab). Examples of CCS-eligible conditions include, but are not limited to the following:

- Congenital heart disease
- Cancers
- Tumors
- Hemophilia
- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts
- Cerebral palsy
- Transplants, including cornea
- Seizures under certain circumstances
- Rheumatoid arthritis

- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

If you live in a county with CCS

If you qualify to get this type of care, CCS providers working with Kaiser Permanente assign a personal care coordinator to help coordinate treatment for the CCS-eligible condition using a care team and care plan. Kaiser Permanente does not cover services provided by the CCS program. For CCS to cover these services, CCS must approve the provider, services, and equipment.

If you do not qualify for CCS program services, you will keep getting Medically Necessary care from Kaiser Permanente. To learn more about CCS, you can visit the CCS web page at **www.dhcs.ca.gov/services/ccs** or call our Member Services at **1-855-839-7613** (TTY **711**).

If you live in a County with the Whole Child Model program

The Whole Child Model ("WCM") Program incorporates the California Children's Services ("CCS") program for Medi-Cal eligible CCS children and youth into Medi-Cal Managed Care. Under the WCM Program, Kaiser Permanente is responsible for covering services for CCS-eligible conditions.

Travel expenses for CCS and WCM services

You may be able to get help with travel expenses, such as transportation, meals, lodging parking, and tolls, if you do not have a way to get to your medical appointment for a CCS-qualifying condition. You should call us before you pay out of pocket for transportation since we do cover non-medical and non-emergency medical transportation as noted in benefits and services. However, if you do pay out of pocket you may be able to receive reimbursement from us if you pay for the necessary transportation expenses up front. If your transportation is determined to be necessary, we must approve and reimburse you within 60 calendar days of you submitting the required receipts and documentation for transportation expenses.

Home and Community-Based Services outside of WCM services

If you are eligible to enroll in a 1915(c) waiver, you may be able to receive home and community-based services that are not related to a CCS-eligible condition but are necessary for you to remain in a community setting, instead of in an institution. For example, if you require home modifications to meet your needs in a community-based setting, we cannot pay those costs as a CCS-related condition; however, if you are enrolled in a 1915(c) waiver, home modifications may be covered if they are medically necessary to prevent institutionalization.

Counties with Whole Child Model programs and CCS

The table below lists which counties participate in the Whole Child Model Program and which counties participate in California Children's Services.

County	Whole Child Model – we pay for services for CCS-eligible conditions	CCS –CCS program pays for services related to CCS-eligible conditions
Alameda		X
Amador		X
Contra Costa		X
El Dorado		X
Fresno		X
Imperial		X
Kern		X
Kings		X

County	Whole Child Model – we pay for services for CCS-eligible conditions	CCS –CCS program pays for services related to CCS-eligible conditions
Los Angeles		X
Madera		X
Marin	X	
Mariposa		X
Napa	X	
Orange	X	
Placer	X	
Riverside		X
Sacramento		X
San Bernardino		X
San Diego		X
San Francisco		X
San Mateo	X	
Santa Cruz	X	

County	Whole Child Model – we pay for services for CCS-eligible conditions	CCS –CCS program pays for services related to CCS-eligible conditions
Solano	X	
Sonoma	X	
Stanislaus		X
Sutter		X
Tulare		X
Ventura		X
Yolo	X	
Yuba		X

Other Medi-Cal programs and services not covered by Kaiser Permanente

Kaiser Permanente does not cover some services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. We will coordinate with other programs to make sure you get all medically necessary services, including those covered by another program and not by us. This section lists some of these services. To learn more, call our Member Services at **1-855-839-7613**, (TTY **711**), 24 hours a day, 7 days a week.

Dental Managed Care in Sacramento and Los Angeles Counties

Medi-Cal Dental Managed Care Program uses managed care plans to provide your dental services. You must enroll in Dental Managed Care. In some cases, you may qualify for

an exemption from enrolling in Dental Managed Care. To learn more, go to Health Care Options at **http://dhcs.ca.goc/mymedi-cal**. You can also call Health Care Options at **1-800-430-4263.**

Note: Anesthesia services for certain dental procedures are covered under the terms of this Member Handbook. See the "Anesthesiologist services" heading under "Outpatient Care" in Chapter 4, "Benefits and services", of this Member Handbook for more information.

Dental services in other counties

The Medi-Cal Dental Program is the same as Fee-for-Service Medi-Cal for your dental services. Before you get dental services, you must show your BIC to the dental provider and make sure the dental provider takes FFS Dental.

Medi-Cal covers some dental services, including:

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

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

Outpatient Prescription Drugs Covered by Medi-Cal Rx

Prescription drugs given by an outpatient pharmacy are covered by Medi-Cal Rx, which is part of FFS Medi-Cal. If your provider prescribes drugs given in the doctor's office or infusion center, these may be considered physician-administered drugs. Read "Treatment therapies" in Chapter 4, "Benefits and services", for more information on physician-administered drugs that we cover. You can also learn more about prescription drugs we cover in "Outpatient prescription drugs covered by Kaiser Permanente" in this chapter.

Medi-Cal Rx Contract Drugs List ("CDL")

The Medi-Cal Contract Drugs List is the list of drugs including drugs that require pre-approval from Medi-Cal Rx. Your provider can tell you if a drug is on the Medi-Cal Rx Contract Drugs List. To be covered by Medi-Cal Rx, the item must be on the Medi-Cal Contract Drugs List ("CDL") or must be pre-approved for you by Medi-Cal Rx. Your provider can tell you if a drug is on the Medi-Cal Rx CDL.

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

- A pharmacist at your outpatient pharmacy may give you a 14-day emergency supply if they think you need it. Medi-Cal Rx will pay for the emergency medicine an outpatient pharmacy gives.

- Medi-Cal Rx may say no to a non-emergency request. If they do, they will send you a letter to tell you why. They will tell you what your choices are. To learn more, read "Complaints" in Chapter 6, "Child and youth well care", of this Member handbook.

To find out if a drug is on the Contract Drugs List or to get a copy of the Contract Drugs List, call Medi-Cal Rx **Customer Service** at **1-800-977-2273** (TTY **1-800-977-2273**) and press **7** or **711**, 24 hours a day, 7 days a week. You can also visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Medi-Cal Rx Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with Medi-Cal Rx. All Kaiser Permanente outpatient pharmacies in

California work with Medi-Cal Rx. You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at: https://medi-calrx.dhcs.ca.gov/home/

You can call Medi-Cal Rx Customer Service at **1-800-977-2273** (TTY **1-800-977-2273**) and pressing **7** or **711**, 24 hours a day, 7 days a week.

Once you choose a pharmacy, your provider may send a prescription to your pharmacy electronically. Your provider may also give you a written prescription to take to your pharmacy. Give the pharmacy your prescription with your Medi-Cal Benefits Identification Card ("BIC") and your Kaiser Permanente ID card. Make sure the pharmacy knows about all medicines you are taking and any allergies you have. If you have any questions about your prescription, ask the pharmacist.

You can get transportation help from us to get to the pharmacy to pick up your prescription. For more information, go to the heading "Transportation benefits for situations that are not emergencies" earlier in Chapter 4, "Benefits and services", of this Member Handbook.

Specialty mental health services ("SMHS")

Some mental health services are covered by county mental health plans instead of us. These include SMHS for Medi-Cal Members who meet the rules for SMHS. Specialty mental health services include the following:

Outpatient services

- Mental health services
- Medication support services
- Day treatment intensive services
- Day rehabilitation services
- Crisis intervention services
- Crisis stabilization services
- Targeted case management
- Therapeutic behavioral services covered (for members under 21)
- Intensive care coordination ("ICC")
- Intensive home-based services ("IHBS") covered (for members under 21)
- Therapeutic foster care ("TFC") covered (for members under 21)
- Mobile crisis services
- Peer Support Services ("PSS") (optional)

Residential services

- Adult and pediatric residential treatment services
- Crisis residential treatment services

Inpatient services

- Psychiatric inpatient hospital services
- Psychiatric health facility services

To learn more about specialty mental health services in your county, you can call the county. To locate all counties' free telephone numbers online, go to dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Substance use disorder treatment services

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

Kaiser Permanente members can have an assessment to match them to the services that best fit their health needs and preferences. When medically necessary, available services include outpatient treatment, residential treatment, and medicines for substance use disorders (also called Medications for Addiction Treatment ("MAT") such as buprenorphine, methadone, and naltrexone. We will provide or arrange for MAT to be given in primary care, inpatient hospitals, emergency departments, and other medical settings.

The county provides substance use disorder services to Medi-Cal members who qualify for these services. Members who are identified for substance use disorder treatment services are referred to their county department for treatment.

For a list of all counties' telephone numbers go to https://dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

1915(c) waiver Home and Community-Based Services

California's six Medi-Cal 1915(c) waivers allow the state to provide services to persons who would otherwise need care in a nursing facility or hospital in the community-based setting of their choice. Medi-Cal has an agreement with the Federal Government that allows waiver services to be offered in a private home or homelike community setting.

The services offered under the waivers must cost no more than the alternative institutional level of care. HCBS Waiver recipients must have full-scope Medi-Cal.

Some 1915(c) waivers have limited availability across the State of California and/or may have a waitlist. The six Medi-Cal 1915(c) waivers are:

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

To learn more about the Medi-Cal Waivers, go to https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx. Or call our Member Services at **1-855-839-7613** (TTY **711**).

In-Home Supportive Services ("IHSS")

The In-Home Supportive Services ("IHSS") program provides in-home personal care assistance as an alternative to out-of-home care to qualified Medi-Cal-eligible persons, including those who are aged, blind, and/or disabled. IHSS allows recipients to stay safely in their own homes. Your health care provider must agree that you need in-home personal care assistance and that you would be at risk of placement in out-of-home care if you did not get IHSS services. The IHSS program will also perform a needs assessment.

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

Local Education Agency ("LEA") assessment services

Health Plan is not responsible for coverage for LEA assessment services as specified in Title 22 CCR Section 51360(b) when provided to a Member who qualifies for LEA services based on Title 22 CCR Section 51190.1.

LEA services related to IEPs and IFSPs

Health Plan is not responsible for coverage for LEA services provided pursuant to an Individualized Education Plan ("IEP") as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan ("IFSP") as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22 CCR Section 51360.

Laboratory services for State alpha-fetoprotein testing program

Coverage for services under the State's serum alpha-fetoprotein testing program is through FFS Medi-Cal.

Pediatric Day Health Care

Coverage for pediatric day health care services is through FFS Medi-Cal. Please contact your county for more information on how to access these services.

Prayer or spiritual healing

Prayer or spiritual healing services as specified in Title 22 CCR Section 51312 are available through FFS Medi-Cal. Please contact your county for more information on how to access these services.

Targeted case management services

Targeted case management services as specified in Title 22 CCR Sections 51185 and 51351 are through FFS Medi-Cal. Please contact your county for more information on how to access these services.

Services not covered by Kaiser Permanente or Medi-Cal

Medi-Cal will not cover some services. In these situations, we cannot cover them either. This section describes the services that neither we nor Medi-Cal will cover. Read each of the sections below to learn more or call our Member Services at **1-855-839-7613** (TTY **711**)

Certain exams and services

Medi-Cal coverage does not include exams and services needed:

- 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. For more information on Community Support, go to that heading earlier in chapter 4, "Benefits and services", of this Member Handbook.

Cosmetic services

Medi-Cal coverage does not include services to change the way you look (including surgery on normal parts of your body to change how you look). This exclusion does not apply to covered prosthetic devices:

- 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 in Chapter 4, “Benefits and services”, of this Member Handbook:

- Dialysis/hemodialysis treatment
- Durable medical equipment
- Home health care
- Hospice and palliative care
- Medical supplies, equipment, and appliances
- Prescription drugs

Experimental services

Experimental services are drugs, equipment, procedures or services that are being tested in a laboratory or on animals, but they are not ready to be tested in humans. Medi-Cal coverage does not include experimental services.

Fertility 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.

Hair loss or growth treatment

Medi-Cal coverage does not include items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Items and services that are not health care items and services

Medi-Cal coverage does not include items that are not health care items or services

unless they are approved for you under Community Supports or approved for you under 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 under “Behavioral Health Treatment” in Chapter 4, “Benefits and services”, of this Member Handbook
- 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 in Chapter 4, “Benefits and services”, of this Member Handbook:
    - Home health care
    - Hospice and palliative care
    - Rehabilitative and habilitative services
    - Skilled nursing facility services

Massage therapy

Medi-Cal coverage does not include 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 in Chapter 4, “Benefits and services”, of this Member Handbook:

- Home health care
- Hospice and palliative care
- Rehabilitative and habilitative services

Personal care services

Medi-Cal coverage does not include services that are not Medically Necessary, 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 sections:

- Hospice and palliative care
- Long-term care services and supports
- Skilled nursing/intermediate/subacute facility care
- Community Supports

Reversal of sterilization

Medi-Cal coverage does not include services to reverse voluntary surgical birth control.

Routine foot care items and services

Medi-Cal coverage does not include foot care items and services that are not Medically Necessary.

Services not approved by the Food and Drug Administration

Medi-Cal coverage does not include 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:

- Covered Emergency Care received in Canada or Mexico
- Services covered under “Clinical trials” in Chapter 4, “Benefits and services”, of this Member Handbook
- Services provided as part of covered investigational services as described in Chapter 4, “Benefits and services”, of this Member Handbook

Services performed by unlicensed people

Medi-Cal 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:

- Services covered under the “Behavioral health treatments” heading under “Rehabilitative and habilitative services” in Chapter 4, “Benefits and services”, of this Member Handbook.
- Covered Community Supports approved for you.
- Covered doula services
- Covered community health worker services

Services related to a non-covered 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 non-covered Services if those complications would be covered by Medi-Cal. 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 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 by Medi-Cal.

Lead poisoning case management by county health departments

Please contact your county for more information on lead poisoning case management services.

Evaluation of new and existing technologies

Kaiser Permanente has a rigorous process for monitoring and evaluating the clinical evidence for new medical technologies that are treatments and tests. Network doctors decide if new medical technologies shown to be safe and effective in published, peer-reviewed clinical studies are medically appropriate for their patients.

5. Child and youth well care

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

Medi-Cal for Kids and Teens

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

- Well-child visits and teen check-ups (important visits children need)
- Immunizations (shots)
- Behavioral health assessment and treatment
- Mental health evaluation and treatment, including individual, group, and family psychotherapy (specialty mental health services (“SMHS”) are covered by the county)
- Adverse childhood experiences (“ACE”) screening
- Enhanced Care Management (“ECM”) for Children and Youth Populations of Focus (“POFs”) (a Medi-Cal managed care plan (“MCP”) benefit)
- Lab tests, including blood lead poisoning screening
- Health and preventive education
- Vision services
- Dental services (covered by FFS Medi-Cal Dental or Dental Managed Care)

- Hearing services (covered by the Whole Child Model or for children who qualify. We will cover Medically Necessary hearing services that Whole Child Model or CCS do not cover)
- Home Health Services, such as private duty nursing ("PDN"), occupational therapy, physical therapy, and medical equipment and supplies

These services are called Medi-Cal for Kids and Teens (also known as Early and Periodic Screening, Diagnostic and Treatment ("EPSDT")) services.

Additional information for members regarding Medi-Cal for Kids and Teens can be found here, https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Member-Information.aspx.

Medi-Cal for Kids and Teens services that are recommended by pediatricians' Bright Futures guidelines to help you, or your child, stay healthy are covered for free. To read the Bright Futures guidelines, go to https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Enhanced Care Management ("ECM")

Enhanced Care Management ("ECM") is a Medi-Cal managed care plan ("MCP") benefit available in all California counties to support comprehensive care management for MCP members with complex needs.

Because children and youth with complex needs are often already served by one or more case managers or other service providers within a fragmented delivery system, ECM offers coordination between systems. Children and Youth Populations of Focus eligible for this benefit include:

- Children and Youth Experiencing Homelessness
- Children and Youth at Risk for Avoidable Hospital or Emergency Department ("ED") Utilization
- Children and Youth with Serious Mental Health and/or Substance Use Disorder ("SUD") Needs
- Children and Youth Enrolled in California Children's Services ("CCS") or CCS Whole Child Model ("WCM") With Additional Needs Beyond the CCS Condition
- Children and Youth Involved in Child Welfare

Additional information on ECM can be found here: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Children-And-Youth-POFs-Spotlight.pdf

In addition, ECM Lead Care Managers are strongly encouraged to screen ECM members for needs for Community Supports services provided by MCPs as cost-effective alternatives to traditional medical services or setting and refer to those Community Supports when eligible and available. Children and youth may benefit from many of the Community Supports services, including asthma remediation, housing navigation, medical respite, and sobering centers.

Community Supports are services provided by Medi-Cal managed care plans ("MCPs") and are available to eligible Medi-Cal members regardless of whether they qualify for ECM services.

More information on Community Supports can be found here: https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf

Some of the services available through Medi-Cal for Kids and Teens, such as PDN, are considered supplemental services. These are not available to Medi-Cal members ages 21 and older. To keep getting these services for free, you or your child may have to enroll in a 1915(c) Home and Community-Based Services ("HCBS") waiver or other Long-Term Services and Supports ("LTSS") on or before turning the age of 21.

If you or your child is getting supplemental services through Medi-Cal for Kids and Teens and will be turning 21 years of age soon, contact Kaiser Permanente to talk about choices for continued care.

Well-child health check-ups and preventive care

Preventive care includes regular health check-ups and screenings to help your doctor find problems early, and counseling services to detect illnesses, diseases, or medical conditions before they cause problems. Regular check-ups help you or your child's doctor look for any problems. Problems can include medical, dental, vision, hearing, mental health, and any substance (alcohol or drug) use disorders. We cover check-ups to screen for problems (including blood lead level assessment) any time there is a need for them, even if it is not during your or your child's regular check-up.

Preventive care also includes immunizations (shots) you or your child need. We must make sure all enrolled children are up to date with all the immunizations (shots) they need when they have their visits with their PCP. Preventive care services and screenings are available for free and without pre-approval (prior authorization).

Your child should get check-ups at these ages:

- 2-4 days after birth
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Once a year from 3 to 20 years old

Well-child health check-ups include:

- A complete history and head-to-toe physical exam
- Age-appropriate immunizations (shots) (California follows the American Academy of Pediatrics Bright Futures schedule: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Lab tests, including blood lead poisoning screening
- Health education
- Vision and hearing screening
- Oral health screening
- Behavioral health assessment

If the health care provider finds a problem with your or your child's physical or mental health during a check-up or screening, you or your child might need to get further medical care. We will cover that care for free, including:

- Doctor, nurse practitioner, and hospital care
- Immunizations (shots) to keep you healthy

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

Blood lead poisoning screening

All children enrolled in Kaiser Permanente should get blood lead poisoning screening at 12 and 24 months of age, or between 24 and 72 months of age if they were not tested earlier. Children can get a blood lead screening if a parent or guardian requests one. Children should also be screened whenever the doctor believes a life change has put the child at risk.

Help getting child and youth well care services

We will help members under 21 years old and their families get the services they need.

A Kaiser Permanente care coordinator can:

- Tell you about available services
- Help find Medi-Cal Network Providers or Out-of-Network Medi-Cal providers, when needed
- Help make appointments

- Arrange Medical Transportation and Non-Medical Transportation so children can get to their appointments
- Help coordinate care for services available through Fee-for-Service (“FFS”) Medi-Cal, such as, but not limited to:
  - Treatment and rehabilitative services for mental health and substance use disorders
  - Treatment for dental issues, including orthodontics

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

Dental check-ups

Keep your baby’s gums clean by gently wiping the gums with a washcloth every day. At about 4 to 6 months, “teething” will begin as the baby teeth start to come in. You should make an appointment for your child’s first dental visit as soon as their first tooth comes in or by their first birthday, whichever comes first.

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

Babies ages 0-3

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

Kids ages 4-12

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

Youth ages 13-20

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

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

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

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

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

Additional preventive education referral services

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

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

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

The California Department of Education provides and pays for these services. Together with your child's doctors and teachers, you may be able to make a custom plan that will best help your child.

6. Reporting and solving problems

There are two ways to report and solve problems:

- Use a **complaint** (**grievance**) when you have a problem or are unhappy with Kaiser Permanente or a provider or with the health care or treatment you got from a provider.
- Use an **appeal** when you do not agree with our decision to change your services or to not cover them.

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

You may contact Kaiser Permanente first to let us know about your problem. Call us between 24 hours a day, 7 days a week (except closed holidays) at **1-855-839-7613** (TTY **711**) to tell us about your problem. You can also tell us online at **kp.org** or in person at a Member Services office at your local Plan Facility.

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

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

Call KP member services at **1-855-839-7613** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is free. Visit online at **kp.org**

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call our Member Services at **1-855-839-7613** (TTY **711**).

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

Complaints

A complaint (grievance) is when you have a problem or are unhappy with the services you are getting from Kaiser Permanente or a provider. There is no time limit to file a complaint.

If you have a complaint about outpatient prescription drugs or pharmacy services you got through Medi-Cal Rx, submit your complaint to Medi-Cal Rx. You can submit a complaint either in writing or by telephone by going to www.Medi-CalRx.dhcs.ca.gov or calling 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.

For all other issues, you can file a complaint with us any time by phone, in writing, in person, or online. Your authorized representative or provider can also file a complaint for you with your permission.

Standard Procedure

- **By phone:** Call Member Services toll free at **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week. Give your health medical record number, your name, and the reason for your complaint.
- **By mail:** To file a grievance in writing, please use our grievance form, which is available on kp.org under “Forms & Publications.” You can also get the form from any Member Services office at a Plan Facility, or from Medi-Cal Network Providers. Be sure to include your name, medical record number, and the reason for your complaint. Tell us what happened and how we can help you.

  Mail the form to:
  Member Case Resolution Center (for standard grievances)
  P.O. Box 939001
  San Diego, CA 92193-9001

- **Online:** Fill out the online grievance form at **kp.org**.

If you need help filing your complaint, we can help you. We can give you free language services. Call our Member Services at **1-855-839-7613** (TTY **711**).

Within 5 calendar days of getting your complaint, we will send you a letter telling you we got it. Within 30 days, we will send you another letter that tells you how we resolved your problem. If you call us about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and your grievance is resolved by the end of the next business day, you may not get a letter.

Urgent Procedure

If you have an urgent matter involving a serious health concern, we will start an expedited (fast) review and provide you with a decision within 72 hours. If you want us to consider your grievance on an urgent basis, please tell us when you file your grievance.

Note: Urgent is sometimes referred to as “exigent.” If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- **By phone**: Call our Expedited Review Unit at **1-888-987-7247** (TTY **711**)
- **By mail**: Send a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566

- **By fax**: Fax your written request to our Expedited Review Unit at **1-888-987-2252**
- **In person**: Visit a Member Services office at a Plan Facility (for addresses, refer to your Medi-Cal Provider Directory or call Member Services)
- **Online**: Fill out the online grievance form at kp.org

If you need help filing your urgent grievance, we can help you. We can give you no-cost

language services. Call our Member Services at **1-855-839-7613** (TTY **711**). Within 72 hours of getting your complaint, we will decide how we will handle your complaint and whether we will expedite it. If we find that we will not expedite your complaint, we will let you know that we will resolve your complaint within 30 days. You may contact DMHC directly for any reason, including if you believe your concern qualifies for expedited review, if we do not respond to you within the 72-hour period, or if you are unhappy with our decision.

Complaints related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. DMHC's toll-free telephone number is **1-888-466-2219** (TTY **1-877-688-9891**). You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: https://www.dmhc.ca.gov/.

Appeals

An appeal is different from a complaint. An appeal is a request for Kaiser Permanente to review and change a decision we made about your services. If we sent you a Notice of Action ("NOA") letter telling you that we are denying, delaying, changing, or ending a service, and you do not agree with our decision, you can file an appeal. Your authorized representative or provider can also file an appeal for you with your written permission.

You must file an appeal within 60 calendar days from the date on the NOA you got from Kaiser Permanente. If we decide to reduce, suspend, or stop a service you are getting now, you can continue getting that service while you wait for your appeal to be decided. This is called Aid Paid Pending. To get Aid Paid Pending, you must ask us for an appeal within 10 days from the date on the NOA or before the date we said your service will stop, whichever is later. When you request an appeal under these circumstances, your service will continue while you wait for your appeal decision. We may require you to pay for the cost of services if the final decision denies or changes a service.

If you want to appeal a decision made by Medi-Cal Rx, you can request a State Hearing. The California Department of Social Services has a State Hearing process if you want to appeal a Medi-Cal Rx decision. This process is different from the appeals process you use for your other benefits. In a State Hearing, a judge reviews your request with clinical input from DHCS pharmacists to make sure the decision aligns with Medi-Cal pharmacy policy.

For all other issues, you can file an appeal by phone, in writing by mail, or online:

Standard appeal

- **By phone:** Call our Member Services free at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week . Give your name, medical record number, and the reason for your complaint.

- **By mail:** To file an appeal in writing, please use our grievance form, which is available on kp.org under "Forms & Publications." You can also get the form from any Member Services office at a Plan Facility, or from Medi-Cal Network Providers. Be sure to include your name, medical record number, and the reason for your appeal. Tell us what happened and how we can help you.
  Mail the form to:
  Member Case Resolution Center (for standard appeal)
  P.O. Box 9390011
  San Diego, CA 92193-90011
- **Online:** Fill out the online grievance form at **kp.org**

If you need help asking for an appeal or with Aid Paid Pending, we can help you. We can give you free language services. Call our Member Services at **1-855-839-7613** (TTY **711**).

Within 5 calendar days of getting your appeal, we will send you a letter telling you we got it. Within 30 days, we will tell you our appeal decision and send you a Notice of Appeal Resolution ("NAR") letter. If we do not give you our appeal decision within 30 days, you can request a State Hearing from the California Department of Social Services ("CDSS") or an Independent Medical Review ("IMR") from DMHC.

But if you ask for a State Hearing first, and the hearing to address your specific issues has already happened, you cannot ask for an IMR with DMHC on the same issues . In this case, the State Hearing has the final say. But you may still file a complaint with DMHC if your issues do not qualify for an IMR, even if the State Hearing has already happened.

If you or your doctor wants us to make a fast decision because the time it takes to decide your appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. We will decide within 72 hours for getting your appeal.

Urgent appeal procedure

If you or your doctor wants us to make a fast decision because the time it takes to decide your appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. We will decide within 72 hours for getting your appeal.

You can ask for an expedited review in one of the following ways:

- **By phone**: Call our Expedited Review Unit **1 888 987 7247** (TTY **711**)
- **By mail**: Send a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566

- **By fax**: Fax your written request to our Expedited Review Unit at **1-888-987-2252**
- **In person**: Visit a Member Services office at a Plan Facility (for addresses, refer to your Medi-Cal Provider Directory or call Member Services)

Online: Fill out the online grievance form at kp.org

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

If you filed an appeal and got a Notice of Appeals Rights ("NAR") letter from us telling you that we did not change our decision, or you never got a NAR letter and it has been past 30 days, you can:

- Ask for a **State Hearing** from the California Department of Social Services ("CDSS") and a judge will review your case. CDSS' free telephone number is **1-800-743-8525** (TTY **1-800-952-8349**). You can also ask for a State Hearing online at https://www.cdss.ca.gov. More ways of asking for a State Hearing can be found in "State hearings" later in this chapter.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care ("DMHC") to have our decision reviewed. If your complaint qualifies for DMHC's Independent Medical Review ("IMR") process, an outside doctor who is not part of Kaiser Permanente will review your case and make a

decision that we must follow.

DMHC's free telephone number is **1-888-466-2219** (TTY **1-877-688-9891**). You can find the IMR/Complaint form and instructions online at DMHC's website: https://www.dmhc.ca.gov.

You will not have to pay for a State Hearing or an IMR.

You are entitled to both a State Hearing and an IMR. But if you ask for a State Hearing first and the hearing to address your specific issues has already happened, you cannot ask for an IMR with DMHC on the same issues. In this case, the State Hearing has the final say. But you may still file a complaint with DMHC if the issues do not qualify for IMR, even if the State Hearing has already happened.

The sections below have more information on how to ask for a State Hearing and an IMR.

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by Kaiser Permanente. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by call **1-800-977-2273** (TTY **1-800-977-2273**) and press **7** or **711**. Complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review ("IMR") with DMHC.

If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing. Medi-Cal Rx pharmacy benefit decisions are not subject to the IMR process with the DMHC.

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

An IMR is when an outside doctor who is not related to the health plan reviews your case. If you want an IMR, you must first file an appeal with us for non-urgent concerns. If you do not hear from us within 30 calendar days, or if you are unhappy with our decision, then you may request an IMR. You must ask for an IMR within 6 months from the date on the notice telling you of the appeal decision. You only have 120 days to request a State Hearing. So, if you want an IMR and a State hearing, file your complaint as soon as you can.

Remember, if you ask for a State Hearing first, and the hearing to address your specific

issues has already happened, you cannot ask for an IMR with DMHC on the same issues. In this case, the State Hearing has the final say. But you may still file a complaint with DMHC if the issues do not qualify for IMR, even if the State Hearing has already happened.

You may be able to get an IMR right away without first filing an appeal with Kaiser Permanente. This is in cases where your health concern is urgent, such as those involving a serious threat to your health or if you were denied a service on the basis that it is experimental or investigational.

If your complaint to DMHC does not qualify for an IMR, DMHC will still review your complaint to make sure we made the correct decision when you appealed our denial of services. We have to comply with DMHC's IMR and review decisions.

Here is how to ask for an IMR. 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 **1-855-839-7613 (TTY 711)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review ("IMR"). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with us and a judge from the California Department of Social Services ("CDSS"). The judge will help to resolve your problem and decide whether we made the correct decision or not. You have the right to ask for a State Hearing if you already filed an appeal with Kaiser Permanente and you are still not happy with our

decision, or if you did not get a decision on your appeal after 30 days.

You must ask for a State Hearing within 120 calendar days from the date on our Notice of Appeals Rights ("NAR") letter. If we gave you Aid Paid Pending during your appeal and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 days of our NAR letter or before the date we said your service(s) will stop, whichever is later.

If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, call our Member Services at **1-855-839-7613** (TTY **711**) Your authorized representative or provider can ask for a State Hearing for you with your written permission.

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

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

You can ask for a State Hearing in these ways:

- **By phone:** Call the State Hearings Division at **1-800-743-8525** (TTY **1-800-952-8349** or **711**).
- **By fax:** Fill out the form provided with your appeals resolution notice and fax it to the State Hearings Division at **1-833-281-0905**.
- **By mail**: Fill out the form provided with your appeals resolution notice. Send it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-3
Sacramento, CA 94244-2430

- **Online** Request a hearing online at **www.cdss.ca.gov**

- **By email:** Fill out the form that came with your appeals resolution notice and email it to **Scopeofbenefits@dss.ca.gov**
  - Note: If you send it by email, there is a risk that someone other than the State Hearings Division could intercept your email. Consider using a more secure method to send your request.

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call our Member Services at **1-855-839-7613** (TTY **711**).

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

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

Fraud, waste, and abuse

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

Provider fraud, waste, and abuse includes:

- Falsifying medical records
- Prescribing more medication than is Medically Necessary
- Giving more health care services than is Medically Necessary

- Billing for services that were not given
- Billing for professional services when the professional did not perform the service
- Offering free or discounted items and services to members in an effort to influence which provider is selected by the member
- Changing member's primary care provider without the knowledge of the member

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

- Lending, selling, or giving a health plan ID card or Medi-Cal Benefits Identification Card ("BIC") to someone else
- Getting similar or the same treatments or medicines from more than one provider
- Going to an emergency room when it is not an emergency
- Using someone else's Social Security number or health plan ID number
- Taking Medical Transportation and Non-Medical Transportation rides for non-healthcare related services or for services not covered by Medi-Cal, or when there is no medical appointment or prescriptions to pick up

To report fraud, waste, or abuse, write down the name, address, and ID number of the person who committed the fraud, waste, or abuse. Give as much information as you can about the person, such as the phone number or the specialty if it is a provider. Give the dates of the events and a summary of exactly what happened.

If you notice potential signs of misconduct, contact our Member Services at **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week (closed holidays). You can also submit your report in writing at a Member Services office. You can find locations of our Member Services offices in your Medi-Cal Provider Directory.

Binding Arbitration

When you choose to enroll in Kaiser Foundation Health Plan, Inc. as your Medi-Cal health plan, you agree to use binding arbitration to settle disputes. This is a required step before you can enroll in our Medi-Cal Plan.

In binding arbitration, both sides give up the right to a jury or court trial. Binding arbitration

is a way to solve problems using a neutral third party. This third party hears both sides of the issue and makes a decision that both sides have to obey.

What are the rules for Binding Arbitration?

There are rules developed by the Arbitration Oversight Board in consultation with the Office of the Independent Administrator ("OIA"), Kaiser Permanente, and other interested parties that describe how arbitration cases are handled. These rules are the Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator. These rules are also called The Rules of Procedure. The OIA is a neutral, independent office responsible for administering arbitrations between Kaiser Foundation Health Plan, Inc. and its California health plan members. The OIA is not part of Kaiser Permanente. You can call Member Services to ask for a copy of the Rules of Procedure.

Scope of Arbitration

Binding Arbitration shall apply to any dispute if all of the following requirements are met:

- The claim is for:
  - Malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered); or
  - Delivery of services or items; or
  - Premises liability
- The claim is brought by:
  - You against us; or
  - Us against you
- Governing law does not prevent the use of binding arbitration to resolve the claim

Keep in mind:

- Claims that can be settled through Small Claims court do not go through Binding Arbitration.

- You do not have to use binding arbitration for claims that can be settled through a State Hearing
- You cannot use binding arbitration if you have gotten a decision on the claim through a State Hearing

In this “Binding Arbitration” section only, “you” means:

- You (a Member)
- Your heir, relative, or someone you name to act for you
- Someone who claims that a duty to them exists due to your relationship with us

In this “Binding Arbitration” section only, “us” and “we” mean:

- Kaiser Foundation Health Plan, Inc. (“KFHP”)
- Kaiser Foundation Hospitals (“KFH”)
- Southern California Permanente Medical Group (“SCPMG”)
- The Permanente Medical Group, Inc. (“TPMG”)
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any SCPMG or TPMG doctor
- Any person or organization with a contract with any of these parties that requires the use of binding arbitration
- Any employee or agent of any of these parties

Rules of Procedure

Binding arbitrations are conducted using the Rules of Procedure:

- The Rules of Procedure were developed by the Arbitration Oversight Board in consultation with the Office of the Independent Administrator ("OIA"), Kaiser Permanente, and other interested parties.
- You can get a copy of the Rules of Procedure from Member Services at **1-855-839-7613** (TTY **711**)

How to Ask for Arbitration

To ask for binding arbitration, you must make a formal request. This is called a Demand for Arbitration, which includes:

- Your description of the claim against us
- The amount of damages or resolution you are asking for
- The names, addresses, and phone numbers of all the parties who are making the claim. If any of these parties have a lawyer, include the name, address, and phone number of the lawyer
- The names of the parties whom you are filing the claim against

All claims resulting from the same incident should be included in one request.

If we are filing a claim against you, we must follow the same steps outlined above for making a formal request.

Where to send a Demand for Arbitration

If you are filing a claim against KFHP, KFH, SCPMG, TPMG, The Permanente Federation, LLC, or The Permanente Company, LLC, mail the Demand for Arbitration to:

Kaiser Permanente
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

If you are filing a claim against any other party, you must give them notice as required by the California Code of Civil Procedure for a civil action.

We are served when we get your Demand for Arbitration.

If we are filing a claim against you, we will mail the Demand for Arbitration to your address on file.

Costs related to Binding Arbitration

Filing fee

There is a filing fee of $150 for each Demand for Arbitration that you request, payable to "Arbitration Account," and is the same amount, no matter how many claims you request or the number of parties you name. The filing fee is not refundable.

If you cannot afford the filing fee or your share of the Binding Arbitration costs, you can ask the Office of the Independent Administrator for a fee waiver. To do this, you must fill out and send in a Fee Waiver Form to:

- The Office of the Independent Administrator; and
- The parties you are filing the claim against

The Fee Waiver Form:

- Tells you how the Independent Administrator decides whether to waive the fees
- Tells you the fees that can be waived

You can get a copy of the Fee Waiver Form from our Member Services at **1-855-839-7613** (TTY **711**).

Arbitrators' Fees and Expenses

We will pay the fees of the neutral arbitrator in some cases. To find out when we will pay the fees, look in the Rules of Procedure. You can get a copy of the Rules of Procedure from Member Services at **1-855-839-7613** (TTY **711**). In all other cases, this cost is shared equally by both parties. If the parties select party arbitrators, each party pays the fees of their party arbitrator.

Costs

Usually, each party must pay their own costs of the binding arbitration, no matter the outcome, such as lawyers' fees, witness fees, and other costs.

Number of Arbitrators

Some cases are heard by one arbitrator that both sides agree on (a neutral arbitrator). In other cases, there may be one neutral arbitrator and an arbitrator chosen by each side, known as party arbitrators.

Cases that request up to $200,000 in damages go before one neutral arbitrator, who must stay neutral. In those cases, both sides can agree to add two party arbitrators, for a total of three arbitrators. The agreement for more than one arbitrator must be made after the Demand for Arbitration has been filed. When there are three arbitrators, one represents each side and the third is neutral. The arbitrator(s) cannot award more than $200,000.

Cases that request more than $200,000 in damages may go before three arbitrators, one neutral and two party arbitrators, one chosen by each side. Either side can waive their right to have party arbitrators. Both sides in a dispute can agree to have the case heard by a single neutral arbitrator. The agreement for a single neutral arbitrator must be made after the Demand for Arbitration has been filed.

General Provisions

You cannot ask for binding arbitration if the claim would not meet the statute of limitations for that claim in a civil action.

Your claim will be dismissed if either of the following occurs:

- You did not follow The Rules of Procedure
- The hearing has not occurred, and more than five years have passed after the earlier of:
  - The date you served the Demand for Arbitration; or
  - The date you filed a civil action based on the same incident

A claim may be dismissed on other grounds by the neutral arbitrator. Good cause must be shown for this to happen.

If one of the parties does not attend the hearing, the neutral arbitrator may decide the case in that party's absence.

The California Medical Injury Compensation Reform Act (and any amendments) applies to claims as allowed by law, such as:

- The right to introduce evidence of any insurance or disability benefit payment to you
- Limits on the amount of money you can recover for noneconomic losses
- The right to have an award for future damages made in periodic payments

Arbitrations are governed by this “Binding Arbitration” section. These standards also apply as long as they do not conflict with this section:

- Section 2 of the Federal Arbitration Act
- The California Code of Civil Procedure
- The Rules of Procedure

7. Rights and responsibilities

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

Your rights

These are your rights as a member of Kaiser Permanente:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health
- To be provided with information about the health plan and its services, including covered services, Medi-Cal Network Providers, and member rights and responsibilities
- To get fully translated written member information in your preferred language, including all grievance and appeals notices
- To make recommendations about our member rights and responsibilities policy
- To be able to choose a primary care provider within our Medi-Cal Provider Network
- To have timely access to Medi-Cal Network Providers
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care you got

- To know the medical reason for our decision to deny, delay, terminate (end), or change a request for medical care
- To get care coordination
- To ask for an appeal of decisions to deny, defer, or limit services or benefits
- To get free interpreting and translation services for your language
- To get free legal help at your local legal aid office or other groups
- To formulate advance directives
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with us and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible
- To disenroll (drop) from Kaiser Permanente and change to another managed care plan in the county where you live
- To access minor consent services
- To get free written member information in other formats such as braille, large-size print, audio, and accessible electronic formats upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (“W&I”) Code section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage
- To have access and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how you are treated by Kaiser Permanente, your providers, or the State
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery

services, Rural Health Centers, sexually transmitted infection services, and Emergency Care outside our network pursuant to federal law.

- To know the names of the people who provide your care and what kind of training they have
- To get care in a place that is safe, secure, clean, and accessible
- To get a second opinion from a Medi-Cal network provider at any time

Your responsibilities

Kaiser Permanente members have these responsibilities:

- Reading this Member Handbook to learn what coverage you have and how to get services
- Using your ID cards properly. Bring your Kaiser Permanente ID card, a photo
- ID, and your Medi-Cal ID card with you when you come in for care
- Keeping appointments
- Telling your provider about your health and health history
- Following the care plan you and your provider agree on
- Recognizing the effect of your lifestyle on your health
- Being considerate of network doctors, other health care staff, and Members
- Paying for services that are not covered by Medi-Cal
- Solving problems using the ways described in this Member Handbook
- Telling us if you are admitted to an out-of-network hospital
- Understanding your health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible

Notice of Nondiscrimination

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:

- 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 of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of 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 of 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 of 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 of Civil Rights Complaint Portal at:**
  https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Ways to get involved as a member

We want to hear from you. Each quarter, we have meetings to talk about what is working well and how we can improve. Members are invited to attend. Come to a meeting.

Medi-Cal Consumer Advisory Committee

We have a group in each California Region called the Medi-Cal Consumer Advisory Committee ("CAC"). This group is made up of Members, providers, and community-based organizations. You can join this group if you would like. The CAC provides input and recommendations to the Kaiser Foundation Health Plan, Inc. Board of Directors on how we can improve service to our Medi-Cal Members. There is one committee in each California Region.

To learn more about the Medi-Cal Consumer Advisory Committee in either of the California Regions, you may contact the Medi-Cal Care Delivery and Operations Team:

- **Email**: MediCalCommunity@kp.org

- **Mail**:

  Kaiser Permanente
  393 E. Walnut St.
  Pasadena, CA 91188

  ATTN: Medi-Cal Care Delivery and Operations Team 5th floor/CAC

Notice of privacy practices

A statement describing Kaiser Permanente's policies and procedures for preserving the confidentiality of medical records is available and will be given to you upon request.

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

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

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

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a Confidential Communication Request Form. The form is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you tell us to stop using the form or you send a new request for confidential communication. If you have questions, please call Member Services.

Kaiser Permanente will protect the privacy of your protected health information ("PHI"). We also require all contracting providers to protect the privacy of your PHI. Your PHI is individually identifiable information (oral, written, or electronic) about your health, health care services you received, or payment for your health care.

You can generally see and get a copy of your PHI, fix errors, or update your PHI, and ask us for a list of certain disclosures of your PHI. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

We may use or let others see your PHI for care, health research, payment, or health care operations, such as for research or measuring quality of care and services. Also, by law we may have to give your PHI to the government or provide it in legal actions.

We will not use or disclose your PHI for any other purpose without written authorization from you (or someone you name to act for you), except as described in our Notice of Privacy Practices (see below) and Medi-Cal privacy rules. You do not have to authorize this other use of your PHI.

If you see anyone using your information improperly, contact Member Services at **1-855-839-7613** (TTY **711**) or the California Department of Health Care Services, Privacy Officer, at **1-866-866-0602** Option 1 (**TTY 1-877-735-2929**). You can also e-mail the California Department of Health Care Services at **privacyofficer@dhcs.ca.gov**.

This is only a short summary of some of our key privacy practices. OUR NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PHI, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To get a copy, call Member Services at **1-855-839-7613** (TTY **711**). You can also find the notice at a Kaiser Permanente facility or by going online at **kp.org**.

Notice about laws

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

Medi-Cal program. Other federal and state laws may apply too.

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

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

Medi-Cal members may have other health coverage ("OHC"), also referred to as private health insurance. As a condition of Medi-Cal eligibility, you must apply for or retain any available OHC when it is free.

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

If you do not have access to the internet, you can report OHC to us by calling our Member Services at **1-855-839-7613** (TTY **711**). Or you can call DHCS's OHC Processing Center at **1-800-541-5555** (TTY **1-800-430-7077** or **711**) inside California or **1-916-636-1980** (outside California).

The California Department of Health Care Services ("DHCS") has the right and responsibility to be paid back for covered Medi-Cal services for which Medi-Cal is not the first payer. For example, if you are injured in a car accident or at work, auto or workers' compensation insurance may have to pay for your health care first or pay back Medi-Cal if Medi-Cal pays.

If you are injured, and another party is liable for your injury, you or your legal representative must notify DHCS within 30 days of filing a legal action or a claim. Submit your notification online to:

- Personal Injury Program at https://dhcs.ca.gov/PIForms
- Workers' Compensation Recovery Program at https://dhcs.ca.gov/WC

To learn more, visit the DHCS Third Party Liability and Recovery Division website at https://dhcs.ca.gov/tplrd or call **1-916-445-9891**.

Notice about estate recovery

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-for-Service ("FFS") and managed care premiums/capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the DHCS Estate Recovery Program website at https://dhcs.ca.gov/er or call **1-916-650-0590.**

Notice of Action

Kaiser Permanente will send you a Notice of Action ("NOA") letter any time we deny, delay, terminate, or modify a request for health care services. If you disagree with our decision, you can always file an appeal. Go to the "Appeals" section in Chapter 6 of this Member Handbook for important information on filing your appeal. When we send you an NOA it will tell you of all the rights you have if you disagree with a decision we made.

Content in notices

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

- A statement of the action we intend to take
- A clear and concise explanation of the reasons for our decision
- How we decided, including the rules we used
- The medical reasons for the decision. We must clearly state how your condition does not meet the rules or guidelines.

Translations

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

The fully translated notice must include the medical reason for our decision to deny, delay, modify, terminate, suspend, or reduce a request for health care services.

If translation in your preferred language is not available, we will provide verbal help in your preferred language so that you can understand the information you get.

Notice about unusual circumstances

If something happens that limits our ability to provide and arrange for care, like a major disaster, we will make a good-faith effort to provide you with the care that you need with Medi-Cal Network Providers and network facilities that are available. If you have an emergency medical condition, go to the nearest hospital. You have coverage for Emergency Care as described in the “Emergency Care” section of this Member Handbook.

Notice about administration of your benefits

You must fill out any forms that we ask for in our normal course of business. Also, we may create standards (policies and procedures) in order to better provide your services.

If we make an exception to the terms of this Member Handbook for you or someone else, we do not have to do the same for you or someone else in the future.

Notice about changes to this Member Handbook

We, with the approval of DHCS, can make changes to this Member Handbook at any time. We will let you know in writing of any changes 30 days before they happen.

Notice about lawyer and advocate fees and costs

In any dispute between you and us, The Permanente Medical Group, or Kaiser Foundation Hospitals, each party will pay their own fees and costs. These include lawyers’ fees and advocates’ fees.

Notice that this Member Handbook is binding on Members

The terms of this Member Handbook are binding on you when you choose to enroll in the Kaiser Permanente Medi-Cal Plan.

Notices about your coverage

We may send you updates about your health care coverage. We will send this to the most recent address we have for you. If you move or have a new address, let us know your new address as soon as you can by calling our Member Services at **1-855-839-7613** (TTY **711**). Also, let your County Eligibility Worker know your new address.

8. Important numbers and words to know

Important phone numbers

- Kaiser Permanente Member Services:
  - English (and more than 150 languages using interpreter services) **1-855-839-7613**
  - Spanish **1-800-788-0616**
  - Chinese dialects **1-800-757-7585**
  - TTY **711**
- Authorization for post-stabilization care **1-800-225-8883** (TTY **711**)
- Kaiser Permanente appointments and Advice Line
  - Northern California **1-866-454-8855** (TTY **711**)
  - Southern California **1-833-574-2273** (TTY **711**)
- Health Care Options **1-800-430-4263** (TTY **1-800-430-7077**)
- Medi-Cal Rx **1-800-977-2273** (TTY **711**)

Words to know

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

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

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

following:

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

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

Benefits: Health care services and drugs covered under this health plan. Community Supports, however, are not considered benefits.

Binding arbitration: A way to solve problems using a neutral third party. For problems that are settled through binding arbitration, the third party hears both sides of the issue and makes a decision that both sides must accept. Both sides give up the right to a jury or court trial.

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

Case manager: Registered nurses, licensed vocational nurses, social workers or other designated staff who can help a member understand major health problems and arrange care with the member's providers.

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

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

Chronic condition: A disease or other medical problem that cannot be completely cured

or that gets worse over time or that must be treated so the member does not get worse.

Clinic: A facility that members can select as a primary care provider ("PCP"). It can be either a Federally Qualified Health Center ("FQHC"), community clinic, Rural Health Clinic ("RHC"), Indian Health Care Provider ("IHCP"), or other primary care facility.

Community-based adult services ("CBAS"): Outpatient, facility-based services for skilled nursing care, social services, therapies, personal care, family and caregiver training and support, nutrition services, transportation, and other services for members who qualify.

Complaint: A member's verbal or written expression of dissatisfaction about a service covered by Medi-Cal, Kaiser Permanente, a county mental health plan, or a Medi-Cal provider. A complaint is the same as a grievance.

Continuity of care: The ability of a plan member to keep getting Medi-Cal services from an Out-of-Network Medi-Cal Provider for up to 12 months without a break in service, if the provider and Kaiser Permanente agree.

Contract Drugs List ("CDL"): The approved drug list for Medi-Cal Rx from which a provider may order covered drugs a member needs.

Coordination of Benefits ("COB"): The process of determining which insurance coverage (Medi-Cal, Medicare, commercial insurance, or other) has primary treatment and payment responsibilities for members with more than one type of health insurance coverage.

Copayment (copay): A payment a member makes, generally at the time of service, in addition to the insurer's payment.

Covered Services: The Medi-Cal services for which Kaiser Permanente is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage ("EOC") and Disclosure Form ("DF")).

DHCS: The California Department of Health Care Services. This is the state office that oversees the Medi-Cal program.

Disenroll: To stop using Kaiser Foundation Health Plan, Inc. as your Medi-Cal managed care plan because the member no longer qualifies or changes to a new health plan. The member must sign a form that says they no longer want to use the health plan or call Health Care Options and disenroll by phone.

DMHC: The California Department of Managed Health Care. This is the state office that oversees managed care health plans.

Durable medical equipment ("DME"): 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 or injury
- The item is appropriate for use in the home
- The item is needed to help you with activities of daily living ("ADLs")

Early and periodic screening, diagnostic, and treatment ("EPSDT"): Go to "Medi-Cal for Kids and Teens." EPSDT services are a benefit for Medi-Cal Members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early as well as any treatment to take care of or help the conditions that might be found in the check-ups.

Emergency medical condition: A medical or mental condition with such severe symptoms, such as active labor (go to definition above) or severe pain, that someone with a prudent layperson's average knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place the member's health or the health of their unborn baby in serious danger
- Cause impairment to a bodily function
- Cause a body part or organ to not work right
- Result in death

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

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

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

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

Experimental treatment: Drugs, equipment, procedures, or services that are in a testing phase with laboratory or animal studies before testing in humans. Experimental services are not undergoing a clinical investigation.

Family planning services: Services to prevent or delay pregnancy. Services are provided to members of childbearing age to enable them to determine the number and spacing of children.

Federally Qualified Health Center ("FQHC"): A health center in an area that does not have many providers. A member can get primary and preventive care at an FQHC.

Fee-for-Service ("FFS") Medi-Cal: Sometimes your Medi-Cal plan does not cover services, but a member can still get them through FFS Medi-Cal, such as many pharmacy services through Medi-Cal Rx.

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

Formulary: A list of drugs or items that meet certain criteria and are approved for Members.

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

Freestanding Birth Centers ("FBCs"): Health facilities where childbirth is planned to occur away from the pregnant member's residence and that are licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan. These facilities are not hospitals.

Grievance: A member's verbal or written expression of dissatisfaction about a service covered by Medi-Cal, Kaiser Permanente, a county mental health plan, or a Medi-Cal provider. A complaint filed with us about a Medi-Cal Network Provider is an example of a grievance.

Habilitation services and devices: Health care services that help a member keep, learn, or improve skills and functioning for daily living.

Health Care Options ("HCO"): The program that can enroll or disenroll a member from a health plan.

Health insurance: Insurance coverage that pays for medical and surgical expenses by

repaying the insured for expenses from illness or injury or paying the care provider directly.

Home health care: Skilled nursing care and other services given at home.

Home health care providers: Providers who give members skilled nursing care and other services at home.

Home Region: The Kaiser Foundation Health Plan, Inc. Region in which a member is enrolled. For Medi-Cal members, the Home Region is either the Northern California Region or the Southern California Region.

Home Region Service Area: The geographic area that defines the Kaiser Foundation Health Plan, Inc. Region in which the member is enrolled.

Northern California Home Region Service Area

- Alameda County (full): All zip codes
- Amador County (partial): Zip Codes 95640, 95669
- Contra Costa County (full): All zip codes
- El Dorado County (partial): Zip codes 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno County (partial): Zip codes 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 (partial): Zip codes 93230, 93232, 93242, 93631, 93656
- Madera County (partial): Zip codes 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- Marin County (full): All zip codes
- The following ZIP codes in Mariposa County: 93601, 93623, 93653
- Napa County: (full): All zip codes

- The following ZIP codes in Placer: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- Sacramento County (full): All zip codes
- San Francisco (full): All zip codes
- San Joaquin County (full): All zip codes
- San Mateo County (full): All zip codes
- Santa Clara County (partial): Zip codes 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, 95196
- All ZIP codes in Santa Cruz County
- Solano County (full): All zip codes
- Sonoma County (partial): Zip codes 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, 95492
- All ZIP codes in Stanislaus County
- Sutter County (partial): Zip codes 95626, 95645, 95659, 95668, 95674, 95676, 95692, 9583795836-7
- The following ZIP codes in Tulare County: 93618, 93631, 93646, 93654, 93666, 93673
- Yolo County (partial): Zip codes 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- The following ZIP codes in Yuba County: 95692, 95903, 95961

Southern California Home Region Service Area

- Imperial County: (partial): Zip codes 92274-75
- Kern (partial): Zip codes 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, 93581
- Los Angeles County (partial): All zip codes, 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- Orange County (full): All zip codes
- Riverside County (partial): Zip codes 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

- San Bernardino County (partial): Zip codes 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 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
- San Diego County (partial): Zip codes 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, 92195-99
- Tulare County (partial): Zip codes 93238, 93261
- Ventura County (partial): Zip codes 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, 93252

Hospice: Care to reduce physical, emotional, social, and spiritual discomforts for a member with a terminal illness. Hospice care is available when the member has a life expectancy of 6 months or less.

Hospital: A place where a member gets inpatient and outpatient care from doctors and nurses.

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

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

Indian Health Care Provider (“IHCP”): A health care program operated by the Indian Health Service (“”is"), an Indian Tribe, Tribal Health Program, Tribal Organization or Urban Indian Organization (“UIO”). Indian Tribe, Tribal Organization or Urban Indian Organization as those terms are defined in Section 4 of the Indiane Health Care

Improvement Act (25 U.S.C. section 1603).

Inpatient care: When a member has to stay the night in a hospital or other place for medical care that is needed.

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

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

Kaiser Foundation Health Plan, Inc.: A California nonprofit corporation. In this Member Handbook, "we", "us", or "our" means Kaiser Foundation Health Plan, Inc.

Kaiser Permanente: Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals (a California nonprofit corporation), and The Permanente Medical Group.

Kaiser Permanente Medi-Cal Plan: Your Medi-Cal managed care health plan.

Kaiser Permanente Medi-Cal Plan Service Area: The geographic area for the Kaiser Permanente Medi-Cal Plan: You must live within this area to enroll and stay enrolled in the Kaiser Medi-Cal Plan:

Northern California Home Region Service Area

- Alameda County (full): All zip codes
- Amador County (partial): Zip Codes 95640, 95669
- Contra Costa County (full): All zip codes
- El Dorado County (partial): Zip codes 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno County (partial): Zip codes 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 (partial): Zip codes 93230, 93232, 93242, 93631, 93656
- Madera County (partial): Zip codes 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
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- Sacramento County (full): All zip codes
- San Francisco (full): All zip codes
- San Joaquin County (full): All zip codes
- San Mateo County (full): All zip codes
- Santa Clara County (partial): Zip codes 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, 95196
- All ZIP codes in Santa Cruz County
- Solano County (full): All zip codes
- Sonoma County (partial): Zip codes 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, 95492
- All ZIP codes in Stanislaus County

- Sutter County (partial): Zip codes 95626, 95645, 95659, 95668, 95674, 95676, 95692, 9583795836-7
- The following ZIP codes in Tulare County: 93618, 93631, 93646, 93654, 93666, 93673
- Yolo County (partial): Zip codes 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- The following ZIP codes in Yuba County: 95692, 95903, 95961

Southern California Home Region Service Area

- Imperial County: (partial): Zip codes 92274-75
- Kern (partial): Zip codes 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, 93581
- Los Angeles County (partial): All zip codes, 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-

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- Orange County (full): All zip codes
- Riverside County (partial): Zip codes 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
- San Bernardino County (partial): Zip codes 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 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
- San Diego County (partial): Zip codes 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, 92195-99
- Tulare County (partial): Zip codes 93238, 93261
- Ventura County (partial): Zip codes 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, 93252

Long-term care: Care in a facility for longer than the month of admission plus 1 month.

Managed care plan: A Medi-Cal health plan that uses only certain doctors, specialists, clinics, pharmacies, and hospitals for Medi-Cal recipients enrolled in that plan. Kaiser Permanente is a managed care plan.

Medi-Cal for Kids and Teens: A benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early. They must get treatment to take care of or help the conditions that might be found in the check-ups. This benefit is also known as the Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") benefit under federal law.

Medi-Cal Rx: A pharmacy benefit service that is part of FFS Medi-Cal and known as "Medi-Cal Rx" that provides pharmacy benefits and services, including prescription drugs and some medical supplies to all Medi-Cal beneficiaries.

Medical Group: For Northern California Region Members, The Permanente Medical Group, Inc., a for-profit professional corporation. For Southern California Region Members, the Southern California Permanente Medical Group is a for-profit professional partnership.

Medical home: A model of care that provides the main functions of primary health care. This includes comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Medically Necessary (or medical necessity): Medically necessary are important services that are reasonable and protect life. This care is needed to keep patients from getting seriously ill or disabled. The care reduces severe pain by diagnosing or treating the disease, illness, or injury. For members under the age of 21, Medically Necessary services include care that is needed to fix or help a physical or mental illness or condition, including substance use disorders.

Medical transportation: Transportation that a provider prescribes for a member when the member is not physically or medically able to use a car, bus, train, or taxi to get to a covered medical appointment or to pick up prescriptions. We pay for the lowest-cost form of transportation for your medical needs when you need a ride to your appointment.

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

Member: Any eligible Medi-Cal beneficiary enrolled with Kaiser Permanente who is entitled to get covered services.

Mental health services provider: Health Care professionals who provide mental health and behavioral health services to patients.

Midwifery services: Prenatal, intrapartum, and postpartum care, including family planning services for the mother and immediate care for the newborn, provided by certified nurse midwives ("CNM") and licensed midwives ("LM").

Network: A group of doctors, clinics, hospitals, and other providers contracted with Kaiser Permanente to provide Covered Services.

Medi-Cal Network Provider (or in-network provider): See "Participating provider." below

Non-covered service: A service that Kaiser Permanente does not cover.

Non-Medical Transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by a member's provider and when picking up prescriptions and medical supplies.

Non-participating provider: A provider not in the Kaiser Permanente network.

Other health coverage ("OHC"): Private health insurance and service payers other than Medi-Cal. Services may include medical, dental, vision, pharmacy, Medicare Advantage plans ("Part C"), Medicare drug plans ("Part D"), and/or Medicare supplemental plans ("Medigap").

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

Out-of-area services: Services while a member is anywhere outside the Medi-Cal Plan Service Area.

Out-of-network provider: A provider who is not part of the Kaiser Permanente network and who may not be designated by DHCS as a Medi-Cal provider.

Out-of-Network Medi-Cal Provider: A provider who is not part of the Kaiser Permanente network, but who is designated by DHCS as a Medi-Cal provider. For example, a provider who participates in FFS Medi-Cal and is not in the Kaiser Permanente provider network is an Out-of-Network Medi-Cal Provider.

Outpatient care: When a member does not have to stay the night in a hospital or other place for the medical care that is needed.

Outpatient mental health services: Outpatient services for members with mild to moderate mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory, supplies, and supplements

Palliative care: Care to reduce physical, emotional, social, and spiritual discomforts for a member with a serious illness. Palliative care does not require the member to have a life expectancy of 6 months or less.

Participating hospital: A licensed hospital that has a contract with Kaiser Permanente to provide services to members at the time a member gets care. The covered services that some participating hospitals might offer to members are limited by our utilization review and quality assurance policies or our contract with the hospital.

Participating provider (or participating doctor): A doctor, hospital, or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with Kaiser Permanente to offer covered services to members at the time a member gets care.

Physician services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while a member is admitted in a hospital that are charged in the hospital bill.

Plan: Go to the definition of “Managed care plan.”

Plan Facility: Any facility listed on our website at **kp.org/finddoctors** that is part of our network. Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call Member Services.

Plan Hospital: Any hospital listed on our website at **kp.org/finddoctors** that is part of our network. Plan Hospitals are subject to change at any time without notice. For the

current locations of Plan Hospitals, please call Member Services.

Plan Physician: Any licensed physician who is an employee of The Permanente Medical Group, or any licensed physician who contracts to provide Covered Services to Members. Physicians who contract with us only to provide referral services are not considered Plan Physicians.

Plan Provider: A Plan Hospital, a Plan Physician, The Permanente Medical Group, a Plan Pharmacy, or any other provider Health Plan designates as a Plan Provider.

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized to keep the member stabilized. Post-stabilization care services are covered and paid for. Out-of-network hospitals might need pre-approval

Pre-approval (or prior-authorization): The process by which a member or their provider must request approval from Kaiser Permanente for certain services to make sure we will cover them. A referral is not an approval. Pre-approval is the same as prior authorization.

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

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

Primary care: Go to the definition of "Routine care."

Primary care provider ("PCP"): The licensed provider a member has for most of their health care. The PCP helps the member get the care they need.

A PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- OB/GYN
- Indian Health Care Provider ("IHCP")

- Federally Qualified Health Center (“FQHC”)
- Rural Health Clinic (“RHC”)
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (or pre-approval): The process by which a member or their provider must request approval from Kaiser Permanente for certain services to make sure we will cover them. A referral is not an approval. Pre-approval is the same as prior authorization

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

Medi-Cal Provider Directory: A list of providers in the Kaiser Permanente Medi-Cal Provider Network.

Psychiatric emergency medical condition: A mental disorder in which the symptoms are serious or severe enough to cause an immediate danger to the member or others or the member is immediately unable to provide for or use food, shelter, or clothing due to the mental disorder.

Public health services: Health services targeted at the whole population. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified provider: A doctor qualified in the area of practice appropriate to treat a member’s condition.

Reconstructive surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors, or disease.

Referral: When a member’s PCP says the member can get care from another provider. Some covered care services require a referral and pre-approval. See Chapter 3, "How to get care", for more about services that require referrals or pre-approval.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and

are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of region locations, please visit our website at **kp.org** or call Member Services.

Rehabilitative and habilitative therapy services and devices: Services and devices to help members with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

Routine care: Medically necessary services and preventive care, well-child visits, or care such as routine follow-up care. The goal of routine care is to prevent health problems.

Rural Health Clinic ("RHC"): A health center in an area that does not have many providers. Members can get primary and preventive care at an RHC.

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

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

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

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

Specialist (or specialty provider): 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.

Specialty mental health services ("SMHS"): Services for members who have mental health services needs that are a higher level than mild to moderate level of impairment.

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

Telehealth visits: Interactive video visits and scheduled telephone visits between you and your provider.

Terminal illness: A medical condition that cannot be reversed and will most likely cause

death within 1 year or less if the disease follows its natural course.

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

Triage (or screening): The evaluation of a member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of your need for care.

Urgent care (or urgent services): Services provided to treat a non-emergency illness, injury or condition that requires medical care. Members can get urgent care from an Out-of-Network Medi-Cal Provider if Medi-Cal Network providers are temporarily not available or not accessible.

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