2027 Summary of Benefits

Kaiser Permanente Dual Complete South P1 (HMO D-SNP)

Kaiser Permanente Dual Complete South P6 (HMO D-SNP)

Kaiser Permanente Dual Complete South P7 (HMO D-SNP)

Kaiser Permanente Dual Complete South P9 (HMO D-SNP)

Kaiser Permanente Dual Complete South P10 (HMO D-SNP)

Kaiser Permanente Dual Complete South P11 (HMO D-SNP)

Kaiser Permanente Dual Complete North P2 (HMO D-SNP)

Kaiser Permanente Dual Complete North P16 (HMO D-SNP)

Kaiser Permanente Dual Complete North P17 (HMO D-SNP)

Kaiser Permanente Dual Complete North P18 (HMO D-SNP)

Kaiser Permanente Dual Complete North P19 (HMO D-SNP)

Kaiser Permanente Dual Complete North P20 (HMO D-SNP)

Kaiser Permanente Dual Complete North P21 (HMO D-SNP)

Kaiser Permanente Dual Complete North P22 (HMO D-SNP)

Kaiser Permanente Dual Complete North P23 (HMO D-SNP)

Kaiser Permanente Dual Complete North P24 (HMO D-SNP)

Kaiser Permanente Dual Complete North P25 (HMO D-SNP)

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KAISER PERMANENTE®

Introduction

This document is a brief summary of the benefits and services covered by Kaiser Permanente Dual Complete. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of Kaiser Permanente Dual Complete. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Disclaimers

This is a summary of health services covered by Kaiser Permanente Dual Complete for 2027. This **Summary of Benefits** includes the following plans:

- Kaiser Permanente Dual Complete South P1
- Kaiser Permanente Dual Complete South P6
- Kaiser Permanente Dual Complete South P7
- Kaiser Permanente Dual Complete South P9
- Kaiser Permanente Dual Complete South P10
- Kaiser Permanente Dual Complete South P11
- Kaiser Permanente Dual Complete North P2
- Kaiser Permanente Dual Complete North P16
- Kaiser Permanente Dual Complete North P17
- Kaiser Permanente Dual Complete North P18
- Kaiser Permanente Dual Complete North P19
- Kaiser Permanente Dual Complete North P20
- Kaiser Permanente Dual Complete North P21
- Kaiser Permanente Dual Complete North P22
- Kaiser Permanente Dual Complete North P23
- Kaiser Permanente Dual Complete North P24
- Kaiser Permanente Dual Complete North P25

When you enroll in one of our plans listed above, you will also be assigned to Kaiser Permanente for your Medi-Cal managed care coverage.

This is only a summary. Please read the *Member Handbook* for the full list of benefits. For details, see the *Member Handbook*, which is located on our website at kp.org/eocncal or kp.org/eocscal or ask for a copy from Member Services by calling **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

- **Southern California members only:** The healthy food benefit is part of a special supplemental program for the chronically ill. Not all members qualify. Members must have specific chronic conditions, like diabetes, obesity, cardiovascular disorders, osteoarthritis, or chronic kidney disease, to be eligible. There are other conditions that may qualify you for the benefit. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.

- Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Member Services number or see your *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.

- We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

- 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.

- For more information about **Medicare**, you can read the *Medicare & You* handbook. It has a summary of Medicare benefits, rights, and protections and answers to the most frequently asked questions about Medicare. You can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days a week. TTY users should call 1-877-486-2048. For more information about **Medi-Cal**, you can check the California Department of Healthcare Services (DHCS) website (www.dhcs.ca.gov/) or contact the Medi-Cal Office of the Ombudsman at 1-888-452-8609, Monday through Friday, between 8 a.m. and 5 p.m. You can also call the special Ombudsman for people who have both Medicare and Medi-Cal, at 1-855-501-3077, Monday through Friday, between 9 a.m. and 5 p.m.

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

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

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

ARABIC

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

ARMENIAN

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

CHINESE

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

PUNJABI

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

HINDI

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

HMONG

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

JAPANESE

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

KOREAN

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

LAOTIAN

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

MIEN

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

CAMBODIAN

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

FARSI

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

RUSSIAN

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

SPANISH

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

TAGALOG

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

THAI

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

UKRAINIAN

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

VIETNAMESE

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

❖ You can get this document for free in other formats, such as large print, braille, audio file or data file. Call Member Services at 1-800-443-0815 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week. The call is free.

❖ Call Member Services 1-800-443-0815 (TTY 711), 8 a.m. to 8 p.m., 7 days a week, 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.

B. Frequently asked questions (FAQ)

The following table lists frequently asked questions.

Frequently Asked Questions	Answers
What's a Medi-Medi Plan?	A Medi-Medi Plan is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. It's for people age 21 and older. A Medi-Medi Plan is an organization made up of doctors, hospitals, pharmacies, providers of Long-term Services and Supports (LTSS), and other providers. It also has care coordinators to help you manage all your providers and services and supports. They all work together to provide the care you need.
Will I get the same Medicare and Medi-Cal benefits in Kaiser Permanente Dual Complete that I get now?	You'll get most of your covered Medicare and Medi-Cal benefits directly from Kaiser Permanente Dual Complete. You'll work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change based on your needs, and your doctor and care team's assessment. You may also get other benefits outside of your health plan the same way you do now, directly from a State or county agency like In-Home Supportive Services (IHSS), specialty mental health and substance use disorder services, or regional center services. When you enroll in Kaiser Permanente Dual Complete, you and your care team will work together to develop a care plan to address your health and support needs, reflecting your personal preferences and goals. If you're taking any Medicare Part D drugs that Kaiser Permanente Dual Complete doesn't normally cover, you can get a temporary supply and we'll help you to transition to another drug or get an exception for Kaiser Permanente Dual Complete to cover your drug if medically necessary. For more information, call Member Services at the numbers listed at the bottom of this page.

Frequently Asked Questions	Answers
Can I use the same doctors I use now? (continued on the next page)	Often that's the case. If your providers (including doctors, hospitals, therapists, pharmacies, and other health care providers) work with Kaiser Permanente Dual Complete and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." Network providers participate in our plan. That means they accept members of our plan and provide services our plan covers. **You must use the providers in Kaiser Permanente Dual Complete's network.** If you use providers or pharmacies that aren't in our network, the plan may not pay for these services or drugs. • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of Kaiser Permanente Dual Complete's plan. • 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. • If you're currently under treatment with a provider that's out of Kaiser Permanente Dual Complete's network, or have an established relationship with a provider that's out of Kaiser Permanente Dual Complete's network, call Member Services to check about staying connected and ask for continuity of care. You may be able to continue going to your Out-of-Network Provider for up to 12 months if you meet specific criteria and if the provider agrees to our terms and conditions. You must request

Frequently Asked Questions	Answers
Can I use the same doctors I use now? (continued from previous page)	continuity of care within 30 days of your enrollment. Call our Member Service department for more information on continuity of care services. To find out if your doctors are in the plan's network, call Member Services at the numbers listed at the bottom of this page or read Kaiser Permanente Dual Complete's provider and pharmacy directories on the plan's website at kp.org/directory. If Kaiser Permanente Dual Complete is new for you, we'll work with you to develop a care plan to address your needs.
What's a Kaiser Permanente Dual Complete care coordinator?	A Kaiser Permanente Dual Complete care coordinator is one main person for you to contact. This person helps to manage all your providers and services and make sure you get what you need.
What are Long-term Services and Supports (LTSS)?	Long-term Services and Supports (LTSS) are help for people who need assistance to do everyday tasks like bathing, toileting, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. In some cases, a county or other agency may administer these services, and your care coordinator or care team will work with that agency.
What's a Multipurpose Senior Services Program (MSSP)?	A MSSP provides on-going care coordination with health care providers beyond what your health plan already provides and can connect you to other needed community services and resources. This program helps you get services that help you live independently in your home.
What happens if I need a service but no one in Kaiser Permanente Dual Complete's network can provide it?	Most services will be provided by our network providers. If you need a service that can't be provided within our network, Kaiser Permanente Dual Complete will pay for the cost of an out-of-network provider.

Frequently Asked Questions	Answers
Where's Kaiser Permanente Dual Complete available? (continued on the next page)	The service area for these plans include: **Our Southern California region includes the following South plans:** • **Kaiser Permanente Dual Complete South P1 Plan**, which includes these **San Diego County** zip codes only: ○ 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–46, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–28, 92029–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–61, 92163, 92165–79, 92182, 92186–87, 92191–93, and 92195–99. • **Kaiser Permanente Dual Complete South P6 Plan**, which includes: ○ Parts of **Riverside County**, in these zip codes only: 91752, 92028, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–92255, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–14, 92516–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83. ○ Parts of **San Bernardino County**, in these zip codes only: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 92305, 92307–08, 92313–18, 92321–22, 92324–25, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–11, 92413, 92415, 92418, 92423, 92427, 92880.

Frequently Asked Questions	Answers

Where's Kaiser Permanente Dual Complete available? (continued on the next page)	• **Kaiser Permanente Dual Complete South P7 Plan**, which includes these **Kern County** zip codes only:
	  ○ 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, and 93581.
	• **Kaiser Permanente Dual Complete South P9 Plan**, which includes all of **Los Angeles County** except Catalina Island.
	• **Kaiser Permanente Dual Complete South P10 Plan**, which includes all of **Orange County**.
	• **Kaiser Permanente Dual Complete South P11 Plan**, which includes these **Ventura County** zip codes only:
	  ○ 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, and 93252.
	Our Northern California region includes the following North plans:
	• **Kaiser Permanente Dual Complete North P2 Plan**, which includes these counties:
	  ○ All of **Sacramento County**.
	  ○ **Amador County**, in these zip codes only: 95640 and 95669.
	  ○ **El Dorado County**, in these zip codes only: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, and 95762.
	• **Kaiser Permanente Dual Complete North P16 Plan**, which includes all of **Alameda County**.

Frequently Asked Questions	Answers
Where's Kaiser Permanente Dual Complete available? (continued on the next page)	• **Kaiser Permanente Dual Complete North P17 Plan**, which includes all of **Contra Costa County**. • **Kaiser Permanente Dual Complete North P18 Plan**, which includes these counties: ○ **Fresno County**, in these zip codes only: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888. ○ **Kings County**, in these zip codes only: 93230, 93232, 93242, 93631, 93656. ○ **Madera County**, in these zip codes only: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720. ○ **Mariposa County**, in these zip codes only: 93601, 93623, and 93653. ○ **Tulare County**, in these zip codes only: 93238, 93261, 93618, 93631, 93646, 93654, 93666, and 93673. • **Kaiser Permanente Dual Complete North P19 Plan**, which includes all of **San Francisco County**. • **Kaiser Permanente Dual Complete North P20 Plan**, which includes all of **San Joaquin and Stanislaus** counties. • **Kaiser Permanente Dual Complete North P21 Plan**, which includes all of **Santa Cruz County**. • **Kaiser Permanente Dual Complete North P22 Plan**, which includes all of **San Mateo County**.

Frequently Asked Questions	Answers
Where's Kaiser Permanente Dual Complete available? (continued from previous page)	• **Kaiser Permanente Dual Complete North P23 Plan**, which includes these **Santa Clara County** zip codes only: ○ 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, and 95196. • **Kaiser Permanente Dual Complete North P24 Plan**, which includes these counties: ○ **Placer County**, in these zip codes only: 95602–04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95703, 95722, 95736, 95746–47, and 95765. ○ **Yolo County**, in these zip codes only: 95605, 95607, 95612, 95615–18, 95620, 95645, 95691, 95694–95, 95697–98, 95776, and 95798–99. ○ **Yuba County**, in these zip codes only: 95692, 95903, and 95961. • **Kaiser Permanente Dual Complete North P25 Plan**, which includes these counties: ○ All of **Marin, Napa, and Solano** counties. ○ **Sonoma County**, in these zip codes only: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, and 95492. You must live in one of these areas to join the plan.

Frequently Asked Questions	Answers
What's prior authorization?	Prior authorization means an approval from Kaiser Permanente Dual Complete to seek services outside of our network or to get services not routinely covered by our network **before** you get the services. Kaiser Permanente Dual Complete may not cover the service, procedure, item, or drug if you don't get prior authorization. **If you need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first.** Kaiser Permanente Dual Complete can provide you or your provider with a list of services or procedures that require you to get prior authorization from Kaiser Permanente Dual Complete before the service is provided. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services at the numbers listed at the bottom of this page for help.
What's a referral?	A referral means that your primary care provider (PCP) must give you approval to go to someone that's not your PCP. A referral is different than a prior authorization. If you don't get a referral from your PCP, Kaiser Permanente Dual Complete may not cover the services. Kaiser Permanente Dual Complete can provide you with a list of services that require you to get a referral from your PCP before the service is provided. Refer to the *Member Handbook*, Chapters 3 and 4, to learn more about when you'll need to get a referral from your PCP.
Do I pay a monthly amount (also called a premium) under Kaiser Permanente Dual Complete?	No. Because you have Medi-Cal, you won't pay any monthly premiums, including your Medicare Part B premium, for your health coverage.
Do I pay a deductible as a member of Kaiser Permanente Dual Complete?	No. You don't pay deductibles in Kaiser Permanente Dual Complete.

Frequently Asked Questions	Answers
What's the maximum out-of-pocket amount that I'll pay for medical services as a member of Kaiser Permanente Dual Complete?	There's no cost-sharing for medical services in Kaiser Permanente Dual Complete, so your annual out-of-pocket costs will be $0.
What happens if I lose my full-scope Medi-Cal coverage?	If you are within our plan's 4-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered benefits and your cost share will change as described in the *Member Handbook*. During this time, your Medi-Cal benefits may not be covered.

C. List of covered services

The following table is a quick overview of what services you may need, your costs, and rules about the benefits.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Hospital stay	$0	A referral is required. Prior authorization is required for transplants for Northern California members. There's no limit to the number of medically necessary inpatient hospital days.
	Doctor or surgeon care	$0	
	Outpatient hospital services, including observation	$0	
	Ambulatory surgical center (ASC) services	$0	

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor	Visits to treat an injury or illness	$0	
	Specialist care	$0	A referral is required for most specialists. Refer to your *Member Handbook* for a list of services that do not require a referral.
	Wellness visits, such as a physical	$0	Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice. Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.
	Care to keep you from getting sick, such as flu shots and screenings to check for cancer	$0	The following preventive care services require a referral: abdominal aortic aneurysm screenings, medical nutritional therapy, flexible sigmoidoscopy, screening colonoscopy, bone density screening, and lab tests.
	"Welcome to Medicare" (preventive visit one time only)	$0	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.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care	Emergency room services	$0	You have worldwide emergency care coverage. Prior authorization is not required. 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.
	Urgent care	$0	Prior authorization is not required. Urgent care is covered out-of-network as follows: **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). **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.
You need medical tests (continued on the next page)	Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs)	$0	A referral is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests (continued from previous page)	Lab tests and diagnostic procedures, such as blood work	$0	A referral is required.
You need hearing/auditory services	Hearing screenings	$0	
	Hearing aids	$0	Hearing aids are covered according to Medi-Cal coverage rules.
You need dental care (continued on the next page)	Dental check-ups and preventive care	$0	Dental benefits are available through the Medi-Cal Dental Fee-for-Service (FFS) or Dental Managed Care (Dental MC), depending on your county. For information on Medi-Cal dental coverage, contact: Dental FFS: **1-800-322-6384** (TTY **1-800-735-2922**) or **www.smilecalifornia.org**. Dental MC in Los Angeles and Sacramento counties: **1-800-430-4263** (TTY **1-800-430-7077**) or **www.dental.dhcs.ca.gov/**.
	Restorative and emergency dental care	$0	Dental benefits are available through the Medi-Cal Dental Fee-for-Service (FFS) or Dental Managed Care (Dental MC), depending on your county. For information on Medi-Cal dental coverage, contact: Dental FFS: **1-800-322-6384** (TTY **1-800-735-2922**) or **www.smilecalifornia.org**.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued from previous page)			Dental MC in Los Angeles and Sacramento counties: **1-800-430-4263** (TTY **1-800-430-7077**) or **www.dental.dhcs.ca.gov/**.
You need eye care	Eye exams	$0	A referral is required for ophthalmology.
	Glasses or contact lenses	$0	A referral is required. Eyeglasses or contact lenses after cataract surgery: $0 up to Medicare's limit, but you pay any amounts beyond that limit. Every 12 months, we provide an allowance through your Medicare coverage. If your eyewear costs more than the allowance for your plan, **you pay the difference**: • South P1 and North P2, P16, P17, P18, P19, P20, P21, P22, P23, P24, P25 – **$350** • South P6 – **$400** • South P7, P9, P10, P11 – **$500** Medi-Cal also covers new or replacement frames that cost **$80** or less, every 24 months. New or replacement eyeglass lenses are provided by DHCS' eyeglass lens vendor. If you want eyeglasses, lenses, or features that are not covered by Medi-Cal, then **you may have to pay extra for those upgrades**. Ask a plan optical facility for more information.
	Other vision care	$0	A referral is required. Low vision devices are covered in accordance with Medi-Cal Program rules.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need mental health services	Mental health services	$0	Inpatient and outpatient mental health services are covered. In addition, you have coverage for additional specialty mental health services that are not covered by Medicare through your county behavioral health plan.
	Inpatient and outpatient care and community-based services for people who need mental health services	$0	Inpatient and outpatient mental health services are covered. You might qualify for community-based services under Medi-Cal. Ask your care coordinator for more information. You have coverage for additional specialty mental health services that are not covered by Medicare through your county behavioral health plan.
You need substance use disorder services (continued on the next page)	Substance use disorder services	$0	The following services are covered, and maybe other services not listed here: • Alcohol misuse screening and counseling. • Treatment of drug abuse. • Group or individual counseling by a qualified clinician, including marriage and family therapist. • Alcohol and/or drug services in an intensive outpatient treatment center. • Extended release Naltrexone (vivitrol) treatment.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need substance use disorder services (continued from previous page)			You have coverage for additional substance use disorder treatment services that are not covered by Medicare through your county behavioral health plan.
You need a place to live with people available to help you	Skilled nursing care	$0	A referral is required.
	Nursing home care	$0	
	Adult Foster Care and Group Adult Foster Care	$0	
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Prior authorization is required.
You need help getting to health services (continued on the next page)	Ambulance services	$0	

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting to health services (continued from previous page)	Emergency transportation	$0	
	Transportation to medical appointments and services	$0	Prior authorization and referral are required. Medi-Cal covers non-emergency medical transportation and non-medical transportation to help you get to appointments and to the pharmacy when you don't have a way to get there yourself.
You need drugs to treat your illness or condition (continued on the next page)	Medicare Part B drugs	$0	Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs.
	Medicare Part D drugs Tier 1: Preferred generic Tier 2: Generic Tier 3: Preferred brand-name Tier 4: Nonpreferred Tier 5: Specialty Tier 6: Vaccines	**Tiers 1–2:** Your copay for up to a one-month (30-day) supply is **$0–$5.80 per prescription**. **Tiers 3–5:** Your copay for up to a one-month (30-day) supply is **$0–$14.40 per prescription**. **Tier 6:** $0	There may be limitations on the types of drugs covered. Please refer to Kaiser Permanente Dual Complete *List of Covered Drugs* (*Drug List*) for more information. Once you or others on your behalf pay $2,400, you have reached the catastrophic coverage stage and you pay $0 for all your Medicare Part D drugs for the rest of the calendar year. Read the *Member Handbook* for more information on this stage. A long-term (100-day) supply may be available from either a retail pharmacy or our mail-order pharmacy. The cost share for a long-term supply is the same as a one-month supply. Not all drugs are available through mail order.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued on the next page)		Copays for drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.	
	Over-the-counter (OTC) drugs	$0 for nicotine replacement therapies at network pharmacies.	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. There may be limitations on the types of drugs covered. Please refer to Kaiser Permanente Dual Complete's *List of Covered Drugs (Drug List)* for more information.
		$0 for other OTC eligible items for purchase online and at participating retail stores, including at Kaiser Permanente retail pharmacies. You will receive a preloaded healthy extras card with the quarterly allowance for your plan.	You may purchase OTC items with your healthy extras card, using the **quarterly allowance** described below for your plan: • North P2 – **$50** • North P16, P17, P18, P19, P20, P21, P22, P23, P24, P25 – **$75** • South P1 – **$75** • South P6 – **$100** • South P7, P11 – **$150** • South P9 – **$170** • South P10 – **$125**

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued from previous page)			Your card will be reloaded on January 1, April 1, July 1, and October 1. Any unused portion of the quarterly allowance will not roll over to the next quarter. Note: The healthy extras card cannot be used for tips or fees (such as delivery or shipping fees). **Southern California members only:** If you qualify for SSBCI benefits described in the Special Supplemental Benefits for the Chronically Ill row, you may use your quarterly OTC allowance to also purchase healthy foods. You can decide how to use your allowance on your healthy extras card between OTC items and healthy food. For more information, please see the *Member Handbook*, visit mybenefitscenter.com, or call 1-833-524-7035 (TTY 711), 5 a.m. to 5 p.m. PST, 7 days a week. 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/.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting better or have special health needs	Rehabilitation services	$0	A referral is required for certain services.
	Medical equipment for home care	$0	Prior authorization is required.
	Dialysis services	$0	A referral is required.
You need foot care	Podiatry services	$0	A referral is required.
	Orthotic services	$0	Prior authorization is required.
You need durable medical equipment (DME) **Note: This isn't a complete list of covered DME. For a complete list, contact Member Services or refer to Chapter 4 of the *Member Handbook*.**	Wheelchairs, crutches, and walkers	$0	Prior authorization is required.
	Nebulizers	$0	Prior authorization is required.
	Oxygen equipment and supplies	$0	Prior authorization is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued on the next page)	Home health services	$0	A referral is required. You must be homebound, which means leaving home is a major effort. We cover the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued from previous page)	Home services, such as cleaning or housekeeping, or home modifications such as grab bars	$0	Community Supports are suitable and cost-effective alternative services or settings to those covered under Medi-Cal. If you qualify, Community Supports may help you live more independently. These services do not replace benefits 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.
	Adult day health, Community Based Adult Services (CBAS), or other support services	$0	Community Based Adult Service ("CBAS") is a service you may be eligible for if you have health problems that make it hard for you to take care of yourself and you need extra help. For information about CBAS services, ask your care coordinator.
	Day habilitation services	$0	
	Services to help you live on your own (home health care services or personal care attendant services)	$0	We cover home health services as described under "Home health services" above. In addition, you may be eligible for In-Home Support Services or home and community-based waiver services under your Medi-Cal coverage. To get more information on these services, call your care coordinator.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued on the next page)	California Integrated Care Management (CICM)	$0	Our plan identifies members who are eligible to receive additional care coordination services known as CICM. Eligible members include certain: • Adults Experiencing Homelessness • Adults At Risk for Avoidable Hospital or Emergency Department Utilization • Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs • Adults Transitioning from Incarceration • Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization • Adult Nursing Facility Residents Transitioning to the Community • Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities • Adults with Documented Dementia Needs
	Chiropractic services	$0	We cover adjustments of the spine to correct alignment. These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please refer to the *Provider and Pharmacy Directory*. Prior authorization is required for Northern California members.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued on the next page)			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. Prior authorization is required for Northern California members. 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.
	Diabetes supplies and services	$0	Prior authorization is required.
	Fitness benefit — One Pass ®	$0	You have access to the One Pass complete fitness program for the body and mind. One Pass includes: • A large core and premium gym network featuring national, local, and community fitness centers and boutique fitness studios. You can use any in-network location. • Live, on-demand, and digital fitness programs at home. • Social clubs and activities available on the One Pass member website and mobile app. • One home fitness kit annually for strength, yoga, or dance. • Online brain health cognitive training programs. For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, visit **YourOnePass.com** or call **1-877-614-0618** (TTY **711**), Monday through Friday, 6 a.m. to 7 p.m.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued on the next page)	Home-delivered meals	$0	Under Medi-Cal, you may qualify 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.
	Home medical care not covered by Medicare (Advanced Care At Home) **for North P16, P17, P19, P23 members** Note: This benefit is not available for all other members.	$0 when prescribed as part of your home treatment plan, otherwise you pay the applicable cost share	A referral is required. We cover medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status, to provide you with an alternative to receiving acute care in a hospital and post-acute care services in the home to support your recovery. See the *Member Handbook* for details.
	Non-emergency medical transportation (non-routine)	$0	We cover medically necessary, non-emergency medical transportation to home (within 100 miles), a skilled nursing facility (SNF), or another higher level of care, immediately following an inpatient hospitalization or after certain emergency, urgent care, or outpatient hospital encounters, **when ordered by a network provider**. Refer to the *Member Handbook* for more details.
	Prosthetic services	$0	Prior authorization is required.
	Radiation therapy	$0	A referral is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued on the next page)	Services to help manage your disease	$0	
	Special Supplemental Benefits for the Chronically Ill – healthy food **(Southern California members only)**** Note: This benefit is not available for Northern California members. **The healthy food benefit is part of a special supplemental program for the chronically ill. Not all members qualify. Members must have specific chronic conditions, like diabetes, obesity, cardiovascular disorders, osteoarthritis, or chronic kidney disease, to be eligible. There are other conditions that may qualify you for the benefit. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.	$0 for approved healthy food purchased both online and at participating retail stores. You will receive a preloaded healthy extras card with a quarterly allowance for your plan described in the Over-the-counter (OTC) drugs row.	If you qualify for SSBCI, you may use your quarterly OTC allowance to also purchase healthy foods. You can decide how to use your allowance on your healthy extras card between OTC items and healthy food. You must meet all criteria, including one or more of the SSBCI-eligible conditions listed below: • Chronic alcohol use disorder and other substance use disorders (SUDs) • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic heart failure • Dementia • Diabetes mellitus • Overweight, obesity, and metabolic syndrome • Chronic gastrointestinal disease • Chronic kidney disease (CKD) • Severe hematologic disorders • HIV/AIDS • Chronic lung disorders • Chronic and disabling mental health conditions • Neurologic disorders • Stroke

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued from previous page)			• Post-organ transplantation care • Immunodeficiency and Immunosuppressive disorders • Conditions associated with cognitive impairment • Conditions with functional challenges and require similar services • Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell • Conditions that require continued therapy services in order for individuals to maintain or retain functioning Your card will be reloaded on January 1, April 1, July 1, and October 1. Any unused portion of the quarterly allowance will not roll over to the next quarter. For more information, please see the *Member Handbook*, visit mybenefitscenter.com, or call **1-833-524-7035** (TTY **711**), 5 a.m. to 5 p.m. PST, 7 days a week.

The above summary of benefits is provided for informational purposes only and isn't a complete list of benefits. For a complete list and more information about your benefits, you can read the Kaiser Permanente Dual Complete *Member Handbook*. If you don't have a *Member Handbook*, call Kaiser Permanente Dual Complete Member Services at the numbers listed at the bottom of this page to get one. If you have questions, you can also call Member Services or visit kp.org/medicare.

D. Benefits covered outside of Kaiser Permanente Dual Complete

There are some services that you can get that aren't covered by Kaiser Permanente Dual Complete but are covered by Medicare, Medi-Cal, or a State or county agency. This isn't a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about these services.

Other services covered by Medicare, Medi-Cal, or a State Agency	Your costs
Certain hospice care services covered outside of Kaiser Permanente Dual Complete	$0
Psychosocial rehabilitation	$0
Targeted case management	$0
Medi-Cal Rx Outpatient Prescription Drug Program	$0
Certain dental services Dental benefits are available through the Medi-Cal Dental Fee-for-Service (FFS) or Dental Managed Care (Dental MC), depending on your county. For information on Medi-Cal dental coverage, contact: ○ Dental FFS: **1-800-322-6384** (TTY **1-800-735-2922**) or **www.smilecalifornia.org**. ○ Dental MC in Los Angeles and Sacramento counties: **1-800-430-4263** (TTY **1-800-430-7077**) or **www.dental.dhcs.ca.gov/**.	$0
Substance Use Disorder Treatment Services	$0
Specialty Mental Health Services	$0
In-Home Support Services	$0
Home and Community-Based Waiver Services	$0
Multipurpose Senior Services Program	$0

Other services covered by Medicare, Medi-Cal, or a State Agency	Your costs
Regional Center Services covered by Medi-Cal	$0
Rest home room and board	$0

E. Services that Kaiser Permanente Dual Complete, Medicare, and Medi-Cal don't cover

This isn't a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other excluded services.

Services Kaiser Permanente Dual Complete, Medicare, and Medi-Cal don't cover	
Certain exams and services needed: • To get or keep a job • To get insurance • To get any kind of license • By order of a court, or if for parole or probation	This exclusion does not apply if a network doctor finds that the services are medically necessary.
Comfort, 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. Services to change the way you look (including surgery on normal parts of your body to change how you look).	This exclusion does not apply to covered prosthetic devices: • Testicular implants implanted as part of a covered reconstructive surgery • Breast prostheses needed after a mastectomy or lumpectomy • Prostheses to replace all or part of an external facial body part

Services Kaiser Permanente Dual Complete, Medicare, and Medi-Cal don't cover	
Experimental services	Experimental services are drugs, equipment, procedures, or services that are being tested in a laboratory or on animals, but they are not ready to be tested in humans, except as a covered clinical research study described in the *Member Handbook*.
Items and services that are not health care items and services	Unless they are approved under your Medi-Cal coverage under the In Lieu of Services program or Durable Medical Equipment.
Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.	
Massage therapy services	This exclusion does not apply to therapy services that are part of a physical therapy treatment plan.
Private duty nurses or full-time nursing care in your home	
Routine foot care and services not covered by Medicare	
Services considered not "reasonable and medically necessary," according to Medicare and Medi-Cal standards	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.
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: Covered emergency services received in Canada or Mexico, services covered under Clinical Trials, and services provided as part of covered investigational services.

Services Kaiser Permanente Dual Complete, Medicare, and Medi-Cal don't cover	
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, if any.
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 the *Member Handbook*.
Personal care services that are not medically necessary, such as help with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).	This exclusion does not apply to assistance with activities of daily living that is provided as part of coverage described under the following sections: • Hospice and palliative care • Long-term care services and supports • Skilled nursing/intermediate/subacute facility care • Community Supports
Reversal of sterilization.	
Services by unlicensed people. These include services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the member's condition does not require that the services be provided by a licensed health care provider.	This exclusion does not apply to the following: • Covered Community Supports approved for you. • Covered doula services. • Covered community health worker services.

F. Your rights as a member of the plan

As a member of Kaiser Permanente Dual Complete, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We'll tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but aren't limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
  - Get covered services without concern about medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex, sexual orientation, national origin, race, color, religion, creed, or public assistance
  - Get information in other languages and formats (for example, large print, braille, or audio) free of charge
  - Be free from any form of physical restraint or seclusion
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a language and format you can understand. This includes the right to get information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they're covered
  - Refuse treatment, even if your health care provider advises against it
  - Stop taking medicine, even if your health care provider advises against it
  - Ask for a second opinion. Kaiser Permanente Dual Complete will pay for the cost of your second opinion visit

- Make your health care wishes known in an advance directive

- **You have the right to timely access to care that doesn't have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your health care providers and your health plan

- **You have the right to seek emergency and urgent care when you need it.** This means you have the right to:
  - Get emergency services without prior authorization in an emergency
  - Use an out-of-network urgent or emergency care provider, when necessary

- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private

- **You have the right to file a complaint or appeal a denied, delayed, or modified service. Please see section G below.** This includes the right to:
  - File a complaint or grievance against us or our providers
  - Appeal certain decisions made by us or our providers
  - File a complaint with the California Department of Managed Health Care (DMHC) through a toll-free phone number (1-888-466-2219), or a TDD line (1-877-688-9891) for the hearing and speech impaired. The DMHC website (www.dmhc.ca.gov/) has complaint forms, Independent Medical Review (IMR) application forms, and instructions available online.
  - Ask DMHC for an IMR of Medi-Cal services or items that are medical in nature
  - Ask for a State Hearing
  - Get a detailed reason for why services were denied and ask for free copies of all the information used to make the decision

For more information about your rights, you can read the *Member Handbook.* If you have questions, you can call Kaiser Permanente Dual Complete Member Services at the numbers listed at the bottom of this page.

You can also call the special Ombudsman for people who have Medicare and Medi-Cal at 1-855-501-3077, Monday through Friday, between 9 a.m. and 5 p.m., or the Medi-Cal Office of the Ombudsman at 1-888-452-8609, Monday through Friday, between 8 a.m. and 5 p.m.

G. How to file a complaint or appeal a denied, delayed, or modified service

If you have a complaint or think Kaiser Permanente Dual Complete improperly denied, delayed, or modified a service, call Member Services at the numbers listed at the bottom of this page. You may also submit a complaint in writing to the address listed below. You may be able to appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of the *Member Handbook*. You can also call Kaiser Permanente Dual Complete Member Services at the numbers listed at the bottom of this page.

Coverage Decisions, Appeals and Complaints about medical 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.

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.

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** about the quality of the care you got to us or to the Quality Improvement Organization. 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 Ombuds Program by calling **1-888-452-8609**. Monday through Friday, 8 a.m. to 5 p.m., excluding state holidays.

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

Coverage decisions for Part D prescription drugs

A coverage decision about your Medicare drugs is a decision about:

- your benefits and Medicare covered drugs or
- the amount we pay for your Medicare drugs.

CALL	**1-877-645-1282** This call is free. 7 days a week, 8 a.m. to 8 p.m. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-844-403-1028**
WRITE	OptumRx c/o Prior Authorization P.O. Box 25183 Santa Ana, CA 92799
WEBSITE	**kp.org**

Appeals for Part D prescription drugs

An appeal is a way to ask us to change a coverage decision.

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

Complaints for Part D prescription drugs

You can make a complaint about us or any pharmacy. This includes a complaint about your Medicare prescription drugs.

If your complaint is about a coverage decision about your Medicare prescription drugs, you can make an appeal (see "Appeals for Part D prescription drugs" above).

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

Quality Improvement Organization (QIO)

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

- Questions about your health care rights
- You can make 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.

CALL	**1-877-588-1123** Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays, 10 a.m. to 4 p.m.
TTY	**711**
WRITE	Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23450
WEBSITE	**www.livantaqio.cms.gov**

Help from the California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-443-0815** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **1-888-466-2219** and a TDD line **1-877-688-9891** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at Kaiser Permanente Dual Complete Member Services. Phone numbers are listed at the bottom of this page.
- Or, call the Medi-Cal Customer Service Center at 1-800-541-5555. TTY users may call 1-800-430-7077.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free.

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call Kaiser Permanente Dual Complete Member Services:

- **1-800-443-0815** (TTY **711**).
- Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week.
- Member Services also has free language interpreter services available for non-English speakers.

Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

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

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office for Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**