**Senior Advantage Medicare Medi-Cal North P2 (HMO D-SNP), offered by Kaiser Foundation Health Plan, Inc., Northern California Region**

# *Member Handbook*

**January 1, 2024 – December 31, 2024**

## Your Health and Drug Coverage under Senior Advantage Medicare Medi-Cal (HMO D-SNP), offered by Kaiser Foundation Health Plan, Inc., Northern California Region

## *Member Handbook* Introduction

This **Member Handbook***,* otherwise known as the Evidence of Coverage*,* tells you about your coverage under our plan through December 31, 2024. It explains health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this **Member Handbook**.

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

When this **Member Handbook** says "we," "us," "our," or "our plan," it means **Senior Advantage Medicare Medi-Cal**.

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

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

Call Member Services to request the following:

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



KAISER PERMANENTE®

Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. You can also request auxiliary aids and devices at our facilities. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

## Disclaimers

- Kaiser Permanente is an HMO D-SNP plan with a Medicare contract and a contract with the Medi-Cal program. Enrollment in Kaiser Permanente depends on contract renewal.
- Coverage under this plan is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information on the individual shared responsibility requirement.
- The health care services provided to Members of Kaiser Permanente under Medi-Cal are subject to the terms, conditions, limitations and exclusions of the contract between Kaiser Foundation Health Plan, Inc. and the California Department of Health Care Services (DHCS), and as listed in this **Member Handbook** and any amendments.

# Chapter 1: Getting started as a member

## Introduction

This chapter includes information about **Senior Advantage Medicare Medi-Cal North P2**, a health plan that covers all of your Medicare and Medi-Cal services and coordinates all of your Medicare and Medi-Cal services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

## Chapter 1 Table of Contents

## A. Welcome to our plan

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

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

## B. Information about Medicare and Medi-Cal

### B1. Medicare

Medicare is the federal health insurance program for:

People 65 years of age or over,

- Some people under age 65 with certain disabilities, and
- People with end-stage renal disease (kidney failure).

### B2. Medi-Cal

Medi-Cal is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources to pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

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

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

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

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

## C. Advantages of our plan

You will now get all your covered Medicare and Medi-Cal services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

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

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

**New members to Senior Advantage Medicare Medi-Cal North P2**: In most instances you will be enrolled in our **Senior Advantage Medicare Medi-Cal North P2 Plan** for your Medicare benefits the 1st day of the month after you request to be enrolled in **Senior Advantage Medicare Medi-Cal North P2**. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through **Senior Advantage Medicare Medi-Cal North P2**. There will be no gap in your Medi-Cal coverage. Please call us at **1-800-443-0815** (TTY **711**) if you have any questions. Hours are 8 a.m. to 8 p.m., 7 days a week.

## D. Our plan's service area

Our service area for this plan includes **San Mateo County** and **Sacramento County** in California. Also, our service area includes the following:

- **Fresno County,** with the exception of the following Zip Codes**:** 93210, 93234, 93605, 93608, 93620-22, 93628, 93634, 93640-42, and 93664
- **Kings County,** with the exception of the following Zip Codes**:** 93202, 93204, 93212, 93239, 93245-46, and 93266.
- **Madera County**, with the exception of the following Zip Codes**:** 93610, 93620, and 93622.
- **Santa Clara County** with the exception of the following Zip Code**:** 95023

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

**You cannot stay in our plan if you move outside of our service area**. Refer to **Chapter 10** of this **Member Handbook** for more information about the effects of moving out of our service area.

## E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), **and**
- Are age 21 and older at the time of enrollment, **and**
- Have both Medicare Part A and Medicare Part B, **and**

- Are a United States citizen or are lawfully present in the United States, **and**
- Are currently eligible for Medi-Cal.

If you lose your Medi-Cal eligibility but can be expected to regain eligibility within 4 month(s), then you are still eligible for membership in our plan.

Call Member Services for more information.

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

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

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

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

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

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.
    - We determine an existing relationship by reviewing your available health information available or information you give us.
    - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. If you are at risk of harm, we must respond within 3 days.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

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

After the continuity of care period ends, you will need to use doctors and other providers in our Medicare Medi-Cal Plan network, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Refer to Chapter 3 of your Member Handbook for more information on getting care.

**If your provider stops working with us**, 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.

**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
- The provider agrees to our standard contractual terms and conditions
- The services are Medically Necessary and would be Covered Services under this Member Handbook if you got them from a network provider
- You request continuity of care within the required timeframes:
- Within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member under standard continuity of care. Requests received outside of 30 days will be decided on a case-by-case basis.
- Within 30 days of the date the provider leaves our Medi-Cal provider network. Requests received outside of 30 days will be decided on a case-by-case basis.
- 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 providers if either of the following is true:

- The services are not covered by our Medicare Medi-Cal Plan
- Your out-of-network provider won't work with us. You will need to find a new 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 department.

Refer to **Chapter 3** of this **Member Handbook** for more information on getting care.

## G. Your care team and care plan

### G1. Care team

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

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

### G2. Care plan

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

Your care plan includes:

- Your health care goals, **and**
- A timeline for getting the services you need.

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

## H. Your monthly costs for our Medicare Medi-Cal (HMO D-SNP) Plan

Our Plan has no premium.

## I. Your Member Handbook

This **Member Handbook** is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of this **Member Handbook** or call **1-800-MEDICARE** (**1-800-633-4227**).

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

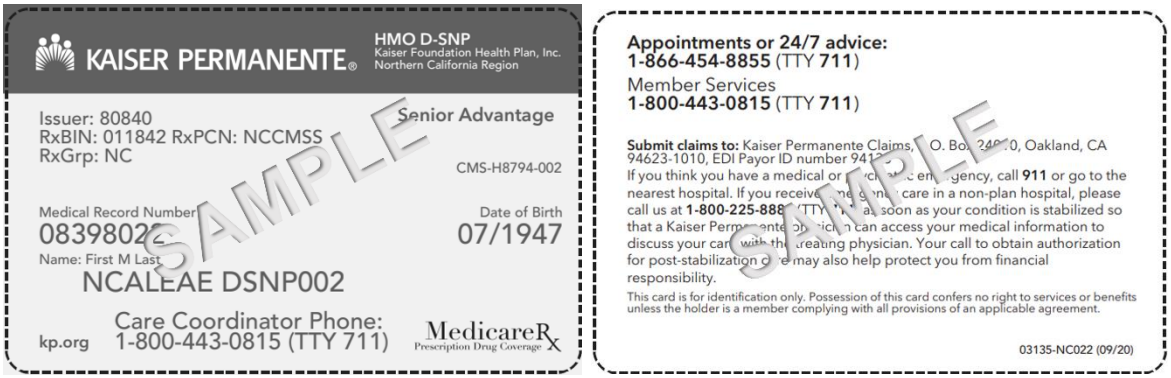
The contract is in effect for the months you are enrolled in our plan between January 1, 2024, and December 31, 2024.

## J. Other important information you get from us

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

### J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:




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

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medi-Cal card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of this **Member Handbook** to find out what to do if you get a bill from a provider.

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

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

### J2. Provider and Pharmacy Directory

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

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

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

**Definition of network providers**

- Our network providers include:
- Doctors, nurses, and other health care professionals that you can use as a member of our plan;
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**

- LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

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

**Definition of network pharmacies**

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

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

### J3. List of Covered Drugs

The plan has a **List of Covered Drugs**. We call it the “Drug List” for short. It tells you which prescription drugs our plan covers.

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

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

### J4. The Explanation of Benefits

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available.

You can talk to your prescriber about these lower cost options. **Chapter 6** of this **Member Handbook** gives more information about the EOB and how it helps you track your drug coverage.

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

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

## K. Keeping your membership record up to date

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

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you**.

Tell us right away about the following:

- Changes to your name, your address, or your phone number;
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- Any liability claims, such as claims from an automobile accident;
- Admission to a nursing facility or hospital;
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you); **and**,
- If you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

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

### K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For

more details about how we protect your PHI, refer to **Chapter 8** of this **Member Handbook**.

# Chapter 2: Important phone numbers and resources

## Introduction

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

## Chapter 2 Table of Contents

## A. Member Services

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

Contact Member Services to get help with:

- Questions about the plan.
- Questions about claims or billing.

## Coverage Decisions, Appeals and Complaints about medical care

| | |
|---|---|
| **CALL** | **1-800-443-0815**<br>This call is free. 7 days a week, 8 a.m. to 8 p.m.<br>We have free interpreter services for people who do not speak English.<br>If your coverage decision, appeal, or complaint qualifies for a fast decision as described in **Chapter 9**, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., Monday through Saturday. |
| **TTY** | **711**<br>This call is free. 7 days a week, 8 a.m. to 8 p.m. |
| **FAX** | If your coverage decision, appeal, or complaint qualifies for a fast decision, fax your request to our Expedited Review Unit at **1-888-987-2252**. |
| **WRITE** | For a standard coverage decision or complaint, write to your local Member Services office (see the **Provider and Pharmacy Directory** for locations).<br>For a standard appeal, write to the address shown on the denial notice we send you.<br>If your coverage decision, appeal, or complaint qualifies for a fast decision, write to:<br>Kaiser Permanente<br>Expedited Review Unit<br>P.O. Box 1809<br>Pleasanton, CA 94566 |
| **WEBSITE** | You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.** |

Contact the numbers above to get help with:

- Coverage decisions about your health care.
- A coverage decision about your health care is a decision about:
  - your benefits and covered services **or**
  - the amount we pay for your health services.
- Call us if you have questions about a coverage decision about your health care.

- To learn more about coverage decisions, refer to **Chapter 9** of this **Member Handbook**.
- Appeals about your health care.
- An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
- To learn more about making an appeal, refer to **Chapter 9** of this **Member Handbook** or contact Member Services.
- Complaints about your health care.
- You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
- You can call us and explain your complaint at **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.
- If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
- You can send a complaint about our plan to Medicare. You can use an online form at **www.medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE** (**1-800-633-4227**) to ask for help.
- You can make a complaint about our plan to the Medicare Medi-Cal Ombuds Program by calling **1-888-804-3536**. Monday through Friday, 8 a.m. to 5 p.m., excluding state holidays.
- To learn more about making a complaint about your health care, refer to **Chapter 9** of this **Member Handbook**.

### Coverage decisions for Part D prescription drugs

| | |
|---|---|
| **CALL** | **1-877-645-1282**<br>This call is free. 7 days a week, 8 a.m. to 8 p.m.<br>We have free interpreter services for people who do not speak English. |

| | |
|---|---|
| **TTY** | **711**<br>This call is free. 7 days a week, 8 a.m. to 8 p.m. |
| **FAX** | **1-844-403-1028** |
| **WRITE** | OptumRx<br>c/o Prior Authorization<br>P.O. Box 2975<br>Mission, KS 66201 |
| **WEBSITE** | **kp.org** |

Contact the numbers above to get help with:

- Coverage decisions about your drugs.
- A coverage decision about your drugs is a decision about:

– your benefits and covered drugs **or**

– the amount we pay for your drugs.

- Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (**medi-calrx.dhcs.ca.gov/**) for more information. You can also call the Medi-Cal Rx Customer Service Center at **1-800-977-2273** (TTY **711**).
- For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of this **Member Handbook**.

### Appeals for Part D prescription drugs

| | |
|---|---|
| **CALL** | **1-866-206-2973**<br>This call is free. Monday through Friday, 8:30 a.m. to 5 p.m.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free. Monday through Friday, 8 a.m. to 8 p.m. |
| **FAX** | **1-866-206-2974** |
| **WRITE** | Kaiser Permanente<br>Medicare Part D Unit<br>P.O. Box 1809<br>Pleasanton, CA 94566 |
| **WEBSITE** | **kp.org** |

Contact the numbers above to get help with:

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

### Complaints for Part D prescription drugs

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

Contact the numbers above to get help with:

- Complaints about your drugs.
- You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
- If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)

You can send a complaint about our plan to Medicare. You can use an online form at **www.medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE** (**1-800-633-4227**) to ask for help.

For more on making a complaint about your prescription drugs, refer to **Chapter 9** of this **Member Handbook**.

### Payment requests

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

Contact the numbers above to get help with:

- Payment for health care or drugs you already paid for.

For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this **Member Handbook**.

If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this **Member Handbook**.

## B. Your Care Coordinator

We offer services to help you coordinate your health care needs at no cost to you. We will coordinate with other programs to ensure that you receive all medically necessary services covered by Medi-Cal or Medicare, even if those services are covered by another program and not us.

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

Contact your care coordinator to get help with:

- Questions about your health care.
- Questions about getting behavioral health (mental health and substance use disorder) services.
- Questions about dental benefits.
- Questions about transportation to medical appointments.

Long-term Services and Supports (LTSS) include Community-Based Adult Services (CBAS) and Nursing Facilities (NF)

Sometimes you can get help with your daily health care and living needs. 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.

You may also be able to get these services:

- Community Based Adult Services
- In-Home Support Services through your county social service agency

## C. Health Insurance Counseling and Advocacy Program (HICAP)

The Health Insurance Counseling and Advocacy Program (HICAP) gives free health insurance counseling to people with Medicare. HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is not connected with any insurance company or health plan.

| | |
|---|---|
| **CALL** | **1-800-434-0222**<br>Monday through Friday from 8:00 a.m. to 5:00 p.m. |
| **TTY** | **711** |
| **WRITE** | Your HICAP office for your county. |
| **WEBSITE** | **https://www.aging.ca.gov/HICAP/** |

Contact HICAP for help with:

- Questions about our plan or Medicare.
- HICAP counselors can answer your questions about changing to a new plan and help you:
- Understand your rights,
- Understand your plan choices,
- Make complaints about your health care or treatment, **and**
- Straighten out problems with your bills.

## D. Nurse Advice Call Line

We know that sometimes it's difficult to know what type of care you need.

Sometimes it’s 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 our service area

When you call, a trained support person may ask you questions to help determine how to direct your call.

| | |
|---|---|
| **CALL** | **1-833-574-2273**<br>This call is free.24 hours a day, seven days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free. |

## E. Quality Improvement Organization (QIO)

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

| | |
|---|---|
| **CALL** | **1-877-588-1123** |
| **TTY** | **1-855-887-6668**<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. |
| **WRITE** | Livanta LLC<br>BFCC-QIO<br>10820 Guilford Road, Suite 202<br>Annapolis Junction, MD 20701-1105 |
| **WEBSITE** | **www.livantaqio.com** |

Contact Livanta for help with:

- Questions about your health care rights.
- Making a complaint about the care you got if you:
- have a problem with the quality of care,
- think your hospital stay is ending too soon, **or**
- think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

## F. Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

| | |
|---|---|
| **CALL** | **1-800-MEDICARE** (**1-800-633-4227**)<br>Calls to this number are free, 24 hours a day, 7 days a week. |
| **TTY** | **1-877-486-2048**<br>This call is free.<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. |
| **WEBSITE** | **medicare.gov**<br>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.<br>It includes helpful websites and phone numbers. It also has documents you can print right from your computer.<br>If you don’t have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you. |

## G. Medi-Cal

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

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

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

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

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

The Office of the Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Ombudsman also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

| | |
|---|---|
| **CALL** | **1-888-452-8609**<br>This call is free. Monday through Friday, between 8:00 a.m. and 5:00 p.m. |
| **TTY** | **711**<br>This call is free. |
| **WRITE** | California Department of Healthcare Services<br>Office of the Ombudsman<br>1501 Capitol Mall MS 4412<br>PO Box 997413<br>Sacramento, CA 95899-7413 |
| **EMAIL** | **MMCDOmbudsmanOffice@dhcs.ca.gov** |
| **WEBSITE** | **www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx** |

## I. County Social Services

If you need help with your Medi-Cal fee-for-service benefits, contact your local county social services agency.

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

Contact your county social services agency for any questions about your Medi-Cal eligibility.

**Fresno County Department of Social Services**

| | |
|---|---|
| **CALL** | **1-855-832-8082**<br>This call is free.<br>Monday through Friday from 7:30 a.m. - 4:30 p.m. |
| **TTY** | **711** |
| **WRITE** | Fresno County DSS<br>PO Box 1912<br>Fresno, CA 93718-1912 |
| **WEBSITE** | **dsspass.fresnocountyca.gov** |

**Kings County Human Services Agency**

| | |
|---|---|
| **CALL** | **1-559-852-4467**<br>Monday through Friday from 8 a.m. - 5 p.m. |
| **TTY** | **711** |
| **WRITE** | Search for closest office |
| **WEBSITE** | **https://www.countyofkings.com/services/human-services-agency/office-locations-hours**<br>**https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/navigation-help-resources/oc-links** |

**Madera County Department of Public Social Services**

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

**Sacramento County Department of Child, Family, and Adult Services**

| | |
|---|---|
| **CALL** | **1-916-874-9598** |
| **TTY** | **711** |
| **WEBSITE** | **https://dcfas.saccounty.net/SAS/Pages/SAS-Home.aspx** |

**San Mateo County Health**

| | |
|---|---|
| **CALL** | **Aging and Older Adults Emergency and Advice Line**<br>**1-844-868-0938**<br>This call is free.<br>24 hours a day, 7 days a week |
| **TTY** | **711** |
| **WRITE** | Search for the nearest District office. |
| **WEBSITE** | **https://www.smchealth.org/contact-us** |

**Santa Clara County Social Services Agency Assistance Application Center**

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|---|---|
| **CALL** | **1-408-758-3800**<br>This call is free.<br>Monday through Friday from 8 a.m. – 5 p.m. except on county holidays |

| | |
|---|---|
| **TTY** | **711** |
| **WRITE** | 1867 Senter Road<br>San Jose, CA 95112 |
| **WEBSITE** | **https://socialservices.sccgov.org/health-coverage** |

## J. County Specialty Mental Health Plan

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

**Fresno County Department of Behavioral Health**

| | |
|---|---|
| **CALL** | **1-800-654-3937**<br>This call is free.<br>24 hours a day, 7 days a week<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free |

**Kings County Behavioral Health**

| | |
|---|---|
| **CALL** | **1-800-655-2553**<br>This call is free.<br>24 hours a day, 7 days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free |

**Madera County Behavioral Health**

| | |
|---|---|
| **CALL** | **1 (888) 275-9779**<br>This call is free.<br>24 hours a day, 7 days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free |

**Sacramento County Behavioral Health Services**

| | |
|---|---|
| **CALL** | **1-888-881-4881**<br>This call is free.<br>24 hours a day, 7 days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free. |

**San Mateo County Behavioral Health and Recovery Services**

| | |
|---|---|
| **CALL** | **1-800-686-0101**<br>This call is free.<br>24 hours a day, 7 days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free. |

**Santa Clara Behavioral Health Services**

| | |
|---|---|
| **CALL** | **1-800-704-0900**<br>This call is free.<br>24 hours a day, 7 days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **711**<br>This call is free. |

Contact the county specialty mental health plan for help with:

- Questions about special mental health services provided by the county.

## K. California Department of Managed Health Care

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

| | |
|---|---|
| **CALL** | **1-888-466-2219**<br>DMHC representatives are available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday. |
| **TDD** | **1-877-688-9891**<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | Help Center<br>California Department of Managed Health Care<br>980 Ninth Street, Suite 500<br>Sacramento, CA 95814-2725 |
| **FAX** | **1-916-255-5241** |
| **WEBSITE** | **www.dmhc.ca.gov** |

## L. Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website (**www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) p**rovides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

### L1. Extra Help

Because you are eligible for Medi-Cal, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this “Extra Help.”

| | |
|---|---|
| **CALL** | **1-800-MEDICARE** (**1-800-633-4227**)<br>Calls to this number are free, 24 hours a day, 7 days a week. |

| | |
|---|---|
| **TTY** | **1-877-486-2048**<br>This call is free.<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. |
| **WEBSITE** | **www.medicare.gov** |

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your correct copayment level, or if you already have the evidence, to provide this evidence to us.

If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you are qualified for "Extra Help." The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to Kaiser Permanente at:

  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it to **1-877-528-8579**.
- Take it to a network pharmacy or your local Member Services office at a network facility.

When we receive the evidence showing your copayment level, we will update our system so that you will be charged the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will pay you back. Either we will send a check to you in the amount of your overpayment or we will deduct the amount from future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may

make the payment directly to the state. Please contact Member Services if you have questions.

### L2. AIDS Drug Assistance Program (ADAP)

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

## M. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S. Citizens and lawful permanent residents who are 65 and over, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

| | |
|---|---|
| **CALL** | **1-800-772-1213**<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday.<br>You can use their automated telephone services to get recorded information and conduct some business 24 hours a day. |
| **TTY** | **1-800-325-0778**<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. |
| **WEBSITE** | **www.ssa.gov** |

## N. Railroad Retirement Board (RRB)

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

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

## O. Other resources

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

If you have problems with:

- Medi-Cal
- Medicare
- Your health plan
- Accessing medical services
- Appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- Medical billing
- IHSS (In-Home Supportive Services)

The Medicare Medi-Cal Ombuds Program assists with complaints, appeals, and hearings. The phone number for the Ombuds Program is **1-888-804-3536**.

## P. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; includes but is not limited to, services such as:

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns
- Root canal therapy
- Partial and complete dentures, adjustments, repairs, and relines

| | |
|---|---|
| **CALL** | **1-800-322-6384**<br>The call is free.<br>Dental benefits are available through Medi-Cal Dental Fee-for-Service and Dental Managed Care (DMC) Programs. Medi-Cal Dental Fee-For-Service Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. |
| **TTY** | **1-800-735-2922**<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. |
| **WEBSITE** | **https://smilecalifornia.org/** |

In addition to the Medi-Cal Dental Fee-For-Service Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available Sacramento County. If you want more information about dental plans, or want to change dental plans, contact Health Care Options at **1-800-430-4263** (TTY users call **1-800-430-7077**), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free.

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

## Introduction

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

## Chapter 3 Table of Contents

## A. Information about services and providers

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

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

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

## B. Rules for getting services our plan covers

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

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

- The care you get must be a **plan benefit.** This means we include it in our Benefits Chart in **Chapter 4** of this **Member Handbook**.
- The care must be **medically necessary.** By medically necessary, we mean important services that are reasonable and protect life. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another provider**.** As a plan member, you must choose a network provider to be your PCP.
- In most cases, your network PCP must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not

cover the services. To learn more about referrals, refer to Section **D** in this chapter.

- You do not need a referral from your PCP for emergency care or urgently needed care, to use a woman's health provider, or for any of the other kinds of care without having a referral from your PCP (for more information about this, refer to Section **D1** in this chapter).
- **You must get your care from network providers**. Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:
- We cover emergency or urgently needed care from an out-of-network provider for more information, refer to Section **H** in this chapter.
- If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider if we or our Medical Group authorize the services before you get the care. In this situation, we cover the care as if you got it from a network provider.
- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.
- When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of this **Member Handbook**. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network. After 12 months, we no longer cover your care if you continue to use providers that are not in our network.
- New members to **Senior Advantage Medicare Medi-Cal North P2**: In most instances you will be enrolled in our **Senior Advantage Medicare Medi-Cal North P2 Plan** for your Medicare benefits the 1st day of the

month after you request to be enrolled in **Senior Advantage Medicare Medi-Cal North P2**. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through our **Senior Advantage Medicare Medi-Cal North P2 Plan**. There will be no gap in your Medi-Cal coverage. Please call us at **1-800-443-0815** (TTY **711**) if you have any questions. Hours are 8 a.m. to 8 p.m., 7 days a week.

## C. Your care coordinator

### C1. What a care coordinator is

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

### C2. How you can contact your care coordinator

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

### C3. How you can change your care coordinator

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

## D. Care from providers

### D1. Care from a primary care provider

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

#### Definition of a PCP and what a PCP does do for you

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

#### Your choice of PCP

Your PCP will usually practice general medicine (also called adult or internal medicine and family practice) and sometimes obstetrics/gynecology. At some network facilities, if you

prefer, you may choose an available nurse practitioner or physician assistant to be your primary care provider. PCPs are identified in the **Provider and Pharmacy Directory**.

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

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

**Option to change your PCP**

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

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

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

**Services you can get without approval from your PCP**

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

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our plan's service area or during the weekend). **Note:** Urgently needed care must be immediately needed and medically necessary.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations, as well as hepatitis B vaccinations and pneumonia vaccinations, as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Second opinions from another network provider.
- Appointments in the following areas: optometry, substance abuse, and psychiatry.
- Preventive care except for abdominal aortic aneurysm screenings, medical nutritional therapy, flexible sigmoidoscopy, screening colonoscopy, bone density screening, and lab tests.
- Additionally, if eligible to get services from Indian Health Care Providers, you may use these providers without a referral.
- Appointments for sensitive services.

### D2. Care from specialists and other network providers

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

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

#### Referrals from your PCP

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

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

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

If you do not get a written referral when needed, the bill may not be paid. For more information, call Member Services at the number at the bottom of this page.

**Referrals to network providers**

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

**Prior authorization**

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

- Services and items identified in **Chapter 4** with a footnote (†).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to
  out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if

you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.

- After we are notified that you need post-stabilization care from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see **Section H** in this chapter for more information.
- Medically necessary transgender surgery and associated procedures.
- Care from a religious nonmedical health care institution described in **Section J** of this chapter.
- If your network provider makes a written or electronic referral for a transplant evaluation, Medical Group's regional transplant advisory committee or board or case conference (if one exists) will authorize the referral if it determines that you are a potential candidate for organ transplant and the service is covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the services if the transplant center's physician(s) determine that they are medically necessary or covered in accord with Medicare guidelines. Note: A network physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure.

### D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.

  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

- We will help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. Please contact us at **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

### D4. Out-of-network providers

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medi-Cal.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medi-Cal.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

Care you receive from an out-of-network provider will not be covered except in the following situations:

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see **D1** in this chapter.
- We or Medical Group authorize a referral to an out-of-network provider described in **Section D2** of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- If you visit the service area of another Kaiser Permanente region, you can receive certain Medicare-covered care covered under this **Member Handbook** from designated providers in that service area. Please call our care away from home travel line at **1-951-268-3900** (TTY **711**), 24 hours a day, 7 days a week (except holidays), or visit our website at **kp.org/travel** for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations. Kaiser Permanente is located in California, District of Columbia, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. Note: Our care away from home travel line can also answer questions about covered emergency or urgent care services you receive out-of-network, including how to get reimbursement.
- For Medi-Cal Services, you can go to an out-of-network provider without a referral or prior authorization for emergency services or for certain sensitive care services. You can also go to an out-of-network provider for out-of-area urgent care when you are in an area where we do not operate. If you need outpatient mental health services, you can go to either a network provider or a county mental health plan provider without prior authorization. You must have a referral or pre-approval for all other out-of-network services, or they will not be covered.
- Note: If you are an American Indian, you can get care at an Indian Health Care Provider outside of our provider network without a referral.

## E. Long-term services and supports (LTSS)

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

- You can ask your doctor or your care coordinator for more information on LTSS.

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

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and for mild-to-moderate behavioral health conditions covered by Medi-Cal. Our plan does not cover specialty mental health services covered by Medi-Cal, but these services are available to you through your county mental health plan. For more information on mental health services available through your county mental health plan, please contact the following:

- Fresno County Behavioral Health at **1-800-654-3937** (TTY **711**).
- Kings County Behavioral Health at **1-800-655-2553** (TTY **711**).
- Madera County Behavioral Health at **1-888-275-9779** (TTY **711**).
- Sacramento County Behavioral Health Services at **1-888-881-4881** (TTY **711**).
- San Mateo County Behavioral Health and Recovery Services at **1-800-686-0101** (**TTY 711**).
- Santa Clara County Behavioral Health Services at **1-800-704-0900** (TTY **711**).

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

Medi-Cal specialty mental health services are available to you through the county mental health plan ("MHP") if you meet criteria to access specialty mental health services.

- Fresno County Behavioral Health at **1-800-654-3937** (TTY **711**).

- Kings County Behavioral Health at **1-800-655-2553** (TTY **711**).
- Madera County Behavioral Health at **1-888-275-9779** (TTY **711**).
- Sacramento County Behavioral Health Services at **1-888-881-4881** (TTY **711**).
- San Mateo County Behavioral Health and Recovery Services at **1-800-686-0101** (**TTY 711**).
- Santa Clara County Behavioral Health Services at **1-800-704-0900** (TTY **711**).

**Outpatient services**

- Mental health services (assessments, plan development, therapy, rehabilitation and collateral).
- Medication support services.
- Day treatment intensive services.
- Day rehabilitation services.
- Crisis intervention services.
- Crisis stabilization services.
- Targeted case management services.
- Therapeutic behavioral services.

**Residential services**

- Adult residential treatment services
- Crisis residential treatment services.

**Inpatient services**

- Acute psychiatric inpatient hospital services.
- Psychiatric inpatient hospital professional services.
- Psychiatric health facility services.

If you meet the criteria to receive these services, Medi-Cal or Drug Medi-Cal Organized Delivery System services are available to you through:

- Fresno County Behavioral Health at **1-800-654-3937** (TTY **711**).

- Kings County Behavioral Health at **1-800-655-2553** (TTY **711**).
- Madera County Behavioral Health at **1-888-275-9779** (TTY **711**).
- Sacramento County Behavioral Health Services at **1-888-881-4881** (TTY **711**).
- San Mateo County Behavioral Health and Recovery Services at **1-800-686-0101** (**TTY 711**).
- Santa Clara County Behavioral Health Services at **1-800-704-0900** (TTY **711**).

Drug Medi-Cal services include:

- Intensive outpatient treatment services.
- Residential treatment services.
- Outpatient drug free services.
- Narcotic treatment services.
- Naltrexone services for opioid dependence.

Drug Medi-Cal Organized Delivery System Services include:

- Outpatient and intensive outpatient services.
- Medications for addiction treatment (also called Medication Assisted Treatment).
- Residential/inpatient.
- Withdrawal management.
- Narcotic treatment services.
- Recovery services.
- Care coordination.

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

## G. Transportation services

### G1. Medical transportation of non-emergency situations

You are entitled to non-emergency medical transportation if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. Non-emergency medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. You can request non-emergency medical transportation by asking your network provider, dentist, or substance use disorder provider for it. Your provider will decide the correct type of transportation that you need. Non-emergency medical transportation can be an ambulance, litter van, wheelchair van or air transport.

Non-emergency medical transportation must be used when:

- You are not able to physically or medically use a bus, taxi, car or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle or place of treatment due to a physical or mental disability.
- 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. For more information on how to schedule medical transportation, call Member Services at the number at the bottom of this page.

**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 when medically necessary. You cannot get medical transportation if Medicare or Medi-Cal does not cover the service.

If Medi-Cal covers the appointment type, but not through our health plan, we will not cover medical transportation. However, we can help you schedule the transportation you need. If you need medical transportation our service area or to go to an out-of-network provider, we will cover medical transportation only if we have authorized it for you.

### G2. Non-medical transportation

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

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

Our plan allows you to use a car, taxi, bus, or other public/private way of getting to your non-medical appointment for services authorized by your provider. We cover the lowest cost, non-medical transportation type that meets your needs.

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Our plan must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. **You cannot be reimbursed for driving yourself**. Mileage reimbursement requires all of the following:

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

To ask for a ride for services that have been authorized, call our transportation provider at **1-844-299-6230** (TTY **711**) at least three business days (Monday through Friday) before your appointment. For **urgent appointments**, call as soon as possible. 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 Indian Health Clinic to ask for non-medical transportation.

### Non-medical transportation limits

Our plan provides the lowest cost non-medical transportation that meets your needs from your home to the closest provider where an appointment is available. **You cannot drive yourself or be reimbursed directly.**

Non-Medical transportation does **not** apply if:

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

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

### H1. Care in a medical emergency

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

- Serious risk to your health or to that of your unborn child; **or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant woman in active labor, when:
- there is not enough time to safely transfer you to another hospital before delivery.
- a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

### Covered services in a medical emergency

We cover medical services during the emergency. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over. You may get covered emergency medical care whenever you need it, anywhere inside or outside the United States.

If you have a medical emergency:

- **Get help as fast as possible.** Call **911** or use to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care, including ambulance services, whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license.

### Post-stabilization care

**As soon as possible, tell our plan about your emergency.** We will follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay in telling us. The number to call is listed on the back of your plan membership card.

We will partner with the doctors who are providing the emergency care to help manage and follow up on your care. After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. We will cover your follow-up post-stabilization care in accord with applicable law. It is very important that your provider call us to get authorization for post-stabilization care **before** you receive the care from the out-of-network provider. The provider treating you must get authorization from us before we will pay for post-stabilization care. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

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

When the provider calls, we 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 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 authorized. If you ask for and get services that are not covered, we may not pay the provider for the services.

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

- The DME item is covered under as described in **Chapter 4** of this **Member Handbook**.
- It 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.

**Getting emergency care if it wasn't an emergency**

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

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

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

## H2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

**Urgently needed care in our plan's service area**

In most cases, we cover urgently needed care only if:

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

If it is not possible or reasonable to get to a network provider, we cover urgently needed care you get from an out-of-network provider.

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

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

**Urgently needed care outside our plan's service area**

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

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

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

### H3. Care during a disaster

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

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

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

drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this **Member Handbook** for more information.

## I. What to do if you are billed directly for services our plan covers

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay our share of the bill.

**You should not pay the bill yourself. If you do, we may not be able to pay you back.**

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

### I1. What to do if our plan does not cover services

Our plan covers all services:

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

If you get services that our plan does not cover, **you pay the full cost yourself.**

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

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

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

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

## J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

**We encourage you to tell us before you take part in a clinical research study.**

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

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

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

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

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

### J3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (**www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**). You can also call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

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

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

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

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

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

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

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility:
- You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.

- You must get approval from us before you are admitted to the facility, or your stay will **not** be covered.

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

## L. Durable medical equipment (DME)

### L1. DME as a member of our plan

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

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to a person who has an illness 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. Coverage is limited to the lowest cost item that adequately meets your medical needs. We select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

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

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, you will **not** own DME, no matter how long you rent it.

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

### L2. DME ownership if you switch to Original Medicare

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

**Note:** You can find definitions of Original Medicare and MA Plans in **Chapter 12**. You can also find more information about them in the *Medicare & You* 2024 handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/medicare-and-you) or by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

If Medi-Cal is not elected, you will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

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

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

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

### L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

- Rental of oxygen equipment.
- Delivery of oxygen and oxygen contents.
- Tubing and related accessories for the delivery of oxygen and oxygen contents.
- Maintenance and repairs of oxygen equipment.

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

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

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

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

- Oxygen equipment, supplies, and services for another 24 months.
- Oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

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

# Chapter 4: Benefits chart

## Introduction

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

**New members to Senior Advantage Medicare Medi-Cal North P2**: In most instances you will be enrolled in our **Senior Advantage Medicare Medi-Cal North P2 Plan** for your Medicare benefits the 1st day of the month after you request to be enrolled in **Senior Advantage Medicare Medi-Cal North P2**. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through **Senior Advantage Medicare Medi-Cal North P2**. There will be no gap in your Medi-Cal coverage. Please call us at **1-800-443-0815** (TTY **711**) if you have any questions. Hours are 8 a.m. to 8 p.m., 7 days a week.

## Chapter 4 Table of Contents

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

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

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

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

### A1. During public health emergencies

In the event of a public health emergency declaration due to a disease, we will cover the following services at no cost to you:

- Preventive services, including immunizations, with an "A" or "B" recommendation from the United States Preventive Services Task Force.
- Services and products necessary for screening, testing, and diagnosis of the disease that is the subject of the public health emergency.
- Therapeutic approved or granted emergency use authorization by the FDA for treatment of the disease.

## B. Rules against providers charging you for services

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

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

## C. About our plan’s Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

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

- We provide covered Medicare and Medi-Cal covered services according to the rules set by Medicare and Medi-Cal.
- The services (including medical care, services, supplies, equipment, and Part B prescription drugs) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of this **Member Handbook** has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan's network. This is called a referral. **Chapter 3** of this **Member Handbook** has more information about getting a referral and when you do **not** need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with a footnote (†). In addition, see **Chapter 3**, for more information about PA, including other services that require PA that are not listed in the Benefits Chart.
- All preventive services are free. You will find this apple 🍎 next to preventive services in the Benefits Chart.
- **Community Supports:** Community Supports may be available under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings. These services are optional for members. If you qualify, these services may help you live more independently. They do **not** replace benefits that you already get under Medi-Cal. They are not available in all areas. Not all members qualify to receive Community Supports. To qualify, you must meet specific criteria. For more information on Community Supports, talk to your PCP or call Member Services.

## D. Our plan's Benefits Chart

| Services that our plan pays for | | What you must pay |
|---|---|---|
| 🍎 | **Abdominal aortic aneurysm screening**<br><br>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. | **$0**<br><br>Talk to your provider and get a referral. |
| | **Acupuncture for chronic low back pain†**<br><br>We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary.<br><br>We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:<br>• lasting 12 weeks or longer;<br>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);<br>• not associated with surgery; **and**<br>• not associated with pregnancy.<br><br>In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.<br><br>Acupuncture treatments must be stopped if you don't get better or if you get worse. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Acupuncture not covered by Medicare†**<br>We cover acupuncture typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.<br>You may also be able to access acupuncture services under your Medi-Cal coverage. Under Medi-Cal, we cover acupuncture services that are medically necessary to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services do not require a referral or pre-approval. These acupuncture services are covered when obtained through our Network Providers or American Specialty Health network providers. For more information on acupuncture services covered by Medi-Cal, please call American Specialty Health at **1-800-678-9133** (TTY **711**). | **$0**<br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Adult Sensitive Care covered under Medi-Cal**<br>As an adult (18 years or older), you may not want to go to your PCP for certain sensitive or private care. If so, you may choose any doctor or clinic for the following types of care:<br>• Family planning/birth control (including sterilization services).<br>• Pregnancy testing and counseling.<br>• HIV/AIDS prevention/testing/treatment.<br>• Sexually transmitted infections prevention/testing/treatment.<br>• Sexual assault care.<br>• Outpatient abortion services.<br>For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be part of the Kaiser Permanente network. You can choose any Medi-Cal provider and go to them without a referral or prior authorization. For help finding a Medi-Cal provider who is outside the Kaiser Permanente network, call Member Services.<br>Services from an out-of-network provider that are not related to Sensitive Care may not be covered. For help finding a doctor or clinic giving these services, or for transportation help getting to these services, you can call Member Services. You may also call the Appointment and Advice Line and talk to a licensed health care professional, 24 hours a day, 7 days a week. | **$0** |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Alcohol misuse screening and counseling**<br><br>We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.<br><br>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.<br><br>If you need additional counseling and treatment services beyond what is covered by Medicare, you may be able to get services through your county mental health plan. The county provides substance use disorder services to Medi-Cal members who meet medical necessity rules. To find all counties' telephone numbers online, visit<br><br>**http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.** | **$0** |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Ambulance services**<br><br>Covered ambulance services include ground and air (airplane and helicopter). The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life.<br><br>Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. See **Chapter 3** for additional information about non-emergency transportation.<br><br>We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. | If you are eligible for Medicare cost-sharing assistance under Medi-Cal, you pay **$0**. Otherwise, you pay **$200** per one-way trip. |
|  | **Annual routine physical exams**<br><br>Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice. | **$0** |
|  | **Annual wellness visit**<br><br>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.<br><br>**Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" visit. However, you don't need to have had a "Welcome to Medicare" visit to get annual wellness visits after you've had Part B for 12 months. | **$0** |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Asthma Preventive Serivces**<br><br>You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma. | **$0** |
| | **Bone mass measurement**<br><br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br><br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results. | **$0**<br><br>Talk to your provider and get a referral. |
| | **Breast cancer screening (mammograms)**<br><br>We pay for the following services:<br>• One baseline mammogram between the ages of 35 and 39.<br>• One screening mammogram every 12 months for women age 40 and over.<br>• Clinical breast exams once every 24 months. | **$0** |
| | **Cardiac (heart) rehabilitation services**<br><br>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order.<br><br>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | What you must pay |
|---|---|
| **Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)**<br><br>We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may:<br>• Discuss aspirin use,<br>• Check your blood pressure, **and/or**<br>• Give you tips to make sure you are eating well. | **$0** |
| **Cardiovascular (heart) disease testing**<br><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. | **$0** |
| **Cervical and vaginal cancer screening**<br><br>We pay for the following services:<br>• For all women: Pap tests and pelvic exams once every 24 months.<br>• For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months.<br>• For women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months.<br>• For women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years. | **$0** |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Chiropractic services†**<br><br>We pay for the following services:<br>• Adjustments of the spine to correct alignment. These Medicare-covered services are provided by a network provider or a chiropractor if authorized by a network provider. For the list of network chiropractors, please refer to the **Provider and Pharmacy Directory**.<br>• Medi-Cal may cover chiropractic services when received at an Federally Qualified Health Center (FQHC) or Rural Health Clinics (RHC) in Kaiser Permanente's network. FQHCs and RHCs may require a referral to get services. To get more information about services available at an FQHC or RHC, call Member Services. | **$0** |

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| | **Colorectal cancer screening**<br><br>We pay for the following services:<br>• Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.<br>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema.<br>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.<br>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years.<br>• Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every three years.<br>• Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.<br>• Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.<br>• Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Dental services**<br><br>Health Plan has an agreement with Delta Dental of California ("Delta Dental") to offer you DeltaCare® USA Dental HMO Program. DeltaCare USA provides comprehensive dental care through a network of dentists that contract with Delta Dental to provide dental services. For information about dental providers, please refer to the **Dental Provider Directory**. | **$0** for covered services described in the "Dental care (DeltaCare USA Dental HMO Program)" section at the end of this chart. |
| | We pay for certain dental services, including but not limited to, cleanings, fillings, and dentures. What we do not cover is available through the Medi-Cal Dental Program described in **Section E**. | **$0** |
| | **Depression screening**<br><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals. | **$0** |
| | **Diabetes screening**<br><br>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:<br>• High blood pressure (hypertension)<br>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)<br>• Obesity<br>• History of high blood sugar (glucose)<br><br>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.<br><br>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. | **$0** |

| Services that our plan pays for | What you must pay |
|---|---|
| **Diabetic self-management training, services, and supplies**<br><br>We pay for the following services for all people who have diabetes (whether they use insulin or not):<br>• †Supplies to monitor your blood glucose, including the following:<br>  • A blood glucose monitor.<br>  • Blood glucose test strips.<br>  • Lancet devices and lancets.<br>  • Glucose-control solutions for checking the accuracy of test strips and monitors.<br>• †For people with diabetes who have severe diabetic foot disease, we pay for the following:<br>  • One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or**<br>  • One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)<br>• †In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.<br><br>**Note**: You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare. | **$0** |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Doula Services**<br><br>For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery. | **$0** |
| | **Durable medical equipment (DME) and related supplies†**<br><br>Refer to the **Chapter 12** of this Member Handbook for a definition of "Durable medical equipment (DME)."<br><br>We cover the following items:<br>• Wheelchairs, including electric wheelchairs.<br>• Crutches.<br>• Powered mattress systems.<br>• Dry pressure pad for mattress.<br>• Diabetic supplies.<br>• Hospital beds ordered by a provider for use in the home.<br>• Intravenous (IV) infusion pumps and pole.<br>• Speech generating devices.<br>• Oxygen equipment and supplies.<br>• Nebulizers.<br>• Walkers.<br>• Standard curved handle or quad cane and replacement supplies.<br>• Cervical traction (over the door).<br>• Bone stimulator.<br>• Dialysis care equipment.<br><br>**This benefit is continued on the next page** | If you are eligible for Medicare cost-sharing assistance under Medi-Cal, you pay **$0**. Otherwise, you pay **20%** coinsurance, except for peak flow meters and ultraviolet light therapy equipment you pay **$0**. |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Durable medical equipment (DME) and related supplies (continued)**<br><br>Other items may be covered.<br><br>We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**. | |
| | We also cover the following DME not covered by Medicare when medically necessary:<br>• Bed accessories for a hospital bed when bed extension is required.<br>• Heel or elbow protectors to prevent or minimize advanced pressure relief equipment use.<br>• Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example skin infection) or is preventing daily living activities.<br>• Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag.<br><br>**This benefit is continued on the next page** | |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Durable medical equipment (DME) and related supplies (continued)**<br>• Ultraviolet light therapy equipment for conditions other than psoriasis as medically necessary, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through our plan's prior authorization process, as described in **Chapter 3** and (2) the equipment is provided inside our service area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.) | |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Emergency care**<br><br>Emergency care means services that are:<br>• Given by a provider trained to give emergency services, and<br>• Needed to treat a medical emergency.<br><br>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, anyone with an average knowledge of health and medicine could expect it to result in:<br>• Serious risk to your health or to that of your unborn child; or<br>• Serious harm to bodily functions; or<br>• Serious dysfunction of any bodily organ or part; or<br>• In the case of a pregnant woman in active labor, when:<br>  • There is not enough time to safely transfer you to another hospital before delivery.<br>  • A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.<br><br>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.<br><br>**You have worldwide emergency care coverage.** | **$0**<br><br>†If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital. |

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| | **Family planning services**<br><br>The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.<br><br>We pay for the following services:<br>• Family planning exam and medical treatment.<br>• Family planning lab and diagnostic tests.<br>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring).<br>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap).<br>• Counseling and diagnosis of infertility and related services.<br>• Counseling, testing, and treatment for sexually transmitted infections (STIs).<br>• Counseling and testing for HIV and AIDS, and other HIV-related conditions.<br>• Permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.).<br>• Genetic counseling.<br><br>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:<br>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.).<br>• Treatment for AIDS and other HIV-related conditions.<br>• Genetic testing. | **$0** |

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| | **Fitness benefit (the Silver&Fit® Healthy Aging and Exercise Program)**<br>The Silver&Fit program includes the following:<br>• You can join a participating Silver&Fit fitness center and take advantage of the services that are included in the fitness center's standard membership (for example, use of fitness center equipment or instructor-led classes that do not require an additional fee). If you sign-up for a Silver&Fit fitness center membership, the following applies:<br>• The fitness center provides facility and equipment orientation.<br>• Services offered by fitness centers vary by location. Any nonstandard fitness center service that typically requires an additional fee is not included in your standard fitness center membership through the Silver&Fit program (for example, court fees or personal trainer services).<br>• To join a participating Silver&Fit fitness center, register through **kp.org/SilverandFit** and select your location(s). You can then print or download your "Welcome Letter," which includes your Silver&Fit card with fitness ID number to provide to the selected fitness center.<br>• Once you join, you can switch to another participating Silver&Fit fitness center once a month and your change will be effective the first of the following month (you may need to complete a new membership agreement at the fitness center).<br>**This benefit is continued on the next page** | **$0** |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Fitness benefit (the Silver&Fit® Healthy Aging and Exercise Program) (continued)**<br>• If you would like to work out at home, you can select one Home Fitness Kit per calendar year. There are many Home Fitness Kits to choose from, including Wearable Fitness Tracker, Pilates, Strength, Swim, and Yoga Kit options. Kits are subject to change and once selected cannot be exchanged. To pick your kit, please visit **kp.org/SilverandFit** or call Silver&Fit customer service.<br>• Access to Silver&Fit online services at **kp.org/SilverandFit** that provide on-demand workout videos, Workout Plans, the Well-Being Club, a newsletter, and other helpful features. The Well-Being Club enhanced feature of the Silver&Fit website allows members the opportunity to view customized resources as well as attend live-streaming classes and events.<br>For more information about the Silver&Fit program and the list of participating fitness centers and home kits, visit **kp.org/SilverandFit** or call Silver&Fit customer service at **1-877-750-2746** (TTY **711**), Monday through Friday,<br>5 a.m. to 6 p.m. (PST).<br>The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. Participating fitness centers and fitness chains may vary by location and are subject to change. | |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Health and wellness education programs**<br><br>We offer many programs that focus on certain health conditions. These include:<br>• Health Education classes;<br>• Nutrition Education classes;<br>• Smoking and Tobacco Use Cessation; and<br>• Nursing Hotline<br><br>As part of our Healthy Lifestyle Programs, our plan covers a number of group health education classes including: healthy heart, living with chronic conditions and depression. The Healthy Lifestyle Programs are provided by a certified health educator or other qualified health professional.<br><br>We cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for chronic conditions (such as diabetes and asthma). You can also participate in programs that we don't cover, which may require that you pay a fee.<br><br>For more information about our health education counseling, programs, and materials, please contact your local Health Education Department, call Member Services or go to our website at **kp.org**. | **$0** |
| | **Hearing services**<br><br>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.<br><br>**Hearing aids**<br><br>We cover hearing aids if:<br>• You are tested for hearing loss. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **This benefit is continued on the next page**<br>**Hearing services (continued)**<br>• The hearing aids are medically necessary.<br>• You receive a prescription from your doctor.<br>Coverage is limited to the lowest cost aid that meets your medical needs. We will choose who will supply the hearing aid. We cover one hearing aid unless an aid for each ear is needed for results significantly better than you could get with one aid.<br>We cover the following for each covered hearing aid:<br>• Ear molds needed for fitting.<br>• One standard battery package.<br>• Visits to make sure the aid is working right.<br>• Visits for cleaning and fitting your hearing aid.<br>• Repair of your hearing aid.<br>We will cover a replacement hearing aid if:<br>• Your hearing loss is such that your current hearing aid is not able to correct it.<br>• 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.<br>Coverage does not include:<br>• Replacement hearing aid batteries | |

| Services that our plan pays for | | What you must pay |
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| | **HIV screening**<br><br>We pay for one HIV screening exam every 12 months for people who:<br>• Ask for an HIV screening test, or<br>• Are at increased risk for HIV infection.<br><br>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.<br><br>We also pay for additional HIV screening(s) when recommended by your provider. | **$0** |
| | **Home-delivered meals**<br><br>Under Medi-Cal, you may qualify for coverage for home delivered meals under Community Supports. Community Supports are not available in all areas and you have to meet specific eligibility criteria. Ask your doctor for more information about Medi-Cal Community Supports. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Home health agency care**<br><br>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br><br>We pay for the following services, and maybe other services not listed here:<br>• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.)<br>• Physical therapy, occupational therapy, and speech therapy.<br>• Medical and social services.<br>• Medical equipment and supplies. | **$0**<br><br>Talk to your provider and get a referral.<br><br>**Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency. |

| Services that our plan pays for | | What you must pay |
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| | **Home infusion therapy†**<br><br>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:<br>• The drug or biological substance, such as an antiviral or immune globulin;<br>• Equipment, such as a pump; and<br>• Supplies, such as tubing or a catheter.<br><br>Our plan covers home infusion services that include but are not limited to:<br>• Professional services, including nursing services, provided in accordance with your care plan;<br>• Member training and education not already included in the DME benefit;<br>• Remote monitoring; and<br>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. | **$0** for professional services, training, and monitoring. The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Benefits Chart depending on the item**.** |
| | We cover home infusion supplies and drugs if all of the following are true:<br>• Your prescription drug is on our Medicare Part D formulary.<br>• We approved your prescription drug for home infusion therapy.<br>• Your prescription is written by a network provider and filled at a network home-infusion pharmacy. | **$0**<br><br>**Note**: If a covered home infusion supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost-sharing listed elsewhere in this booklet depending on the service. |

| Services that our plan pays for | What you must pay |
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| **Hospice care**<br><br>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider.<br><br>Covered services include:<br>• Drugs to treat symptoms and pain.<br>• Short-term respite care.<br>• Home care.<br><br>**Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.**<br>• Refer to **Section E** of this chapter for more information.<br><br>**For services covered by our plan but not covered by Medicare Part A or Medicare Part B:**<br>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay our plan's cost-sharing amount for these services.<br><br>**For drugs that may be covered by our plan's Medicare Part D benefit:**<br>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this **Member Handbook**.<br><br>**Note:** If you need non-hospice care, call your care coordinator and/or Member Services to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit. | |
| | **Immunizations**<br><br>We pay for the following services:<br>• Pneumonia vaccine.<br>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary.<br>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B.<br>• COVID-19 vaccines.<br>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules.<br><br>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this **Member Handbook** to learn more. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Inpatient hospital care**<br><br>We pay for the following services and other medically necessary services not listed here:<br>• Semi-private room (or a private room if medically necessary).<br>• Meals, including special diets.<br>• Regular nursing services.<br>• Costs of special care units, such as intensive care or coronary care units.<br>• Drugs and medications.<br>• Lab tests.<br>• X-rays and other radiology services.<br>• Needed surgical and medical supplies.<br>• Appliances, such as wheelchairs.<br>• Operating and recovery room services.<br>• Physical, occupational, and speech therapy.<br>• Inpatient substance abuse services.<br>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.<br><br>**This benefit is continued on the next page** | **$0**<br><br>Talk to your provider and get a referral.<br><br>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. |

| Services that our plan pays for | What you must pay |
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| **Inpatient hospital care (continued)**<br>• If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person, in accord with our travel and lodging guidelines, which are available from Member Services.<br>• Blood, including storage and administration.<br>• Physician services.<br>• **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.<br>• You can also find more information in a Medicare fact sheet called "Are you a Hosptial Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week. | |

| Services that our plan pays for | | What you must pay |
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| | **Inpatient services in a psychiatric hospital**<br><br>We pay for mental health care services that require a hospital stay.<br>• If you are 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD). | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Inpatient stay: Covered services in a skilled nursing facility (SNF) during a non-covered inpatient stay**<br><br>We do not pay for your inpatient stay or if the stay is not reasonable and medically necessary.<br><br>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a nursing facility. To find out more, contact Member Services.<br><br>We pay for the following services, and maybe other services not listed here:<br>• Doctor services.<br>• Diagnostic tests, like lab tests.<br>• X-ray, radium, and isotope therapy, including technician materials and services.<br>• Surgical dressings.<br>• Splints, casts, and other devices used for fractures and dislocations.<br>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of:<br>  • An internal body organ (including contiguous tissue), **or**<br>  • The function of an inoperative or malfunctioning internal body organ.<br>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition.<br>• Physical therapy, speech therapy, and occupational therapy. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Kidney disease services and supplies**<br><br>We pay for the following services:<br>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.<br>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care.<br>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments.<br>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.<br>• Routine laboratory tests to monitor the effectiveness of dialysis.<br>• One routine office visit per month with the nephrology team.<br>• Vascular and peritoneal access procedures when performed in an outpatient hospital setting if certain criteria are met.<br>• Nonroutine office visits with the nephrology team.<br>• Vascular and peritoneal access procedures when performed in a medical office.<br><br>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this Benefits Chart. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | • Home dialysis equipment and supplies.<br>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this Member **Handbook**, or when your provider for this service is temporarily unavailable or inaccessible. | If you are eligible for Medicare cost-sharing assistance under Medi-Cal, you pay **$0**. Otherwise, you pay **20%** coinsurance. |
| 🍎 | **Lung cancer screening**<br>Our plan pays for lung cancer screening every 12 months if you:<br>• Are aged 50-77, and<br>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, and<br>• Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.<br>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Medical nutrition therapy**<br><br>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor.<br><br>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.<br><br>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.<br><br>We also cover nutrition/dietary counseling with a network provider not related to diabetes or ESRD. | **$0**<br><br>Talk to your provider and get a referral. |
| | **Medicare Diabetes Prevention Program (MDPP)**<br><br>Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:<br>• Long-term dietary change, and<br>• Increased physical activity, and<br>• Ways to maintain weight loss and a healthy lifestyle. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Medicare Part B prescription drugs†**<br><br>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:<br>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services .<br>• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump).<br>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized.<br>• Clotting factors you give yourself by injection if you have hemophilia.<br>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant.<br>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself.<br>• Antigens.<br>• Certain oral anti-cancer drugs and anti-nausea drugs.<br><br>**This benefit is continued on the next page** | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Medicare Part B prescription drugs (continued)**<br>• Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)<br>• IV immune globulin for the home treatment of primary immune deficiency diseases<br>We also cover some vaccines under our Medicare Part D prescription drug benefit.<br>**Chapter 5** of this **Member Handbook** explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.<br>**Chapter 6** of this **Member Handbook** explains what you pay for your outpatient prescription drugs through our plan. | |

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| | **Nursing facility care covered under your Medicare coverage**<br><br>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.<br><br>Services that we pay for include, but are not limited to, the following:<br>• Semiprivate room (or a private room if medically necessary).<br>• Meals, including special diets.<br>• Nursing services.<br>• Physical therapy, occupational therapy, and speech therapy.<br>• Respiratory therapy.<br>• Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)<br>• Blood, including storage and administration.<br>• Medical and surgical supplies usually given by nursing facilities.<br>• Lab tests usually given by nursing facilities.<br>• X-rays and other radiology services usually given by nursing facilities.<br>• Use of appliances, such as wheelchairs usually given by nursing facilities.<br>• Physician/practitioner services.<br>• Durable medical equipment.<br>• Dental services, including dentures.<br>• Vision benefits.<br><br>**This benefit is continued on the next page** | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Nursing facility care covered under your Medicare coverage (continued)**<br>• Hearing exams.<br>• Chiropractic care.<br>• Podiatry services.<br>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:<br>• A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).<br>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital. | |
| 🍎 | **Obesity screening and therapy to keep weight down**<br>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Opioid treatment program (OTP) services**<br>Our plan pays for the following services to treat opioid use disorder (OUD):<br>• Intake activities.<br>• Periodic assessments.<br>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications.<br>• Substance use counseling.<br>• Individual and group therapy.<br>• Testing for drugs or chemicals in your body (toxicology testing). | **$0**<br>Talk to your provider and get a referral. |
| | **Outpatient diagnostic tests and therapeutic services and supplies**<br>We pay for the following services and other medically necessary services not listed here:<br>• X-rays.<br>• Radiation (radium and isotope) therapy, including technician materials and supplies.<br>• Surgical supplies, such as dressings.<br>• Splints, casts, and other devices used for fractures and dislocations.<br>• Lab tests.<br>• Blood, including storage and administration.<br>• Other outpatient diagnostic tests. | **$0**<br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Outpatient hospital observation**<br><br>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.<br><br>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.<br><br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.<br><br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week. | **$0** |

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| | **Outpatient hospital services**<br><br>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:<br>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services.<br>• Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”<br>• Sometimes you can be in the hospital overnight and still be “outpatient.”<br><br>You can get more information about being inpatient or outpatient in this fact sheet:<br>**www.medicare.gov/media/11101**<br>• Labs and diagnostic tests billed by the hospital.<br>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it.<br>• X-rays and other radiology services billed by the hospital.<br>• Medical supplies, such as splints and casts.<br>• Preventive screenings and services listed throughout the Benefits Chart.<br>• Some drugs that you can’t give yourself.<br>• For dental procedures at a network facility, we provide general anesthesia and the facility's services associated with the anesthesia if all of the following are true:<br>o You are developmentally disabled, or your health is compromised.<br><br>**This benefit is continued on the next page** | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Outpatient hospital services (continued)**<br>○ Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center.<br>○ The dental procedure would not ordinarily require general anesthesia.<br>• We do not cover any other services related to the dental procedure, such as the dentist's services, unless the services are covered by DeltaCare or Medi-Cal Dental. | |

| Services that our plan pays for | | What you must pay |
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| | **Outpatient mental health care**<br><br>We pay for mental health services provided by:<br>• A state-licensed psychiatrist or doctor.<br>• A clinical psychologist.<br>• A clinical social worker.<br>• A clinical nurse specialist.<br>• A licensed professional counselor (LPC).<br>• A licensed marriage and family therapist (LMFT).<br>• A nurse practitioner (NP).<br>• A physician assistant (PA).<br>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws.<br><br>We pay for the following services, and maybe other services not listed here:<br>• Clinic services.<br>• Day treatment.<br>• Psychosocial rehab services.<br>• Partial hospitalization or Intensive outpatient programs.<br>• Individual and group mental health evaluation and treatment.<br>• Psychological testing when clinically indicated to evaluate a mental health outcome.<br>• Outpatient services for the purposes of monitoring drug therapy.<br>• Outpatient laboratory, drugs, supplies and supplements.<br>• Psychiatric consultation. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Outpatient rehabilitation services**<br><br>We pay for physical therapy, occupational therapy, and speech therapy.<br><br>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.<br><br>We also cover:<br>• Physical therapy to prevent falls for adults who are at risk for falls when ordered by your doctor.<br>• Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program. | **$0**<br><br>Talk to your provider and get a referral. |
| | **Outpatient substance abuse services**<br><br>We pay for the following services, and maybe other services not listed here:<br>• Alcohol misuse screening and counseling.<br>• Treatment of drug abuse.<br>• Group or individual counseling by a qualified clinician, including a licensed marriage and family therapist (LMFT).<br>• Subacute detoxification in a residential addiction program.<br>• Alcohol and/or drug services in an intensive outpatient treatment center.<br>• Extended release Naltrexone (vivitrol) treatment. | **$0** |
| | **Outpatient surgery**<br><br>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Over-the-Counter (OTC) Health and Wellness**<br>We also cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items up to the **$140** quarterly benefit limit. Each order must be at least $25. Your order may not exceed your quarterly benefit limit. Any unused portion of the quarterly benefit limit doesn't carry forward to the next quarter. (Your benefit limit resets on January 1, April 1, July 1, and October 1).<br>To view our catalog and place an order online, please visit **kp.org/otc/ca.** You may place an order over the phone or request a printed catalog be mailed to you by calling **1-833-569-2360** (TTY **711**), 7 a.m. to 6 p.m. PST, Monday through Friday.<br>You may have additional coverage for certain OTC items covered under Medi-Cal through the Medi-Cal Rx program. For more information on Medi-Cal Rx, call Medi-Cal Rx Customer Service at **1-800-977-2273**, 24 hours a day, 7 days a week. TTY users can call **711,** Monday through Friday, 8 a.m. to 5 p.m. You can also visit the Medi-Cal Rx website at **https://www.Medi-CalRx.dhcs.ca.gov/home/.** | You pay **$0** up to the **$140** quarterly benefit limit. |
| | **Over-the-Counter (OTC) items for nicotine replacement**<br>We cover certain FDA-approved nicotine replacement therapies for over-the-counter use. The items must be ordered by a network provider and obtained from a network pharmacy. We will provide up to a 100-day supply twice during the calendar year. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Partial hospitalization services**<br><br>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.<br><br>Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Palliative Care**<br><br>We cover palliative care for Members who meet the Medi-Cal eligibility criteria for these services. Palliative care reduces physical, emotional, social and spiritual discomforts for a Member with a serious illness. Palliative care may be provided at the same time as curative care.<br><br>Palliative care includes the following:<br><br>• Advance care planning.<br>• Palliative care assessment and consultation.<br>• A plan of care including all authorized palliative and curative care.<br>• A plan of care team, including, but not limited to the following:<br>  • Doctor of medicine or osteopathy.<br>  • Physician Assistant.<br>  • Registered Nurse.<br>  • Licensed Vocational Nurse or Nurse Practitioner.<br>  • Social Worker.<br>  • Chaplain.<br>• Care coordination.<br>• Pain and symptom management.<br>• Mental health and medical social services.<br><br>Adults who are age 21 or older cannot receive both palliative care and hospice 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. | **$0**<br><br>Talk to your provider and get a referral. |

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| | **Physician/provider services, including doctor's office visits**<br><br>We pay for the following services:<br>• Medically necessary health care or surgery services given in places such as:<br>  • Physician's office.<br>  • Certified ambulatory surgical center.<br>  • Hospital outpatient department.<br>• Consultation, diagnosis, and treatment by a specialist.<br>• Basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment.<br>• We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw.<br>• We also cover dental services necessary to ensure the oral cavity is clear of infection prior to being placed on the transplant wait list for allogeneic stem cell/bone marrow, heart, kidney, liver, lung, pancreas, and multiple-organ transplants. In the case of urgent transplantation, these services may be performed post-transplant. Services include:<br>  • Examination and evaluation of the oral cavity.<br>  • Treatment services including extractions necessary for the transplant.<br>  • Relevant dental X-rays.<br>  • Cleaning.<br>  • Fluoride treatments.<br><br>This benefit is continued on the next page | **$0**<br><br>A referral may be required for some specialty and dental services. |

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| | **Physician/provider services, including doctor's office visits (continued)**<br>• House calls by a network physician (or a network provider who is a registered nurse) inside our service area when care can best be provided in your home as determined by a network provider.<br>• Ultraviolet light treatments.<br>• Second opinion by another network provider before surgery. Under your Medi-Cal coverage, if a network provider is not available or you need a second opinion for a different service, we will arrange it.<br>• Certain telehealth services, including: primary and specialty care, which includes inpatient hospital services, skilled nursing facility services, cardiac rehabilitation services, pulmonary rehabilitation services, emergency services, urgently needed services, partial hospitalization, home health services, occupational therapy services, mental health, podiatry, psychiatric services, physical therapy and speech-language pathology services, opioid treatment program services, outpatient X-ray services, outpatient hospital services, observation services, outpatient substance abuse, dialysis services, nutritional/dietary services, health education, kidney disease education services, diabetes self-management training, and hearing exams, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service.<br>**This benefit is continued on the next page** | |

| Services that our plan pays for | | What you must pay |
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| | **Physician/provider services, including doctor's office visits (continued)**<br>• You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth:<br>• Interactive video visits for professional services when care can be provided in this format as determined by a network provider.<br>• Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider.<br>• Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home.<br>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke.<br>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder.<br>**This benefit is continued on the next page** | |

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| | **Physician/provider services, including doctor's office visits (continued)**<br>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>  • You have an in-person visit within 6 months prior to your first telehealth visit.<br>  • You have an in-person visit every 12 months while receiving these telehealth services.<br>  • Exceptions can be made to the above for certain circumstances.<br>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.<br>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**<br>  • You're not a new patient **and**<br>  • The check-in isn't related to an office visit in the past 7 days **and**<br>  • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment.<br>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**<br>  • You're not a new patient **and**<br>  • The evaluation isn't related to an office visit in the past 7 days **and**<br>  • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment.<br>**This benefit is continued on the next page** | **$0**<br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Physician/provider services, including doctor's office visits (continued)**<br>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient.<br>**Telehealth under your Medi-Cal coverage:** Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider. Or telehealth may involve sharing information with your provider without a live conversation. You can receive many services through telehealth. However, telehealth may not be available for all covered services. You can contact your provider to learn which types of services may be available through telehealth. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. You have the right to in-person services and are not required to use telehealth even if your provider agrees that it is appropriate for you. | |
| | **Podiatry services**<br>We pay for the following services:<br>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs).<br>• Routine foot care for members with conditions affecting the legs, such as diabetes.<br>Under your Medi-Cal coverage, we cover podiatry services as Medically Necessary for diagnosis and medical, surgical, mechanical, manipulative, and electrical treatment of the human foot. This includes the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg controlling the functions of the foot. | **$0**<br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Prostate cancer screening exams**<br><br>For men age 50 and older, we pay for the following services once every 12 months:<br>• A digital rectal exam.<br>• A prostate specific antigen (PSA) test. | **$0** |

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| | **Prosthetic devices and related supplies†**<br><br>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:<br>• Colostomy bags and supplies related to colostomy care.<br>• Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections.<br>• Pacemakers.<br>• Braces.<br>• Prosthetic shoes.<br>• Artificial arms and legs.<br>• Breast prostheses (including a surgical brassiere after a mastectomy).<br>• Prostheses to replace all of part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect.<br>• Incontinence cream and diapers.<br><br>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.<br><br>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.<br><br>We also cover these items not covered by Medicare:<br>• Gradient compression stockings for lymphedema.<br>• Certain surgical boots following surgery when provided during an outpatient visit.<br>• Vacuum erection device for sexual dysfunction.<br>• Certain skin sealants, protectants, moisturizers, ointments that are medically necessary wound care.<br>• We will not pay for prosthetic dental devices, except as described under "Dental services."<br><br>**This benefit is continued on the next page** | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Prosthetic devices and related supplies† (continued)**<br><br>Under your Medi-Cal coverage, we cover prosthetics and orthotic devices if all the following conditions are met:<br>• The item is medically necessary to restore how a body part works (for prosthetics only).<br>• The item is prescribed for you.<br>• The item is medically necessary to support a body part (for orthotics only).<br>• The item is medically necessary for you to perform activities of daily living.<br>• The item makes sense for your overall medical condition.<br>• The item is covered by Medi-Cal.<br>• The item must be pre-approved for you. This includes implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part. Coverage is limited to the lowest cost item of equipment that adequately meets your medical needs. We select the vendor. | |
| | **Pulmonary rehabilitation services**<br><br>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Residential substance use disorder and mental health treatment†**<br><br>We cover the following services when the services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder or mental health treatment, the services are generally and customarily provided by a substance use disorder or mental health residential treatment program in a licensed residential treatment facility, and the services are above the level of custodial care:<br><br>• Individual and group counseling.<br>• Medical services.<br>• Medication monitoring.<br>• Room and board.<br>• Drugs prescribed by a network provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel.<br>• Discharge planning.<br><br>There is no limit to the number of medically necessary days in our residential treatment program to treat mental health conditions and substance abuse when prescribed by a network provider. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Sexually transmitted infections (STIs) screening and counseling**<br><br>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.<br><br>We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Skilled nursing facility (SNF) care**<br><br>We pay for the following services, and maybe other services not listed here:<br>• A semi-private room, or a private room if it is medically necessary.<br>• Meals, including special diets.<br>• Nursing services.<br>• Physical therapy, occupational therapy, and speech therapy.<br>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors.<br>• Blood, including storage and administration.<br>• Medical and surgical supplies given by nursing facilities.<br>• Lab tests given by nursing facilities.<br>• X-rays and other radiology services given by nursing facilities.<br>• Appliances, such as wheelchairs, usually given by nursing facilities.<br>• Physician/provider services.<br>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:<br>• A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care).<br>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Smoking and tobacco use cessation**<br><br>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:<br>• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.<br><br>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:<br>• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Supervised exercise therapy (SET)**<br><br>We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment.<br><br>Our plan pays for:<br>• Up to 36 sessions during a 12-week period if all SET requirements are met.<br>• An additional 36 sessions over time if deemed medically necessary by a health care provider.<br><br>The SET program must be:<br>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication).<br>• In a hospital outpatient setting or in a physician's office.<br>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD.<br>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Transportation: Non-emergency medical transportation†**<br><br>This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit.<br><br>The forms of transportation are authorized when:<br>• Your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, and<br>• Depending on the service, prior authorization may be required.<br><br>For information on how to request non-emergency medical transportation, refer to **Chapter 3**. | **$0**<br><br>Talk to your provider and get a referral. |
| | **Transportation: Non-medical transportation†**<br><br>This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.<br><br>Transportation is required for the purpose of obtaining needed medical care, including travel to dental appointments and to pick up prescription drugs.<br><br>This benefit does not limit your non-emergency medical transportation benefit.<br><br>For information on how to request non-medical transportation, refer to **Chapter 3**. | **$0**<br><br>Talk to your provider and get a referral. |

| Services that our plan pays for | | What you must pay |
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| | **Urgently needed care**<br><br>Urgently needed care is care given to treat:<br>• A non-emergency that requires immediate medical care, or<br>• A sudden medical illness, or<br>• An injury, or<br>• A condition that needs care right away.<br><br>If you require urgently needed care, you should first try to get it from a network provider.<br><br>**Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster).<br><br>**Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. | **$0** |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Vision care**<br><br>We pay for the following services:<br>• One routine eye exam every year.<br>• Outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.<br>• For people with diabetes, screening for and monitoring of diabetic retinopathy.<br>• Visual field tests.<br><br>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:<br>• People with a family history of glaucoma.<br>• People with diabetes.<br>• African-Americans who are age 50 and older.<br>• Hispanic Americans who are 65 or older. | **$0**<br><br>Talk to your provider and get a referral for ophthalmology. |
| | **Eyewear following cataract surgery:** We pay for the following:<br>• One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.<br>• Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. | **$0** for eyewear in accord with Medicare guidelines.<br><br>**Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference. |

| Services that our plan pays for | | What you must pay |
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| | **Eyeglasses and contact lenses:** Once every 12 months, we provide a **$350** allowance for you to use toward the purchase price of eyewear from a plan optical facility when a physician or optometrist prescribes an eyeglass or contact lens for vision correction. The allowance can be used to pay for the following items:<br>• Eyeglass lenses when a network provider puts the lenses into a frame.<br>• Eyeglass frames when a network provider puts two lenses (at least one of which must have refractive value) into the frame.<br>• Contact lenses, fitting, and dispensing.<br>We will not provide the allowance if we have provided an allowance toward (or otherwise covered) lenses or frames within the previous 12 months.<br>The allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later. | If the eyewear you purchase costs more than **$350, you pay the difference**.<br>Medi-Cal covers new or replacement frames that cost **$80** or less, every 24 months. If the frames you purchase costs more than **$80, you pay the difference**. |
| | **Eyeglass lenses under your Medi-Cal coverage:**<br>• New or replacement eyeglass lenses are provided by 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 have to make arrangements because DHCS's vendor cannot make your eyeglass lenses. | **$0**<br>If you want eyeglasses lenses or features that are not covered by Medi-Cal, then **you may have to pay extra for those upgrades**. |

| Services that our plan pays for | | What you must pay |
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| | **Replacement lenses:** If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an allowance toward (or otherwise covered) we will provide an allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The allowance toward one of these replacement lenses is **$30** for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and **$45** for a multifocal or lenticular eyeglass lens. | If the lens you purchase costs more than the **$30** allowance for single vision or **$45** for multifocal or lenticular eyeglass lens, **you pay the amount that exceeds your allowance.** |
| | **Special contact lenses:** We cover the following special contact lenses when prescribed by a network physician or network provider who is an optometrist:<br>• Up to two medically necessary contact lenses, fitting, and dispensing per eye every 12 months to treat aniridia (missing iris).<br>• If contact lenses (other than contact lenses for aniridia) will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 12 months. However, we will not cover any contact lenses if we provided an allowance toward (or otherwise covered) a contact lens within the previous 12 months, but not including covered contact lenses for aniridia. | **$0** |

| Services that our plan pays for | | What you must pay |
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| | **Low Vision devices:** We cover low vision devices under Medi-Cal when the following conditions are met:<br>• 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.<br>• The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means.<br>• 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.<br>Coverage is limited to the lowest cost device that meets the Member's needs. Medi-Cal coverage does not include electronic magnification devices and devices that do not incorporate a lens for use with the eye. | **$0** |
| | **"Welcome to Medicare" preventive visit**<br>We cover the one-time "Welcome to Medicare" preventive visit. The visit includes:<br>• A review of your health,<br>• Education and counseling about the preventive services you need (including screenings and shots), and<br>• Referrals for other care if you need it.<br>**Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Additional Dental Care (DeltaCare® USA Dental HMO Program)**<br><br>Health Plan has an agreement with Delta Dental of California ("Delta Dental") to offer you DeltaCare USA Dental HMO Program. DeltaCare USA provides comprehensive dental care through a network of dentists that contract with Delta Dental to provide dental services. For information about dental providers, please refer to the Dental Provider Directory.<br><br>The benefits shown below are performed as deemed appropriate by the attending DeltaCare USA dentist subject to the limitations and exclusions stated in this chapter. Members should discuss all treatment options with their DeltaCare USA dentist prior to services being rendered. If services for a listed procedure are performed by the assigned contract dentist, the enrollee pays the specified copayment. Listed procedures which require a dentist to provide specialist services, and are referred by the assigned contract dentist, must be authorized by Delta Dental. The enrollee pays the copayment specified for such services.<br><br>If a procedure isn't listed below, it isn't covered. Note: Any service, which is listed below with an asterisk (*) is only a covered benefit when provided with another listed service that is not marked with an asterisk.<br><br>Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA Dental HMO programs and is not to be interpreted as Current Dental Terminology (CDT) 2024 procedure codes, nomenclature or descriptors that are under copyright by the American Dental Association (ADA). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors, or nomenclatures may be used to describe these covered procedures in compliance with federal legislation. | |
| **Diagnostic (D0100-D0999)†**<br><br>D0120: Periodic oral evaluation – established patient. | **$0** |
| D0140: Limited oral evaluation – problem focused. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D0150: Comprehensive oral evaluation – new or established patient. | **$0** |
| D0160: Detailed and extensive oral evaluation – problem focused, by report | **$0** |
| D0180: Comprehensive periodontal evaluation – new or established patient | **$0** |
| D0210: Intraoral – comprehensive series of radiographic images – limited to 1 series every 24 months. | **$0** |
| D0220: Intraoral – periapical first radiographic image. | **$0** |
| D0230: Intraoral – periapical each additional radiographic image. | **$0** |
| D0240: Intraoral – occlusal radiographic image. | **$0** |
| D0250: Extraoral – 2D projection radiographic image created using a stationary radiation source, and detector. | **$0** |
| D0251: Extraoral posterior dental radiographic image. | **$0** |
| D0270: Bitewing – single radiographic image. | **$0** |
| D0272: Bitewings – two radiographic images. | **$0** |
| D0274: Bitewings – four radiographic images – limited to 1 series every 6 months. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D0330: Panoramic radiographic image. | **$0** |
| D0350: 2D oral/facial photographic images obtained intraorally or extra orally – for the diagnosis and treatment of the specific clinical condition not apparent on radiographs – 4 per date of service. | **$0** |
| D0396: 3D printing of a 3D dental surface scan. | **$0** |
| D0419: Assessment of salivary flow by measurement – 1 every 12 months. | **$0** |
| D0502: Other oral pathology procedures, by report. | **$0** |
| D0999: Unspecified diagnostic procedure, by report – includes office visit, per visit (in addition to other services). | **$0** |
| **Preventive (D1000-D1999)**<br>D1110: Prophylaxis cleaning – adult –1 D1110 or D4346 per 6-month period. | **$0** |
| D1206: Topical application of fluoride varnish – 1 D1206 or D1208 per 6-month period. | **$0** |
| D1208: Topical application of fluoride – excluding varnish – 1 D1206 or D1208 per 6-month period. | **$0** |
| D1354 Application of caries arresting medicament – per tooth – *1 per 6 month period* | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Restorative (D2000-D2999)†**<br>Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.<br>Replacement of crowns, inlays, and onlays requires the existing restoration to be 5+ years old. | |
| D2140: Amalgam – one surface, primary or permanent – limited to 1 per 36 months. | **$0** |
| D2150: Amalgam – two surfaces, primary or permanent – limited to 1 per 36 months. | **$0** |
| D2160: Amalgam – three surfaces, primary or permanent – limited to 1 per 36 months. | **$0** |
| D2161: Amalgam – four or more surfaces, primary or permanent – limited to 1 per 36 months. | **$0** |
| D2330: Resin-based composite – one surface, anterior – limited to 1 per 36 months. | **$0** |
| D2331: Resin-based composite – two surfaces, anterior – limited to 1 per 36 months. | **$0** |
| D2332: Resin-based composite – three surfaces, anterior – limited to 1 per 36 months. | **$0** |
| D2335: Resin-based composite – four or more surfaces (anterior) – limited to 1 per 36 months. | **$0** |
| D2390: Resin-based composite crown, anterior – limited to 1 per 36 months. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D2391: Resin-based composite – one surface, posterior – limited to 1 per 36 months. | **$0** |
| D2392: Resin-based composite – two surfaces, posterior – limited to 1 per 36 months. | **$0** |
| D2393: Resin-based composite – three surfaces, posterior – limited to 1 per 36 months. | **$0** |
| D2394: Resin-based composite – four or more surfaces, posterior – limited to 1 per 36 months. | **$0** |
| D2910: Recement or re-bond inlay, onlay, veneer, or partial coverage restoration – limited to 1 per 12 months. | **$0** |
| D2920: Recement or re-bond crown – The original provider is responsible for all re-cementations within the first 12 months following the initial placement of a prefabricated or laboratory processed crown. After the initial 1-month period, limited to 1 per 12-month period. | **$0** |
| D2928 Prefabricated porcelain/ceramic crown-permanent tooth – limited to 1 per 36 months. | **$0** |
| D2931: Prefabricated stainless steel crown – permanent tooth – limited to 1 per 36 months. | **$0** |
| D2932: Prefabricated resin crown – anterior primary tooth – limited to 1 per 36 months. | **$0** |
| D2933: Prefabricated stainless steel crown with resin window – limited to 1 per 36 months. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
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| D2940: Protective restoration – limited to 1 in 6 months. | **$0** |
| D2952: Post and core in addition to crown, indirectly fabricated – includes canal preparation – once per tooth regardless of number of posts placed, and only in conjunction with allowable crowns (prefabricated or laboratory processed). | **$0** |
| D2954: Prefabricated post and core in addition to crown – base metal post; includes canal preparation – once per tooth regardless of number of posts placed, and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth. | **$0** |
| D2976: Band stabilization – per tooth - limited to once in a lifetime per tooth | **$0** |
| D2989: Excavation of a tooth resulting in the determination of non-restorability | **$0** |
| **Endodontics (D3000-D3999)†**<br>D3110: Pulp cap – direct (excluding final restoration). | **$0** |
| D3346: Retreatment of previous root canal therapy – anterior – Not a benefit to the original provider within 12 months of initial treatment. | **$0** |
| **Periodontics (D4000-D4999)†**<br>Includes preoperative and postoperative evaluations and treatment under local anesthetic.<br><br>D4341: Periodontal scaling and root planing – four or more teeth per quadrant – limited to 1 per quadrant in 24 months. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D4342: Periodontal scaling and root planing – one to three teeth per quadrant – limited to 1 per quadrant in 24 months. | **$0** |
| D4346: Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation D1110 or D4346 – 1 per 6-month period | **$0** |
| D4355: Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit – limited to 1 treatment in any 12 consecutive months. | **$0** |
| D4910: Periodontal maintenance – A benefit only for patients residing in a Skilled Nursing Facility or Intermediate Care Facility, only when preceded by a periodontal scaling and root planing (D4341-D4342), only after completion of all necessary scaling and root planings, limited to 1 treatment per calendar quarter, only in the 24-month period following the last scaling and root planing. | **$0** |
| **Prosthodontics, removable (D5000-D5899)†**<br>Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months. Replacement of a denture or a partial denture requires the existing denture to be 5+ years old. **Note:** For all listed dentures copayment for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service. The enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered. | |
| D5110: Complete denture – maxillary. | **$0** |
| D5120: Complete denture – mandibular. | **$0** |
| D5130: Immediate denture – maxillary. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D5140: Immediate denture – mandibular. | **$0** |
| D5410: Adjust complete denture – maxillary – Once per date of service; 2 in a 12-month period. | **$0** |
| D5411: Adjust complete denture – mandibular – Once per date of service; 2 in a 12-month period. | **$0** |
| D5511: Repair broken complete denture base, mandibular. One per arch per date of service; limited to 2 in a 12-month period. | **$0** |
| D5512: Repair broken complete denture base, maxillary. One per arch per date of service; limited to 2 in a 12-month period. | **$0** |
| D5520: Replace missing or broken teeth – complete denture (each tooth)– Up to a maximum of four per arch, per date of service per provider; limited to twice per arch, in a 12-month period. | **$0** |
| D5611: Repair resin partial denture base, mandibular. One per arch per date of service; limited to 2 in a 12-month period. | **$0** |
| D5612: Repair resin partial denture base, maxillary. One per arch per date of service; limited to 2 in a 12-month period. | **$0** |
| D5730: Reline complete maxillary denture (chairside) – limited to 1 per denture in a 12-month period. | **$0** |
| D5731: Reline complete mandibular denture (chairside) – limited to 1 per denture in a 12-month period. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D5750: Reline complete maxillary denture (laboratory) - limited to 1 per denture in a 12-month period. | **$0** |
| D5751: Reline complete mandibular denture (laboratory) – limited to 1 per denture in a 12-month period. | **$0** |
| D5850: Tissue conditioning, maxillary – limited to 2 per denture in a 36-month period. | **$0** |
| D5851: Tissue conditioning, mandibular – limited to 2 per denture in a 36-month period. | **$0** |
| D5863: Overdenture – complete maxillary – limited to 1 per five-year period. | **$0** |
| D5865: Overdenture – complete mandibular – limited to 1 per five-year period. | **$0** |
| **Implant services (D6000-D6199)†**<br>A benefit only when exceptional medical conditions are documented and reviewed for medical necessity. Prior authorization is required. Refer also to limitations and/or exclusions. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of implant/abutment supported crowns. Then limited to 1 per 12-month period of a previous re-cementation by the same provider. | |
| D6092: Recement or re-bond implant/abutment supported crown. | **$0** |
| D6093: Recement or re-bond implant/abutment supported fixed partial denture. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D6096: Remove broken implant retaining screw. | **$0** |
| D6100: Surgical removal of implant. | **$0** |
| D6105: Removal of implant body not requiring bone removal or flap elevation. | **$0** |
| D6197: Replace of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant. | **$0** |
| **Prosthodontics, fixed (D6200-D6999)†**<br>Each retainer and pontic constitutes a unit in a fixed partial denture or bridge. Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old. | |
| D6930: Recement or re-bond fixed partial denture. | **$0** |
| D6999: Unspecified fixed prosthodontic procedure, by report. | **$0** |
| **Oral & Maxillofacial Surgery (D7000-D7999)†**<br>Includes preoperative and postoperative evaluations and treatment under local anesthetic. | |
| D7111: Extraction, coronal remnants – primary tooth. | **$0** |
| D7140: Extraction, erupted tooth or exposed root (elevation and/or forceps removal). | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D7210: Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated. | **$0** |
| D7220: Removal of impacted tooth – soft tissue. | **$0** |
| D7230: Removal of impacted tooth – partially bony. | **$0** |
| D7240: Removal of impacted tooth – completely bony. | **$0** |
| D7241: Removal of impacted tooth – completely bony, with unusual surgical complications. | **$0** |
| D7250: Removal of residual tooth roots (cutting procedure). | **$0** |
| D7270: Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth – for permanent anterior teeth only – once per arch. | **$0** |
| D7284: Excisional biopsy of minor salivary glands. | **$0** |
| D7286: Biopsy of oral tissue – soft – does not include pathology laboratory procedures. | **$0** |
| **Adjunctive General Services (D9000-D9999)†** | |
| D9110: Palliative treatment of dental pain – per visit. | **$0** |
| D9210: Local anesthesia not in conjunction with operative or surgical procedures. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D9211: Regional block anesthesia. | **$0** |
| D9212: Trigeminal division block anesthesia. | **$0** |
| D9215: Local anesthesia in conjunction with operative or surgical procedures. | **$0** |
| D9222: Deep sedation/general anesthesia - first 15 minutes | **$0** |
| D9223: Deep sedation/general anesthesia – each 15-minute increment. | **$0** |
| D9230: Inhalation of nitrous oxide/anxiolysis, analgesia. | **$0** |
| D9239: Intravenous moderate (conscious) sedation/analgesia – first 15 minutes. | **$0** |
| D9243: Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment. | **$0** |
| D9248: Non-intravenous moderate (conscious) sedation. Limited to once per date of service. | **$0** |
| D9310: Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician. This procedure shall only be billed as diagnostic procedures D0120, D0140, D0150, or D0160. | **$0** |
| D9311: Consultation with medical health care professional. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| D9430: Office visit for observation (during regularly scheduled hours) – no other services performed. Once per date of service. | **$0** |
| D9440: Office visit – after regularly scheduled hours – once per date of service and only with treatment that is a benefit. | **$0** |
| D9910: Application of desensitizing medicament – for permanent teeth only – limited to one per 12-month period. | **$0** |
| D9930: Treatment of complications (post-surgical) – unusual circumstances, by report. Once per date of service. | **$0** |
| D9986: Missed appointment – without 24-hour notice. | **$0** |
| D9987: Canceled appointment – without 24-hour notice. | **$0** |
| D9990 Certified translation or sign-language services – per visit. | **$0** |
| D9991: Dental case management – addressing appointment compliance barriers. | **$0** |
| D9992: Dental case management – care coordination. | **$0** |
| D9995: Teledentistry – synchronous; real-time encounter. | **$0** |
| • D9996: Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review. | **$0** |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| **Emergency dental care*†**<br><br>If you need emergency dental care, you should contact your assigned DeltaCare USA dentist or Delta Dental Customer Service at **1-877-644-1774**, Monday through Friday, 8 a.m. to 8 p.m. EST, 7 days a week October 1 – March 31, 8 a.m. to 8 p.m. EST, (TTY users should call **711**).<br><br>• Covered emergency dental care received from your assigned DeltaCare USA dentist. | **$0** |
| • Covered emergency dental care received from a dentist other than your assigned DeltaCare USA dentist is limited to **$100** per emergency, less your cost-sharing. Also, covered emergency care is limited to necessary care required to stabilize your condition and provide palliative relief. In addition, if the following conditions are not met, you are responsible for the full cost of the dental care:<br>  • You made a reasonable attempt to contact your assigned DeltaCare USA dentist and you cannot be seen within 24 hours or you believe that your condition makes it unreasonable or impossible to travel to your assigned DeltaCare USA dentist. If you are a new member without an assigned dentist yet, you should contact Delta Dental Customer Service for help in locating a DeltaCare USA dentist.<br>  • You called Delta Dental Customer Service prior to receiving emergency dental care, or it is reasonable for you to get emergency dental care without calling Customer Service considering your condition and the circumstances.<br>  • Claims for covered emergency dental services must be submitted to Delta Dental within 90 days of the treatment date unless you can prove that it was not reasonably possible to submit the claim within that | You pay any amounts that exceed the **$100** maximum. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| time. In which case, the claim must be received within one year of the treatment date. Send your claim to: Delta Dental Claims Department, P.O. Box 1803, Alpharetta, GA 30023. | |

## E. Benefits covered outside of our plan

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

### E1. California Community Transitions (CCT)

The California Community Transitions (CCT) program uses local Lead Organizations to help eligible Medi-Cal beneficiaries, who have lived in an inpatient facility for at least 90 consecutive days, transition back to, and remaining safely in, a community setting. The CCT program funds transition coordination services during the pre-transition period and for 365 days post transition to assist beneficiaries with moving back to a community setting.

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

**For CCT transition coordination services**

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

**For services not related to your CCT transition**

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

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

**No change in drug coverage benefit**

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

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

### E2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; includes but is not limited to, services such as:

- Initial examinations, X-rays, cleanings, and fluoride treatments.
- Restorations and crowns.
- Root canal therapy.
- Partial and complete dentures, adjustments, repairs, and relines.

Dental benefits are available in the Medi-Cal Dental Fee-For-Service Program. For more information, or if you need help finding a dentist who accepts the Medi-Cal, contact the customer service line at **1-800-322-6384** (TTY users call **1-800-735-2922**). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at **https://smilecalifornia.org/** for more information.

In addition to the Medi-Cal Dental Fee-For-Service Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Sacramento County. If you want more information about dental plans or want to change dental plans, contact Health Care Options at **1-800-430-4263** (TTY users call **1-800-430-7077**), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free.

Our plan offers additional dental services. Go to the Benefits Chart in **Section D** for more information.

### E3. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

**For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis**

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

**For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis**

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

**For drugs that may be covered by our plan's Medicare Part D benefit**

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your Member Handbook.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

### E4. In-Home Supportive Services (IHSS)

- The IHSS Program will help pay for services provided to you so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.
- The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.
- Your care coordinator can help you apply for IHSS with your county social service agency.
    - Fresno County Behavioral Health at **1-800-654-3937** (TTY **711**).

- Kings County Behavioral Health at **1-800-655-2553** (TTY **711**).
- Madera County Behavioral Health at **1-888-275-9779** (TTY **711**).
- Sacramento County Behavioral Health Services at **1-888-881-4881** (TTY **711**).
- San Mateo County Behavioral Health and Recovery Services at **1-800-686-0101** (TTY **711**).
- Santa Clara County Behavioral Health Services at **1-800-704-0900** (TTY **711**).

### E5. 1915(c) Home and Community Based Services (HCBS) Waiver Programs

### Assisted Living Waiver (ALW)

- The Assisted Living Waiver (ALW) offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.
- Members who are enrolled in ALW and were transitioned into Medi-Cal Managed Care can remain enrolled in ALW while also receiving benefits provided by our plan. Our plan works with your ALW Care Coordination Agency to coordinate the services you receive.
- Your care coordinator can help you apply for the ALW.

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

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

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

the State of California. Your care coordinator can help connect you to DD Waiver services.

**Home and Community-Based Alternative (HCBA) Waiver**

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

**Medi-Cal Waiver Program (MCWP)**

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

**Multipurpose Senior Services Program (MSSP)**

- The Multipurpose Senior Services Program (MSSP) provides both social and health care management services to assist individuals remain in their own homes and communities.
- While most of the program participants also receive In-Home Supportive Services, MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases some needed services that are not otherwise available to prevent or delay institutionalization. The total annual combined cost of care management and other services must be lower than the cost of receiving care in a skilled nursing facility.
- A team of health and social service professionals provides each MSSP participant with a complete health and psychosocial assessment to determine needed services. The team then works with the MSSP participant, their physician, family, and others to develop an individualized care plan. Services include:
    - Care management.
    - Adult day care.
    - Minor home repair/maintenance.
    - Supplemental in-home chore, personal care, and protective supervision services.
    - Respite services.
    - Transportation services.
    - Counseling and therapeutic services.
    - Meal services.
    - Communication services.
- Members who are enrolled in the MSSP Waiver and were transitioned into Medi-Cal Managed Care can remain enrolled in the MSSP Waiver while also receiving benefits provided by our plan. Our plan works with your MSSP provider to coordinate the services you receive.
- Your care coordinator can help you apply for MSSP.

### E6. 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.

### E7. LEA services as specified in Title 22 CCR Section 51360

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.

### E8. Laboratory services provided under the State serum alpha-fetoprotein testing program

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

### E9. 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.

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

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medi-Cal do not pay for them either.

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

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

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

- Services considered not "reasonable and medically necessary," according Medicare and Medi-Cal, unless we list these as covered services. This

exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.

- Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community. May be covered by Original Medicare under a Medicare-approved clinical research study. (See Chapter 3 for more information about clinical research studies.)
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair loss or growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Routine foot care, except as described in "Podiatry services" in the Benefits Chart in Section D.
- Orthopedic shoes or supportive devices, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Vision correction surgeries (for example, LASIK surgery).
- Reversal of sterilization procedures. Note that non-prescription contraceptive items are covered by Medi-Cal Rx.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.

- Certain exams and services:
  - To get or keep a job
  - To get insurance
  - To get any kind of license
  - By order of a court, or if for parole or probation
  - This exclusion does not apply if a network doctor finds that the services are medically necessary.
- Comfort or convenience items. Medi-Cal coverage does not include comfort, convenience, or luxury equipment or features. These include items that are solely for the comfort or convenience of a member, a member's family member, or a member's health care provider. This exclusion does not apply to retail-grade breast pumps that are provided to women after a pregnancy. This exclusion also does not apply to items approved for you under Community Supports.
- Cosmetic services or procedures. This exclusion does not apply to the following:
  - Testicular implants implanted as part of a covered reconstructive surgery.
  - Breast prostheses needed after a mastectomy or lumpectomy.
  - Prostheses to replace all or part of an external facial body part.
- Disposable supplies. Medi-Cal coverage does not include the following disposable supplies for home use: bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages. This exclusion does not apply to disposable supplies provided as part of the following benefits described 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.

  - Prosthetics devices and related supplies.

- Fertility services:
  - Services to reverse voluntary, surgically induced infertility and fertility preservation services.
  - Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare).
- Items and services that are not health care items and services unless they are approved under your Medi-Cal coverage under the ILOS program or Durable Medical Equipment. For example, we do not cover:
  - Teaching manners and etiquette.
  - Teaching and support services to develop planning skills such as daily activity planning and project or task planning.
  - Items and services for the purpose of increasing academic knowledge or skills.
  - Teaching and support services to increase intelligence.
  - Academic coaching or tutoring for skills such as grammar, math, and time management.
  - Teaching you how to read, whether or not you have dyslexia.
  - Educational testing.
  - Teaching art, dance, horse riding, music, play, or swimming, except that this exclusion for “teaching play” does not apply to services that are part of a behavioral health therapy treatment plan and covered in Chapter 4.
  - Teaching skills for employment or vocational purposes.
  - Vocational training or teaching vocational skills.
  - Professional growth courses.
  - Training for a specific job or employment counseling.
- Modifications to your home or car, unless they are temporary changes that are determined to be medically necessary or approved for you under Community Supports.

- Aquatic therapy and other water therapy. This exclusion for aquatic therapy and other water therapy does not apply to therapy services that are part of a physical therapy treatment plan and covered as part of the following benefits:
    - Home health care.
    - Hospice and palliative care.
    - Rehabilitative and habilitative services.
    - Skilled nursing facility services.
- Massage therapy. This exclusion does not apply to therapy services that are part of a physical therapy treatment plan and covered as part of the following benefits:
    - Home health care.
    - Hospice and palliative care.
    - Rehabilitative and habilitative services.
    - Skilled nursing facility services.
- Personal care services (custodial care), such as help with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of coverage described under the following sections:
    - Hospice and palliative care.
    - Long-term care services and supports.
    - Skilled nursing/intermediate/subacute facility care.
    - Community Supports.
- Services not approved by the federal Food and Drug Administration. We do not cover drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (“FDA”) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion does not apply to the following situations:
    - Services covered under Clinical Trials.
    - Services provided as part of covered investigational services.

- Services performed by unlicensed people. Coverage generally does not include services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the member's condition does not require that the services be provided by a licensed health care provider.This exclusion does not apply to the following:
    - Services covered in Chapter 4 of this Member Handbook.
    - Covered Community Supports approved for you.
    - Covered doula services.
    - Covered community health worker services.
- Services related to a noncovered service. When a service is not covered, all services related to the noncovered service are excluded. This exclusion does not apply to treatment of complications that result from the noncovered services, if those complications would be otherwise covered. For example, if you have cosmetic surgery that is not covered, we will not cover the services you get to prepare for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion will not apply and we will cover the services needed to treat the complication, as long as the services are covered under this Member Handbook.
- Childhood lead poisoning case management provided by county health departments. Please contact your county for more information on lead poisoning case management services.

**DeltaCare USA exclusions**

If services for a listed procedure are performed by the assigned contract dentist, the enrollee pays the specified copayment. Listed procedures which require a dentist to provide specialist services, and are referred by the assigned contract dentist, must be authorized by Delta Dental. The enrollee pays the copayment specified for such services.

The following services and items are not covered under your DeltaCare USA dental benefit:

- Any procedure that is not specifically listed under "Additional Dental Care (DeltaCare® USA Dental HMO Program)" in this chapter.
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

- Lost or theft of full dentures, space maintainers and crowns.
- Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
- Dental expenses incurred in connection with any dental procedure before the enrollee's eligibility in the prepaid dental program. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.
- Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included under “Additional Dental Care (DeltaCare® USA Dental HMO Program)” in this chapter.
- Dispensing of drugs not normally supplied in a dental facility unless included under “Additional Dental Care (DeltaCare® USA Dental HMO Program)” in this chapter.
- Any procedure that in the professional opinion of the contract dentist, contract specialist, or dental plan consultant:
    - Has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
    - Is inconsistent with generally accepted standards for dentistry.
- Dental services received from any dental facility other than the assigned contract dentist including the services of a dental specialist unless expressly authorized in writing or as cited under "Emergency dental care" under “Additional Dental Care (DeltaCare® USA Dental HMO Program)” in this chapter. To obtain written authorization, the enrollee should call the Customer Service Department at **1-877-644-1774**, Monday through Friday, 8 a.m. to 8 p.m. EST, 7 days a week October 1 – March 31, 8 a.m. to 8 p.m. EST, (TTY users should call **711**).
- Consultations for non-covered benefits.
- Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
- Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures.
- Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of

the temporomandibular joint (TMJ), unless included under “Additional Dental Care (DeltaCare® USA Dental HMO Program)” in this chapter.

- An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns is considered to be full mouth reconstruction under the prepaid dental program. Crowns associated with such a treatment plan are not covered benefits. This exclusion does not eliminate the benefit for other covered services.
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, and personalization and characterization of complete dentures.
- Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.
- Temporomandibular joint dysfunction treatment modalities that involve prosthodontia, orthodontia, and full or partial occlusal rehabilitation or TMJ dysfunction procedures solely for the treatment of bruxism.
- Vestibuloplasty/ridge extension procedures performed on the same date of service as extractions (D7111-D7250) on the same arch.
- Deep sedation/general anesthesia for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia.
- Intravenous conscious sedation/analgesia for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia.
- Inhalation of nitrous oxide when administered with other covered sedation procedures.
- Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
- The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

**DeltaCare USA limitations**

The following services and items are limited under your DeltaCare USA dental benefit:

- The frequency of certain benefits is limited. All frequency limitations are listed under “Additional Dental Care (DeltaCare® USA Dental HMO Program)” in this chapter.
- A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
- A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year limitation.
- The replacement of an existing crown or a removable full denture is covered when:
    - The existing restoration/denture is no longer functional and cannot be made functional by repair or adjustment, and
    - The existing non-functional restoration/denture was placed five or more years prior to its replacement.
- Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture.
- Benefits for a soft tissue management program are limited to those parts, which are listed covered services under “Additional Dental Care (DeltaCare® USA Dental HMO Program)” in this chapter. If an enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.
- A new removable complete or covered immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the enrollee continues to be eligible and the service is provided at the contract dentist's facility where the denture was originally delivered.
- Benefits are limited to either an intraoral comprehensive series radiographic images (D0210) or panoramic radiographic image (D0330) every calendar year.

- Comprehensive intraoral images may include any combination of periapicals and bitewings.
- Panoramic images are not considered part of a comprehensive intraoral series.
- Bitewings of any type are disallowed within 6 months of an intraoral comprehensive intraoral series unless warranted by special circumstances.
- Immediate dentures are covered when one or more of the following conditions are present:
- Extensive or rampant caries are exhibited in the radiographs, or
- Severe periodontal involvement indicated, or
- Numerous teeth are missing resulting in diminished chewing ability adversely affecting the enrollee's health.
- Implant services are a benefit only when exceptional medical conditions are documented, reviewed for medical necessity and are prior authorized. Exceptional medical conditions include, but are not limited to:
    - Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    - Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the Enrollee is unable to function with conventional prosthesis.
    - Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
- Certain listed procedures performed by a specialist may be considered to be primary under the enrollee's medical coverage. Dental benefits will be coordinated accordingly.
- Deep sedation/general anesthesia or intravenous conscious sedation/analgesia for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.
- The administration of deep sedation/general anesthesia (D9223), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9243) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable

associated procedures. Prior authorization or payment shall be denied if all associated procedures by the same provider are denied. Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used.

- The administration of non-intravenous conscious sedation (D9248) requires documentation to justify the medical necessity based on a physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/analgesia (D9243) or when all associated procedures on the same date of service by the same provider are denied.
- Treatment of complications (post-surgical) - unusual circumstances, by report (D9930) is a benefit for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction or for the removal of bony fragments within 30 days of the date of service of an extraction.

# Chapter 5: Getting your outpatient prescription drugs

## Introduction

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

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

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

**Rules for our plan's outpatient drug coverage**

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

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.
2. Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medi-Cal lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on our **List of Covered Drugs**. We call it the "Drug List" for short.

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

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

## Chapter 5 Table of Contents

# A. Getting your prescriptions filled

## A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

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

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

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

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

If you don’t have your Member ID Card or BIC with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

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

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

## A3. What to do if you change your network pharmacy

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

## A4. What to do if your pharmacy leaves the network

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

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

### A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
    - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services.

### A6. Using mail-order services to get your drugs

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

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

#### Filling prescriptions by mail

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

- Register and order online securely at **kp.org/refill**.

- Call **1-888-218-6245** (TTY **711**), Monday through Friday, 8 a.m. to 8 p.m., Saturday 8 a.m. to 6 p.m., and Sunday 9 a.m. to 6 p.m., or the highlighted number listed on your prescription label and follow the prompts. Be sure to select the mail delivery option when prompted.
- Mail your prescription or refill request on a mail-order form available at any Kaiser Permanente network pharmacy.

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

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

**Mail-order processes**

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

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

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

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

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

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

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. When you place your order, please provide your current contact information in case we need to reach you.

### A7. Getting a long-term supply of drugs

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

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

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

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy.

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

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your

prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.

- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

### A9. Paying you back for a prescription

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

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

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

## B. Our plan's Drug List

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

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

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

### B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D.

Most of the prescription drugs you get from a pharmacy are covered by your plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website

(**medi-calrx.dhcs.ca.gov)** for more information. You can also call the Medi-Cal Rx Customer Service Center at **1-800-977-2273**. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting your prescriptions through Medi-Cal Rx.

Our Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to “drugs” this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics drugs and biosimilars work just as well as brand-name drugs or biological products and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

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

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

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

### B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List

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

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage (which includes Medicare Part D drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.
- Under Medi-Cal, most outpatient prescription drugs are covered by Medi-Cal Rx as a service through FFS Medi-Cal. To be covered by Medi-Cal Rx, the item must be on the Medi-Cal Contract Drug 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.

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

- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.*
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride* preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.

- Drugs used for the treatment of anorexia, weight loss or weight gain.*
- Outpatient drugs made by a company that says you must have tests or services done only by them.
    - *Select products may be covered by Medi-Cal. Please visit the Medi-Cal Rx website (**www.medi-calrx.dhcs.ca.gov**) for more information.

## C. Limits on some drugs

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

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

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

### 1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. If there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

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

### 2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don’t get approval, we may not cover the drug.

**3. Quantity limits**

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

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

## D. Reasons your drug might not be covered

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

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

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

### D1. Getting a temporary supply

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

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

**1.** The drug you've been taking:

- Is no longer on our Drug List or
- Was never on our Drug List or
- Is now limited in some way.

**2.** You must be in one of these situations:

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

### D2. Asking for a temporary supply

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

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

- Change to another drug.

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

  **OR**

- Ask for an exception.

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

### D3. Asking for an exception

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

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

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

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

## E. Coverage changes for your drugs

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

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).

- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

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

- A new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- We learn that a drug is not safe, **or**
- A drug is removed from the market.

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

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

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

- **A new generic drug becomes available**. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

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

- **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. Your prescriber will also know about this change, and can work with you to find another drug for your condition.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a *brand* name drug currently on our Drug List or
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we:

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

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

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

**We may make changes to drugs you take that do not affect you now**. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

- For example, if we remove a drug you are taking limit its use, then the change does not affect your use of the drug for the rest of the year.

## F. Drug coverage in special cases

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

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

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

### F2. In a long-term care facility

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

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

### F3. In a Medicare-certified hospice program

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

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

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

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

## G. Programs on drug safety and managing drugs

### G1. Programs to help you use drugs safely

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

- May not be needed because you take another drug that does the same thing.
- May not be safe for your age or gender.
- Could harm you if you take them at the same time.

- Have ingredients that you are or may be allergic to.
- Have unsafe amounts of opioid pain medications.

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

### G2. Programs to help you manage your drugs

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

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

Then, they will give you:

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

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

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

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

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

### G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

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

- Requiring you to get all prescriptions for those medications from certain pharmacies and/or from certain doctors
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

**You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know**. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

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

The DMP may not apply to you if you:

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

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

## Introduction

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

- Medicare Part D prescription drugs, and
- Drugs and items covered under Medi-Cal Rx, and
- Drugs and items covered by our plan as additional benefits.
- Because you are eligible for Medi-Cal, you get “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs. We will send you a separate insert, called the **Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs** (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

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

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

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

- Our List of Covered Drugs.
    - We call this the “Drug List.” It tells you:

– Which drugs we pay for.

– If there are any limits on the drugs.

- If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at **kp.org/seniorrx**.
- Most of the prescription drugs you get from a pharmacy are covered by our plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (**medi-calrx.dhcs.ca.gov/)** for more information. You can also call the Medi-Cal Rx Customer Service Center at **1-800-977-2273**. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.

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

## Chapter 6 Table of Contents

## A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the **Explanation of Benefits**. If you have had one or more prescriptions filled through the plan during the previous month, we will send you an **Explanation of Benefits**. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information.** This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

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

## B. How to keep track of your drug costs

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

1. Use your Member ID Card.

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

2. Make sure we have the information we need.

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for our share of the cost of the drug.

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

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

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

3. Send us information about payments others have made for you.

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

4. Check the EOBs we send you.

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

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

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

For more information, you can call Member Services.

**What if you find mistakes on this summary?**

If something is confusing or doesn't seem right on this EOB, please call Member Services.

**What about possible fraud?**

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

- Call us Member Services.
- Or call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you suspect that a provider who gets Medi-Cal has committed fraud, waste or abuse, it is your right to report it by calling the confidential toll-free number **1- 800-822-6222**. Other methods of reporting Medi-Cal fraud may be found at: **www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx**.

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

## C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| Stage 1: Initial Coverage Stage | Stage 2: Catastrophic Coverage Stage |
|---|---|
| During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.<br><br>You begin in this stage when you fill your first prescription of the year. | During this stage, we pay all of the costs of your drugs through December 31, 2024.<br><br>You begin this stage when you have paid a certain amount of out-of-pocket costs. |

## D. Stage 1: The Initial Coverage Stage

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

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

- Tiers 1 and 2 drugs have the lowest copay. They may be generic drugs. The copay is from **$0** to **$4.50**, depending on your income.
- Tiers 3, 4, and 5 drugs have the highest copay. They are brand name or specialty drugs. The copay is from **$0** to **$11.20**, depending on your income.

### D1. Your pharmacy choices

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

- A network pharmacy **or**
- An out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this **Member Handbook** to find out when we do that.

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

### D2. Getting a long-term supply of a drug

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

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

### D3. What you pay

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

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

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

| | **A network pharmacy or our plan's mail-order service**<br><br>Up to a 100-day supply | **A network long-term care pharmacy**<br><br>Up to a 31-day supply | **An out-of-network pharmacy**<br><br>Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this **Member Handbook** for details. |
|---|---|---|---|
| **Cost-sharing Tier 1** (generic drugs) | **$0-$4.50 per prescription**, depending on your level of Extra Help | | |
| **Cost-sharing Tier 2** (brand name and specialty drugs) | **$0-$11.20 per prescription**, depending on your level of Extra Help | | |

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

### D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$8,000**. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you have paid for your drugs during the year. We let you know if you reach the **$8,000** limit. Many people do not reach it in a year.

## E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of **$8,000** for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, our plan pays all of the cost for your Medicare drugs.

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

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

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you do not pay for the full month's supply for certain drugs.

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

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment is less than $.05 per day multiplied by 7 days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.

- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
    - Better plan when to refill your drugs,
    - Coordinate refills with other drugs you take, **and**
    - Take fewer trips to the pharmacy.

## G. Prescription cost-sharing assistance for persons with HIV/AIDS

### G1. The AIDS Drug Assistance Program (ADAP)

The ADAP helps eligible individuals living with HIV/AIDS access life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Department of Public Health, Office of AIDS for individuals enrolled in ADAP.

### G2. If you are not enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, call **1-844-421-7050** or check the ADAP website at **www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.**

### G3. If you are enrolled in ADAP

ADAP can continue to provide ADAP clients with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. To be sure you continue getting this assistance, notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. If you need help finding the nearest ADAP enrollment site and/or enrollment worker, call **1-844-421-7050** or check the website listed above.

## H. Vaccinations

**Important Message About What You Pay for Vaccines:** Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's **List of Covered Drugs** (**Formulary**). Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to our plan's **List of Covered Drugs** (**Formulary**) or contact Member Services for coverage and cost sharing details about specific vaccines.

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

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.

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

### H1. What you need to know before you get a vaccination

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

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

### H2. What you pay for a vaccination covered by Medicare Part D

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

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this **Member Handbook**.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.

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

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you pay a copay for the vaccine.

2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.

- You pay a copay to the doctor for the vaccine.
- Our plan pays for the cost of giving you the shot.
- The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.

3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you pay a copay for the vaccine.
- Our plan pays for the cost of giving you the shot.

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

## Introduction

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

## Chapter 7 Table of Contents

## A. Asking us to pay for your services or drugs

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

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

for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you do not meet one of the above conditions, we will not pay you back.

- We will not pay you back if:
    - You asked for and received services that are not covered by Medi-Cal, such as cosmetic services.
    - The service is not a covered service under Senior Advantage Medicare Medi-Cal.
    - 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.
- If we do not cover the services or drugs, we will tell you.

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

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

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

Ask the provider to bill us.

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

### 2. When a network provider sends you a bill

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

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

### 3. If you are retroactively enrolled in our plan

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

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

### 4. When you use an out-of-network pharmacy to get a prescription filled

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

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Refer to **Chapter 5** of this **Member Handbook** to learn more about out-of-network pharmacies.

### 5. When you pay the full Medicare Part D prescription cost because you don't have your plan ID card with you

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

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

### 6. When you pay the full Medicare Part D prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our **List of Covered Drugs** (Drug List), on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this **Member Handbook**).
  - If you and your doctor or other prescriber think you need the drug right away (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this **Member Handbook**).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for our share of the cost of *it*.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this **Member Handbook**.

## B. Sending us a request for payment

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made for Medicare services. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months (for Part C medical claims) and within 36 months (for Part D drug claims) of the date you received the service**.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it will help us process the information faster. You can file a claim to request payment by:

- Completing and submitting our electronic form at **kp.org** and upload supporting documentation.
- Either download a copy of the form from our website (**kp.org**) or call Member Services at the phone number on the bottom of this page and ask them to send you the form. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below:
  - A statement with the following information:
  - Your name (member/patient name) and medical/health record number.
  - The date you received the services.
  - Where you received the services.
  - Who provided the services.
  - Why you think we should pay for the services.
  - Your signature and date signed. (If you want someone other than yourself to make the request, we will also need a completed "Appointment of representative" form, which is available at **kp.org**.)
  - A copy of the bill, your medical record(s) for these services, and your receipt if you paid for the services.

Mail your request for payment together with any bills or receipts to this address:

- Mail your request for payment of medical care together with any bills or paid receipts to us at this address:

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

To request payment of a Part D drug that was prescribed by a network provider and obtained from a network pharmacy, write to the address below. For all other Part D requests, send your request to the address above.

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

Contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

## C. Coverage decisions

**When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.** We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay our share of the cost for it. If you already paid for the service or drug, we will mail you a check for our share of the cost. If you haven’t paid, we will pay the provider directly.

**Chapter 3** of this **Member Handbook** explains the rules for getting your services covered. **Chapter 5** of this **Member Handbook** explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.

- To learn more about coverage decisions, refer to **Chapter 9**.

## D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called “making an appeal.” You can also make an appeal if you don’t agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this **Member Handbook**:

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

# Chapter 8: Your rights and responsibilities

## Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

## Chapter 8 Table of Contents

## A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call or write to Member Services (refer to **Chapter 2**). Contact Member services to do the following:
    - Request a preferred language other than English and/or alternate format,
    - Keep your information as a standing request for future mailings and communications, **and**
    - Change a standing request for preferred language and/or format.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at **1-800-MEDICARE** (**1-800-633-4227**). You can call 24 hours a day,
  7 days a week. TTY users should call **1-877-486-2048**.
- Medi-Cal Office of Civil Rights at **1-916-440-7370**. TTY users should call **711**.
- U.S. Department of Health and Human Services, Office for Civil Rights at **1-800-368-1019**. TTY users should call **1-800-537-7697**.

## B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find

more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this **Member Handbook**.

  - Call Member Services or look in the **Provider and Pharmacy Directory** to learn more about network providers and which doctors are accepting new patients.

- You have the right to a women's health specialist without getting a referral as well as other providers described in **Chapter 3** of this **Member Handbook**. A referral is approval from your PCP to use a provider that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** this **Member Handbook**.
- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to **Chapter 1** of this **Member Handbook**.
- You have the right to make your own healthcare decisions with help from your care team and care coordinator.
- You have the right:
  - 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
  - To be provided with information about the plan and its services, including covered services, network providers, and member rights and responsibilities.

- To be able to choose a primary care provider within our network.
- 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 network doctor at any time.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer, or limit services or benefits.
- To get no-cost interpreter services in your language.
- To get no-cost 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. You can ask for a State hearing if you have already filed an appeal with us and you are not happy with the decision. You can also ask for a State Hearing if you did not get a decision within 30 days on the appeal you filed with us. This includes information on the circumstances under which an expedited hearing is possible.
- To have access to, and receive copies of, amend or correct your medical record.
- To get no-cost 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 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 discuss truthfully 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 get a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by Kaiser Permanente, 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 services outside our network pursuant to the federal law.

**Chapter 9** of this **Member Handbook** tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

## C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

- Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.
- You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."
- Members who may consent to receive sensitive services are not required to obtain any other person's authorization to receive sensitive services or to submit a claim for sensitive services. Kaiser Permanente will direct communications regarding sensitive services to a member's alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. Kaiser Permanente will not disclose medical information related to sensitive services to anyone else without written authorization from the member receiving care. Kaiser Permanente will accommodate requests for confidential communication in the form and format requested, if it is readily producible in the requested form and format, or at alternative locations. A member's request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

- Members may request confidential communication by completing a confidential communication request form, which is available on kp.org under “Request for confidential communications forms.”

### C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don’t give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don’t need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan’s quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

### C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

## D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don’t speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. This document is available in Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese, by calling Member Services. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information.
  - how plan members have rated us.
  - the number of appeals made by members.
  - how to leave our plan.
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers.
  - qualifications of our network providers and pharmacies.
  - how we pay providers in our network.
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of this **Member Handbook**) and drugs (refer to **Chapters 5 and 6** of this **Member Handbook**) covered by our plan.
  - limits to your coverage and drugs.
  - rules you must follow to get covered services and drugs.
- Why something is not covered and what you can do about it (refer to **Chapter 9** of this **Member Handbook**), including asking us to:
  - put in writing why something is not covered.
  - change a decision we made.
  - pay for a bill you got.

## E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this **Member Handbook**.

## F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to Chapter 10 of this Member Handbook*:*
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your Medi-Cal benefits if you leave our plan.

## G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

### G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.

- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- Ask us to cover a service or drug that we denied or usually don't cover. This is called a coverage decision. Chapter 9 of this Member Handbook tells how to ask us for a coverage decision.

### G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form giving someone the right to make health care decisions for you.
- Give your doctors written instructions about how to handle your health care if you become unable to make decisions for yourself, including care you do not want.

The legal document that you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.

- The hospital will ask if you have a signed advance directive form and if you have it with you.
- If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Our plan will tell you about changes to the state law no later than 90 days after the change.

Call Member Services for more information.

### G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Quality Improvement Organization listed in **Chapter 2, Section F** of this **Member Handbook**.

## H. Your right to make complaints and ask us to reconsider our decisions

**Chapter 9** of this **Member Handbook** tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

### H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of this **Member Handbook** – or you want more information about your rights, you can call:

- Member Services at **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711**.
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**. For more details about HICAP, refer to **Chapter 2**, **Section E** of this **Member Handbook**.

- The Medicare and Medi-Cal Ombuds Program at **1-888-804-3536**. For more details about this program, refer to **Chapter 2** of this **Member Handbook**.
- The DHCS Ombudsman Program at **1-888-452-8609**, Monday through Friday, 8 a.m. to 5 p.m.
- Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)

## I. Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

## J. You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions.

## K. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this **Member Handbook**. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this **Member Handbook**.

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
    - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment**.**
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and with other provider offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - Medicare Part A and Medicare Part B premiums. For most plan members, Medi-Cal pays for your Medicare Part A premium and your Medicare
      Part B premium.
    - For some of your long-term services and supports or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. **Chapter 4** tells what you must pay for your long-term services and supports. **Chapter 6** tells what you must pay for your drugs.
    - If you **get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision

to not cover a service or drug, you can make an appeal. Please refer to
**Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
    - If you move outside of our service area, you cannot stay in our plan. Only people who live in our service area can be members of this plan. **Chapter 1** of this **Member Handbook** tells you about our service area.
    - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
    - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of this **Member Handbook** for phone numbers for Medicare and Medi-Cal.
    - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Tell us if you have a new phone number** or a better way to contact you.
- Call Member Services for help if you have questions or concerns.

# Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

## Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.
- You have a problem or complaint with your long-term services and supports, which include Community-Based Adult Services (CBAS) and Nursing Facility (NF) services.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you have a problem with your care, you can call the Medicare Medi-Cal Ombuds Program at 1-888-804-3536 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** of this **Member Handbook**.

## Chapter 9 Table of Contents

## A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints;** also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

### A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance.”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination.”
- “Fast coverage decision” instead of “expedited determination.”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

## B. Where to get help

### B1. For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

### Help from the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is **1-800-434-0222**.

### Help from the Medicare Medi-Cal Ombuds Program

You can call the Medicare Medi-Cal Ombuds Program and speak with an advocate about your health coverage questions. They offer free legal help. The Ombuds Program is not connected with us or with any insurance company or health plan. Their phone number is **1-888-804-3536** and their website is **www.healthconsumer.org**.

### Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.
- Visit the Medicare website (**www.medicare.gov**).

### Help from the California Department of Health Care Services

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at **1-888-452-8609**.

### Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care (DMHC) for free help. The DMHC is responsible for overseeing health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is **1-888-466-2219**. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, **1-877-688-9891**. You can also visit DMHC's website at **www.HealthHelp.ca.gov**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1**-800-464-4000** (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 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 **https://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

## C. Understanding Medicare and Medi-Cal complaints and appeals in our plan

You have Medicare and Medi-Cal. Information in this chapter applies to **all** of your Medicare and Medi-Cal benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

<table>
<tr><td colspan="2">Is your problem or concern about your benefits or coverage?<br><br>This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.</td></tr>
<tr><td>Yes.<br>My problem is about benefits or coverage.<br><br>Refer to Section E, "Coverage decisions and appeals."</td><td>No.<br>My problem is not about benefits or coverage.<br><br>Refer to Section K, "How to make a complaint."</td></tr>
</table>

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from them (refer to **Chapter 4**, **Section H** of this **Member Handbook**).

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what is covered for you and how much we pay. In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or Medi-Cal. If you disagree with this coverage decision, you can make an appeal.

### E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

In most cases, you must start your appeal at Level 1. If your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an IMR Medical Review from the Department of Managed Health Care at **www.dmhc.ca.gov.** Refer to the section "Complaints and Independent Medical Reviews ("IMR") with the Department of Managed Health Care" later in this chapter for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- Medicare Medi-Cal Ombuds Program at 1-888-804-3536.
- Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.
- **The Help Center at the Department of Managed Health Care** (DMHC) for free help. The DMHC is responsible for regulating health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is **1-888-466-2219**. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, **1-877-688-9891**. You can also visit DMHC's website at **www.HealthHelp.ca.gov**.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but you are not required to have a lawyer to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

- Ask for a legal aid attorney from the Medicare Medi-Cal Ombuds Program at **1-888-804-3536**.

- Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

- Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**. **You must give us a copy of the signed form.**

### E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D prescription drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page. You can also get help or information from government organizations such as your State Health Insurance Assistance Program (**Chapter 2, Section E**, of this **Member Handbook** has the phone numbers for this program).

## F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of this **Member Handbook**. We generally refer to "medical care coverage" or "medical care" in the rest of this section. The term "medical care" includes medical services and items as well as Medicare Part B prescription drugs,

which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

### F1. Using this section

This section explains what you can do in any of the following situations:

1. You think we cover medical care you need but are not getting.

   **What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   **What you can do:** You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

   **What you can do:** You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   **What you can do:** You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

6. You are experiencing delays in care or you cannot find a doctor.
   - **What you can do:** You can file a complaint. Refer to **Section K2**.

## F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

- You, your doctor, or your representative can ask us for a coverage decision by:
- Calling: **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m., TTY: **711**. If your coverage decision, appeal, or complaint qualifies for a fast decision, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., Monday through Saturday.
- Faxing: 1-888-987-2252.
- Writing:
  - For a standard coverage decision or complaint, write to your local Member Services office (see the **Provider and Pharmacy Directory** for locations).
  - For a standard appeal, write to the address shown on the denial notice we send you. If your coverage decision, appeal, or complaint qualifies for a fast decision, write to:
    Kaiser Permanente
    Expedited Review Unit
    P.O. Box 1809
    Pleasanton, CA 94566

### Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a**:**

- Medical service or item within 14 calendar days after we get your request. For Knox-Keene plans, within 5 business days, and no later than 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

### Fast coverage decision

> The legal term for "fast coverage decision" is "**expedited determination**."

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request, or sooner if your medical condition requires a quicker response.
- Medicare Part B prescription drug within 24 hours after we get your request.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:

- We automatically give you a fast coverage decision if your doctor asks for it.
- How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

**If we say No to part or all of your request**, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn't legally authorized to do so, **or**
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal

### F3. Making a Level 1 Appeal

**To start an appeal,** you, your doctor, or your representative must contact us. Call Member Services.

Ask for a standard appeal or a fast appeal in writing or by calling Member Services.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org.**
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 30 calendar days after getting your appeal request:
    - We dismiss your request, and
    - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal. This request must be in writing.

**If your health requires it, ask for a fast appeal.**

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

**We automatically give you a fast appeal if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

**If we tell you we are stopping or reducing services or items that you already get, you may request to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal, or sooner if your health requires a quicker response**. We will give you our answer sooner if your health requires it.
- If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about a service or item that Medi-Cal usually covers, you can file a Level 2 Appeal yourself. We include more information later in this chapter. We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal, or sooner if your health requires it.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
    - If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process If your problem is about a service or item

that Medi-Cal usually covers, you can file a Level 2 Appeal yourself. We include more information later in this chapter. We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.

**If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 30 calendar days of the date we got your appeal request, or as fast as your health condition requires and within 72 hours of the date we change our decision, or within 7 calendar days of the date we got your appeal if your request is for a Medicare Part B prescription drug.

**If we say No to part or all of your request, you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

### F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the IRO. In addition to the automatic Level 2 Appeal, you can also ask for a State Hearing and an Independent Medical Review with the state. However, an Independent Medical Review is not available if you have already presented evidence in a State Hearing.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by **Medicare**, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by **Medi-Cal**, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

**When your problem is about a service or item Medicare usually covers**

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity,"** sometimes called the **"IRE."**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

**If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.**

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

**If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.**

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.

- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

The IRO gives you their answer in writing and explains the reasons.

- If the IRO says Yes to part or all of a request for a medical item or service, we must promptly implement the decision:
  - Authorize the medical care coverage **within 72 hours**, or
  - Provide the service **within 5 working days** after we get the IRO's decision **for standard requests**, or
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:
  - **Within 72 hours** after we get the IRO's decision for standard requests, or
  - **Within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal**, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (AlJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

**When your problem is about a service or item Medi-Cal usually covers**

**(1) Independent Medical Review**

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

You can file a complaint with or ask for an Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by doctors who are not part of our plan or a part of the DMHC. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it is not medically necessary.
- Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Disputes whether a surgical service or procedure was cosmetic or reconstructive in nature.
- Will not pay for emergency or urgent Medi-Cal services that you already received.
- Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours, or sooner, if your health requires it, for a fast appeal.

**NOTE:** If your provider filed an appeal for you, but we do not get your Appointment of Representative form, you will need to refile your appeal with us before you can file for a Level 2 IMR with the Department of Managed Health Care unless your appeal involves an imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

You are entitled to both an IMR and a State Hearing, but you are not entitled to an IMR if you have already presented evidence in a State Hearing had a State Hearing on the same issue.

In most cases, you must file an appeal with us before requesting an IMR. Refer to **Section G5** for information, about our Level 1 appeal process. If you disagree with

our decision, you can file a complaint with the DMHC or ask the DMHC Help Center for an IMR.

If your treatment was denied because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an IMR.

If your problem is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may bring it immediately to the DMHC's attention without first going through our appeal process.

You must **apply for an IMR within 6 months** after we send you a written decision about your appeal. The DMHC may accept your application after 6 months for good reason, such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice from us of the IMR process.

To ask for an IMR:

- Fill out the Independent Medical Review Application/Complaint Form available at: **www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx** or call the DMHC Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.
- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at **www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx** or call the Department's Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- Mail or fax your forms and any attachments to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, CA 95814-2725
  FAX: **1-916-255-5241**

- You may also submit your Independent Medical Review Application/Complaint Form and Authorized Assistant form online: **www.dmhc.ca.gov/FileaComplaint.aspx**

If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 30 calendar days. You should receive the IMR decision within 45 calendar days of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application. If you are not satisfied with the result of the IMR, you can still ask for a State Hearing.

An IMR can take longer if the DMHC does not receive all of the medical records needed from you or your treating doctor. If you are using a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

If the DMHC decides that your case is not eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

**(2) State Hearing**

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the “Appeal Decision Letter” notice is mailed to you.

**NOTE:** If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read “Will my benefits continue during Level 2 appeals” in this chapter for more information.

There are two ways to ask for a State Hearing:

1. You may complete the "Request for State Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:

    - To the county welfare department at the address shown on the notice.
    - To the California Department of Social Services:

    State Hearings Division
    P.O. Box 944243, Mail Station 9-17-37
    Sacramento, California 94244-2430

    - To the State Hearings Division at fax number **1-916-651-5210** or **1-916-651-2789**.

2. You can call the California Department of Social Services at **1-800-743-8525**. TTY users should call **1-800-952-8349**. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

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 has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say. Medi-Cal Rx pharmacy benefit decisions are not subject to the IMR process.

The sections below will provide you with more information on how to ask for a State Hearing or an IMR.

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by Kaiser Permanente. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling **1-800-977-2273** (TTY **1-800-977-2273 and press 5** or **711**). However, complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing.

Note: Items and services you receive under the Community Supports Program do not qualify for IMR.

The State Hearings Division gives you their decision in writing and explain the reasons.

- If the State Hearings Division says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Hearings Division says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the IRO or State Hearings decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the State Hearings Division describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

### F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for ambulance, dialysis, and certain DME items as described in the Benefits Chart in **Chapter 4** or the cost-sharing described in **Chapter 6**, if you no longer qualify for "Extra Help."

If you get a bill that is more than your copay for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this **Member Handbook**. It describes situations when you may need to ask us to pay your back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you our share of the cost for the service or item within 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and **Medi-Cal** usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this **Member Handbook** for more information about a medically accepted indication.

### G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get).
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it).

**NOTE:** If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

**Which of these situations are you in?**

| | | | |
|---|---|---|---|
| You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover. | You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. | You want to ask us to pay you back for a drug you already got and paid for. | We told you that we won't cover or pay for a drug in the way that you want. |
| **You can ask us to make an exception.** (This is a type of coverage decision.) | **You can ask us for a coverage decision.** | **You can ask us to pay you back.** (This is a type of coverage decision.) | **You can make an appeal.** (This means you ask us to reconsider.) |
| Start with **Section G2**, then refer to **Sections G3 and G4**. | Refer to **Section G4**. | Refer to **Section G4**. | Refer to **Section G5**. |

## G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

**Covering a drug that is not on our Drug List**

- If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies to all of our drugs.
- You can't get an exception to the required copay amount for the drug.

**Removing a restriction for a covered drug**

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of this **Member Handbook** for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization" (PA).

## G3. Important things to know about asking for an exception

**Your doctor or other prescriber must tell us the medical reasons.**

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the

drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request.

**We can say Yes or No to your request.**

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

## G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling Member Services, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this **Member Handbook**.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

**If your health requires it, ask us for a "fast coverage decision."**

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
    - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

**Deadlines for a fast coverage decision**

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.

- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

**Deadlines for a standard coverage decision about a drug you didn't get**

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

**Deadlines for a standard coverage decision about a drug you already bought**

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard or fast appeal** by calling 1**-866-206-2973**, writing, or faxing us. You, your representative, or your doctor (or other prescriber)

can do this. Please include your name, contact information, and information regarding your appeal.

- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

**Deadlines for a fast appeal at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.

- If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.

- If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.

- If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

### G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity,"** sometimes called the **"IRE."**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file." **You have the right to a free copy of your case file**.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

**Deadlines for a fast appeal at Level 2**

- If your health requires it, ask the IRO for a fast appeal.
- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

**Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.
- An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this **Member Handbook**.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Notwithstanding the appeals discussed in this **Section H**, you may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

### H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "**An Important Message from Medicare about Your Rights**." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
    - Be a part of any decisions about the length of your hospital stay.

  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.
  - If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.
- You can look at a copy of the notice in advance if you:
  - Call Member Services at the numbers at the bottom of the page
  - Call Medicare at **1-800 MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
  - Visit **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.**

### H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In California, the QIO is Livanta. Call them at **1-877-588-1123**. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

**Call the QIO before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the QIO will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

**Ask for help if you need it**. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**.

**Ask for a fast review.** Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

**What happens during fast review**

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons

why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) You can also refer to a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.**

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-877-588-1123**.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section E4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the QIO for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

> The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the IRO within 24 hours of saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.

- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services.
- Skilled nursing care in a skilled nursing facility, **and**
- Rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

### I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

### I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the HICAP at **1-800-434-0222**.
- Contact the QIO.
  - Refer to **Section H2** or refer to **Chapter 2** of this **Member Handbook** for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

**Your deadline for contacting this organization**

- You must contact the QIO to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage we sent you.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.
- If the QIO will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or get a copy online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.**

### What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage."**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

## I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-877-588-1123**.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to
  **Section F4** to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

### I4. Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the QIO to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

> The legal term for “fast review” or “fast appeal” is **“expedited appeal.”**

- We look at all of the information about your case.

- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- We agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- Our coverage for these services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### I5. Making a Level 2 Alternate Appeal

During the Level 2 Appeal, we send the information for your Level 2 Appeal to the IRO within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don’t need to do anything.

If you think we didn’t meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to
  **Section F4** to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

**Level 3 Appeal**

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

**Level 4 Appeal**

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

**Level 5 Appeal**

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

### J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the State Hearings Division will tell you what to do if you want to continue the appeals process.

### J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

#### Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.

- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

**Level 5 Appeal**

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

## K. How to make a complaint

### K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

| Complaint | Example |
|---|---|
| **Quality of your medical care** | • You are unhappy with the quality of care, such as the care you got in the hospital. |
| **Respecting your privacy** | • You think that someone did not respect your right to privacy or shared confidential information about you. |
| **Disrespect, poor customer service, or other negative behaviors** | • A health care provider or staff was rude or disrespectful to you.<br>• Our staff treated you poorly.<br>• You think you are being pushed out of our plan. |

| Complaint | Example |
|---|---|
| **Accessibility and language assistance** | • You cannot physically access the health care services and facilities in a doctor or provider's office.<br>• Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).<br>• Your provider does not give you other reasonable accommodations you need and ask for. |
| **Waiting times** | • You have trouble getting an appointment or wait too long to get it.<br>• Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long. |
| **Cleanliness** | • You think the clinic, hospital or doctor's office is not clean. |
| **Information you get from us** | • You think we failed to give you a notice or letter that you should have received.<br>• You think written information we sent you is too difficult to understand. |

| Complaint | Example |
|---|---|
| **Timeliness related to coverage decisions or appeals** | • You think we don't meet our deadlines for making a coverage decision or answering your appeal.<br>• You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.<br>• You don't think we sent your case to the IRO on time. |

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Member Services at **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

### K2. Internal complaints

To make an internal complaint, call Member Services at **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m. You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint involving a serious threat to your health, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, we may give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: **www.medicare.gov/MedicareComplaintForm/home.aspx**.

You do not need to file a complaint with our plan before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users can call **1-877-486-2048**. The call is free.

**Medi-Cal**

You can file a complaint with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling **1-888-452-8609**. TTY users can call **711**. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. For non-urgent matters, you may file a complaint with the DMHC if you disagree with the decision in your Level 1 appeal or if the plan has not resolved your complaint after 30 calendar days. However, you may contact the DMHC without filing a Level 1 appeal if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you are in severe pain, if you disagree with our plan's decision about your complaint, or if our plan has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call **1-888-466-2219**. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TTY number, **1-877-688-9891**. The call is free.
- Visit the Department of Managed Health Care's website (**www.dmhc.ca.gov**).

**Office for Civil Rights (OCR)**

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is **1-800-368-1019**. TTY users should call **1-800-537-7697**. You can visit **www.hhs.gov/ocr** for more information.

You may also contact the local OCR office at:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Customer Response Center: **1-800-368-1019**
Fax: **1-202-619-3818**
TDD: **1-800- 537-7697**
Email: **ocrmail@hhs.gov**

You may also have rights under the Americans with Disability Act (ADA).

**QIO**

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this **Member Handbook**.

In California, the QIO is called Livanta. Their phone number is **1-877-588-1123**.

# Chapter 10. Ending your membership in our plan

## Introduction

This chapter explains how you can end your membership in our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

## Chapter 10 Table of Contents

## A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you can end your membership with our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for Medi-Cal or Extra Help changed, or
- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medi-Cal options and services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Member Services at the numbers at the bottom of the page. The number for TTY users is listed too.
- Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- California Health Insurance Counseling and Advocacy Program (HICAP), at **1-800-434-0222**, Monday through Friday from 8:00 a.m. to 5:00 p.m., TTY users should call **711**. For more information or to find a local HICAP office in your area, please visit **https://aging.ca.gov**. Health Care Options at **1-800-430-4263**, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call **1-800-430-7077**.
- Medi-Cal Managed Care Ombudsman at **1-888-452-8609**, Monday through Friday from 8:00 a.m. to 5:00 p.m. or e-mail **MMCDOmbudsmanOffice@dhcs.ca.gov.**

**NOTE:** If you're in a drug management program, you may not be able to change plans. Refer to **Chapter 5** of this **Member Handbook** for information about drug management programs.

## B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call **1-877-486-2048**. When you call **1-800-MEDICARE**, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section C**.
- Call Health Care Options at **1-800-430-4263**, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call **1-800-430-7077**.

- **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

## C. How to get Medicare and Medi-Cal services separately

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

### C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

| 1. You can change to: | Here is what to do: |
|---|---|
| **Another Medicare health plan** including a plan that combines your Medicare and Medi-Cal coverage | Call Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.<br><br>For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call **1-855-921-PACE (7223)**.<br><br>If you need help or more information:<br><br>Call the California Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, Monday through Friday from 8:00 a.m. to 5:00 p.m., TTY users should call **711**. For more information or to find a local HICAP office in your area, please visit **https://www.aging.ca.gov/HICAP/.**<br><br>**OR**<br><br>Enroll in a new Medicare plan.<br><br>You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. your Medi-Cal plan may change. |

| **2. You can change to:** | **Here is what to do:** |
|---|---|
| **Original Medicare with a separate Medicare prescription drug plan** | Call Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.<br><br>If you need help or more information:<br><br>• Call the California Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, Monday through Friday from 8:00 a.m. to 5:00 p.m., TTY users should call **711**. For more information or to find a local HICAP office in your area, please visit **https://www.aging.ca.gov/HICAP/.**<br><br>**OR**<br><br>Enroll in a new Medicare prescription drug plan.<br><br>You are automatically disenrolled from our plan when your Original Medicare coverage begins. |

| 3. You can change to: | Here is what to do: |
|---|---|
| **Original Medicare without a separate Medicare prescription drug plan**<br><br>**NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join.<br><br>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit **https://www.aging.ca.gov/HICAP/**. | Call Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.<br><br>If you need help or more information:<br><br>• Call the California Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, Monday through Friday from 8:00 a.m. to 5:00 p.m., TTY users should call **711**. For more information or to find a local HICAP office in your area, please visit **https://www.aging.ca.gov/HICAP/.**<br><br>You are automatically disenrolled from our plan when your Original Medicare coverage begins. |

### C2. Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at **1-800-430-4263**, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call **1-800-430-7077**. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

## D. Your medical services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in **Senior Advantage Medicare Medi-Cal North P2** ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

## E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is for people who qualify for both Medicare and Medi-Cal. If you are no longer eligible for Medicaid, we will tell you in writing that you have a four-month grace period to regain Medicaid eligibility before you are required to leave the **Senior Advantage Medicare Medi-Cal North P2** plan. Prior to termination of your enrollment in the **Senior Advantage Medicare Medi-Cal North P2** plan, we will contact you to give you the opportunity to enroll in one of our other Senior Advantage plans. The benefits and out-of-pocket costs in these plans may differ from your benefits and out-of-pocket costs in the **Senior Advantage Medicare Medi-Cal North P2** plan.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.

- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

If you are within our plan's four-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan–covered Medicare benefits. However, during this period, you will need to consult with Medi-Cal to find out what if anything Medi-Cal will cover for services not covered by our plan but covered by Medi-Cal. Also, the cost-sharing for Part D drugs and premiums you pay us may change. The amount you pay for Medicare-covered services may increase during this period. We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

## F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

## G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this **Member Handbook** for information about how to make a complaint.

## H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

# Chapter 11: Legal notices

## Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

## Chapter 11 Table of Contents

## A. 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 are federal and state laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

## B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. In addition, we do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at **1-800-368-1019**. TTY users can call **1-800-537-7697**. You can also visit **www.hhs.gov/ocr** for more information.
- Call the Department of Health Care Services, Office for Civil Rights at **1-916-440-7370**. TTY users can call **711** (Telecommunications Relay Service).

If you believe that you have been discriminated against and want to file a discrimination grievance, you can do so in the following ways:

- **By phone**: Call Member Services, 24 hours a day, 7 days a week (except closed holidays).
- **By mail**: Call Member Services and ask to have a form sent to you.
- I**n person**: Fill out a Complaint or Benefit Claim/Request form at a Member Services office located at a plan facility (go to your **Provider and Pharmacy Directory** or **kp.org/facilities** for addresses).
- **Online**: Use the online form on our website at **kp.org**.
- You may also contact the Kaiser Permanente Civil Rights Coordinators directly at the addresses below:

**Attn: Kaiser Permanente Civil Rights Coordinator**
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

If your grievance is about discrimination in the Medi-Cal program, you can also file a complaint with the Department of Health Care Services, Office of Civil Rights, by phone, in writing, or electronically:

- By phone: Call **1-916-440-7370**. If you cannot speak or hear well, please call **711** (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at **dhcs.ca.gov/Pages/Language_Access.aspx**.

- Electronically: Send an email to **CivilRights@dhcs.ca.gov**

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

## C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.

## D. Notice about Medi-Cal estate recovery

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-For-Service and managed care premiums/capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the Department of Health Care Services' estate recovery website at **www.dhcs.ca.gov/er** or call **1-916-650-0590**.

## E. Administration of this Member Handbook

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Member Handbook**.

## F. Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this **Member Handbook**.

## G. Binding arbitration

The following description of binding arbitration applies to the following members:

- All members enrolled in a Kaiser Permanente Senior Advantage Individual Plan with an effective date prior to January 1, 2008; and
- All members enrolled in a Kaiser Permanente Senior Advantage Individual Plan with an effective date of January 1, 2008 or after who have not expressly opted out of the binding arbitration process within 60 calendar days of his or her Senior Advantage effective date.

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this **Member Handbook**. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

**Scope of arbitration**

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this **Member Handbook** or a member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted.
- The claim is asserted by one or more member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more member Parties.
- Governing law does not prevent the use of binding arbitration to resolve the claim.

Members enrolled under this **Member Handbook** thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court.
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan members (see **Chapter 9** for Medicare appeal information).
- Claims that cannot be subject to binding arbitration under governing law.

As referred to in this "Binding arbitration" section, "member Parties" include:

- A member.
- A member's heir, relative, or personal representative.
- Any person claiming that a duty to him or her arises from a member's relationship to one or more Kaiser Permanente Parties.

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals.
- The Permanente Medical Group, Inc.

- Southern California Permanente Medical Group.
- The Permanente Federation, LLC.
- The Permanente Company, LLC.
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician.
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more member Parties.
- Any employee or agent of any of the foregoing.

"Claimant" refers to a member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a member Party or a Kaiser Permanente Party against whom a claim is asserted.

**Rules of Procedure**

Arbitrations shall be conducted according to the **Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator** ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

**Initiating arbitration**

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

**Serving Demand for Arbitration**

Health Plan, Kaiser Foundation Hospitals, KP Cal, LLC, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
1 Kaiser Plaza, 19th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

**Filing fee**

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

**Number of arbitrators**

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two-party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

**Payment of arbitrators' fees and expenses**

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

**Costs**

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

**General provisions**

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages

conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

## H. Assignment

You may not assign this **Member Handbook** or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

## I. Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses, except as otherwise required by law.

## J. Coordination of benefits

If you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage Medicare Medi-Cal Plan member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see **Section Q** in this chapter, and for primary payments in workers' compensation cases, see **Section R** in this chapter.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

## K. Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services, we may recover the value of the services from the employer.

## L. Member Handbook binding on members

By electing coverage or accepting benefits under this **Member Handbook**, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this **Member Handbook**.

## M. Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

## N. Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

## O. No waiver

Our failure to enforce any provision of this **Member Handbook** will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

## P. Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this booklet) and Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) as soon as possible to report your address change.

## Q. Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

## R. Third party liability

Third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services.

Note: This "Third party liability" section does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any

attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Equian
Kaiser Permanente – Northern California Region
Subrogation Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: **1-502-214-1137**

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

## S. U.S. Department of Veterans Affairs

For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

## T. Workers’ compensation or employer’s liability benefits

Workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

## U. Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

# Chapter 12: Definitions of important words

## Introduction

This chapter includes key terms used throughout this **Member Handbook** with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

**Activities of daily living (ADL):** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

**Administrative law judge:** A judge that reviews a level 3 appeal.

**AIDS drug assistance program (ADAP):** A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this **Member Handbook** explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorder services.

**Brand name drug:** A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

**Care coordinator:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

**Care plan:** Refer to "Individualized Care Plan."

**Care Plan Optional Services (CPO Services):** Additional services that are optional under your Individualized Care Plan (ICP). These services are not intended to replace long-term services and supports that you are authorized to get under Medi-Cal.

**Care team:** Refer to "Interdisciplinary Care Team."

**Catastrophic coverage stage:** The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent **$8,000** for Medicare Part D covered drugs during the year. During this payment stage, the plan pays the full cost for your covered Medicare Part D drugs. You pay nothing.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2** of this **Member Handbook** explains how to contact CMS.

**Community-Based Adult Services (CBAS):** Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

**Copay:** A fixed amount you pay as your share of the cost each time you get certain services or prescription drugs. For example, you might pay $2 or $5 for a service or a prescription drug.

**Cost sharing:** Amounts you have to pay when you get certain services or prescription drugs. Cost sharing includes copays.

**Coverage decision:** A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this **Member Handbook** explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription drugs, and equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

**Department of Health Care Services (DHCS):** The state department in California that administers the Medicaid Program (known as Medi-Cal).

**Department of Managed Health Care (DMHC):** The state department in California responsible for regulating health plans. DMHC helps people with appeals and complaints about Medi-Cal services. DMHC also conducts Independent Medical Reviews (IMR).

**Disenrollment:** The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Drug management program (DMP):** A program that helps make sure members safely use prescription opioids and other frequently abused medications.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

**Excluded Services:** Services that are not covered by this health plan.

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

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

**Health Insurance Counseling and Advocacy Program (HICAP):** A program that provides free and objective information and counseling about Medicare. **Chapter 2** of this **Member Handbook** explains how to contact HICAP.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment (HRA):** A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

**Home health aide:** A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

An enrollee who has a terminal prognosis has the right to elect hospice.

A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

We are required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

As a plan member, you only pay our plan's cost sharing amounts when you get services we cover. We do not allow providers to bill you more than this amount.

**In Home** Supportive Services (IHSS): The IHSS Program will help pay for services provided to you so that you can remain safely in your own home. IHSS is an

alternative to out-of-home care, such as nursing homes or board and care facilities. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. County social service agencies administer IHSS.

**Independent Medical Review (IMR):** If we deny your request for medical services or treatment, you can make an appeal. If you disagree with our decision and your problem is about a Medi-Cal service, including DME supplies and drugs, you can ask the California Department of Managed Health Care for an IMR. An IMR is a review of your case by doctors who are not part of our plan. If the IMR decision is in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

**Independent review organization (IRO):** An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the Independent Review Entity.

**Individualized Care Plan (ICP or Care Plan):** A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

**Initial coverage stage:** The stage before your total Medicare Part D drug expenses reach **$8,000**. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. During this stage, we pay part of the costs of your drugs, and you pay your share.

**Inpatient:** A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Care Team (ICT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

**List of Covered Drugs (Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your

home so you don't have to go to a nursing facility or hospital. LTSS covered by our plan include Community-Based Services, Nursing Facilities (NF), and Community Supports. IHSS and 1915(c) waiver programs are Medi-Cal LTSS provided outside our plan.

**Low-income subsidy (LIS):** Refer to "Extra Help."

**Mail Order Program:** Some plans may offer a mail-order program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

**Medi-Cal:** This is the name of California's Medicaid program. Medi-Cal is managed by the state and is paid for by the state and the federal government.

- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medi-Cal.

**Medi-Cal plans:** Plans that cover only Medi-Cal benefits, such as long-term services and supports, medical equipment, and transportation. Medicare benefits are separate.

**Medicaid** (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. Medi-Cal is the Medicaid program for the State of California.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

**Medicare:** The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare** Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

**Medicare-covered services:** Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

**Medicare** diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

**Medicare-Medi-Cal enrollee:** A person who qualifies for Medicare and Medi-Cal coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual.”

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA” that lets private health insurance companies provide Medicare benefits through an MA Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

**Medication Therapy Management (MTM):** A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to Chapter 5 of this Member Handbook for more information.

**Member (member of our plan, or plan member):** A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Member Services:** A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to Chapter 2 of this Member Handbook for more information about Member Services.

**Network pharmacy:** A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

**Network provider:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

**Nursing home or facility:** A facility that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2 and 9** of this **Member Handbook**.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9** of this **Member Handbook** explains coverage decisions.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of this **Member Handbook** explains out-of-network providers or facilities.

**Out-of-pocket costs:** The cost sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost sharing" above.

**Over-the-counter (OTC) drugs:** Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional. Refer to **Chapter 4** information about covered Over-the-Counter Health and Wellness items.

**Part A:** Refer to "Medicare Part A."

**Part B:** Refer to "Medicare Part B."

**Part C:** Refer to "Medicare Part C."

**Part D:** Refer to "Medicare Part D."

**Part D drugs:** Refer to "Medicare Part D drugs."

**Personal health information (also called Protected health information) (PHI)**: Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our **Notice of Privacy Practices** for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

**Primary care provider (PCP)**: The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this **Member Handbook** for information about getting care from primary care providers.

**Prior authorization (PA):** An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this **Member Handbook**.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the **List of Covered Drugs**.

**Program for All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

**Prosthetics and Orthotics:** Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality improvement organization (QIO):** A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this **Member Handbook** for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Real** Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that

may be used for the same health condition as a given drug, and coverage restrictions (prior authorization or quantity limits) that apply to alternative drugs.

**Referral:** A referral is your primary care provider's (PCP's) or our approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this **Member Handbook**.

**Rehabilitation services**: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this **Member Handbook** to learn more about rehabilitation services.

**Sensitive services**: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care and intimate partner violence.

**Service area**: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

The service area is described in **Chapter 1** for the purposes of cost-sharing, enrollment, and disenrollment. For the purposes of obtaining covered services, you get care from network providers anywhere inside our Northern California Region's service area (refer to our **Provider and Pharmacy Directory**).

**Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

**Specialist:** A doctor who provides health care for a specific disease or part of the body.

**Specialized pharmacy:** Refer to **Chapter 5** of this **Member Handbook** to learn more about specialized pharmacies.

**State Hearing:** If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

**Urgently needed care**: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

# Notice of Nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide 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 Member Services at **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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## Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully 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 Service Contact Center at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call **711**.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

**How to file a grievance with Kaiser Permanente**

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- **By phone:** Call Member Services at **1 800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays)
- **By mail:** Call us at **1 800-464-4000** (TTY **711**) and ask to have a form sent to you
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider 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 Coordinators 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:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **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

  Complaint forms are available at:
  **http:www.hhs.gov/ocr/office/file/index.html**

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**

Form Approved
OMB# 0938-1421

## Multi-Language Insert

## Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-443-0815** (TTY **711**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-443-0815** (TTY **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-800-443-0815** (TTY **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-800-443-0815** (TTY **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-443-0815** (TTY **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-443-0815** (TTY **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-800-443-0815** (TTY **711**) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-443-0815** (TTY **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.



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**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-443-0815** (TTY **711**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-443-0815** (TTY **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY **711**) **1-800-443-0815**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना केबारे में आपकेकिसी भी परश्न केजवाब देने केलिए हमारे पास मुफ्त दुभाषिया सेवाएँउपलब्ध हैं. एक दुभाषिया पराप्त करने केलिए, बस हमें **1-800-443-0815** (TTY **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-443-0815** (TTY **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-443-0815** (TTY **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-443-0815** (TTY **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowanialeków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-443-0815** (TTY **711**). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますござい ます。通訳をご用命になるには、**1-800-443-0815** (TTY **711**) にお電話くださ い。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

# Language Assistance Services

**English:** Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. You can also request auxiliary aids and devices at our facilities. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

**Arabic:** خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

**Armenian:** Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Պարզապես զանգահարեք մեզ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

**Chinese:** 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。您還可以在我們的場所內申請使用輔助工具和設備。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

**Farsi:** خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه مدارک به زبان شما و یا به صورتهای دیگر درخواست کنید. شما همچنین می توانید کمکهای جانبی و وسایل .کمکی برای محل اقامت خود درخواست کنید کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران ناشنوا (TTY) با شماره **711** تماس بگیرند.

**Hindi:** बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

**Hmong:** Muaj kec pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

**Japanese:** 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。補助サービスや当施設の機器についてもご相談いただけます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

**Khmer**: ជំនួយភាសា គឺឥតគិតថ្លៃថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែឯកសារដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ 711។

**Korean:** 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스,귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일휴무). TTY 사용자번호 **711**.

**Laotian:** ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ທ່ານສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ອຸປະກອນ ຕ່າງໆໃນສະຖານບໍລິການຂອງພວກເຮົາໄດ້.ພຽງແຕ່ໂທ ຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

**Mien:** Mbenc nzoih liouh wang-henh tengx nzie faan waac bun muangx maiv zuqc cuotv zinh nyaanh meih, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. Meih se haih tov heuc tengx lorx faan waac mienh tengx faan waac bun muangx, dorh nyungc horngh jaa-sic mingh faan benx meih nyei waac, a'fai liouh ginv longc benx haaix hoc sou-guv daan yaac duqv. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Kungx douc waac mingh lorx taux yie mbuo yiem njiec naaiv **1-800-464-4000**, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. (hnoi-gec se guon gorn zangc oc). TTY nyei mienh nor douc waac lorx **711**.

**Navajo:** Doo bik'é asíníłáágóó saad bee ata' hane' bee áká e'elyeed nich'į' ąą'át'é, t'áá áłahjį' jíigo dóó tł'ée'go áádóó tsosts'íjí ąą'át'é. Ata' hane' yídíikił, naaltsoos t'áá Diné bizaad bee bik'i' ashchíigo, éí doodago hane' bee didíits'íiłígíí yídíikił. Hane' bee bik'i' di'díítíiłígíí dóó bee hane' didíits'íiłígíí bína'ídiłkidgo yídíikił. Kojį hodiilnih **1-800-464-4000**, t'áá áłahjį', jíigo dóó tł'ée'go áádóó tsosts'íjí ąą'át'é. (Dahodílzingóne' doo nida'anish dago éí da'deelkaal). TTY chodayooł'ínígíí kojį dahalne' **711**.

**Punjabi:** ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

**Russian:** Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

**Spanish:** Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (excepto los días festivos). Los usuarios de TTY, deben llamar al **711**.

**Tagalog:** May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Maaari ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

**Thai:** มีบริการช่วยเหลือด้านภาษาฟรีตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ คุณสามารถ ขอใช้บริการล่าม แปลเอกสารเป็นภาษาของคุณ หรือในรูปแบบอื่นได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการให้ความช่วยเหลือของเรา โดยโทรหา เราที่ **1-800-464-4000** ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ (ยกเว้นวันหยุดราชการ) ผู้ใช้ TTY ให้โทร **711**

**Ukrainian:** Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача, отримання матеріалів у перекладі мовою, якою володієте, або в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Просто зателефонуйте нам за номером **1-800-464-4000**. Ми працюємо цілодобово, 7 днів на тиждень (крім святкових днів). Номер для користувачів телетайпа: **711**.

**Vietnamese:** Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

## Senior Advantage Medicare Medi-Cal Member Services

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|---|---|
| **CALL** | **1-800-443-0815**<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.<br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY** | **711**<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **WRITE** | Your local Member Services office (see the **Provider and Pharmacy Directory** for locations). |
| **WEBSITE** | **kp.org** |