KAISER PERMANENTE®

Kern Family Health Care Member Handbook

What you need to know about your benefits

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

July 1, 2019 – June 30, 2020

Kaiser Foundation Health Plan, Inc.

Southern California Region

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call **1-800-464-4000** (TTY **711**). The call is toll free.

Other formats

You can get this information for free in other auxiliary formats, such as braille, 18-point font large print and audio. Call **1-800-464-4000** (TTY **711**). The call is toll free.

Interpreter services

You do not have to use a family member or friend as an interpreter. For free interpreter, linguistic and cultural services and help available 24 hours a day, 7 days a week, or to get this Handbook in a different language, call **1-800-464-4000** (TTY **711**). The call is toll free.

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. 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. 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: 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。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 جزوات به زبان شما و یا به صورتهای دیگر 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 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। 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: Muajkwc 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.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。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 គឺមានឥតអស់ថ្លៃដល់អ្នកទ្បើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សឹងទៀត។ គ្រាន់តែទូរសំព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງ ແຕ່ໂທຣຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທຣ **711**.

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį. Atah halne'é áká'adoolwołígíí jóki, t'áadoo le'é t'áá hóhazaadjį hadilyąą'go, éí doodaii' nááná lá ał'ąą ádaat'ehígíí bee hádadilyaa'go. Kojį hodiilnih **1-800-464-4000**, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojį hodiilnih **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। 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. 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: Contamos con asistencia de idiomas sin costo alguno 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. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado 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. 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: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 **ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่าม ช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแล สุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสา รเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทร หาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 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 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**.

Notice of non-discrimination

Discrimination is against the law. Kaiser Permanente complies with applicable federal and State civil rights laws and does not discriminate (exclude or treat people differently) on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and Kaiser Permanente will provide all Covered Services in a culturally and linguistically appropriate manner. Kaiser Permanente:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call member services at **1-800-464-4000** (TTY **711**).

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, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, you can file a grievance in person or by mail, fax or email:

- By completing a Complaint or Benefit Claim/Request form at a member services office located at a network facility

- By mailing your written grievance to a member services office at a network facility
- By calling member services at **1-800-464-4000** (TTY **711**)
- By completing the grievance form on our website at **kp.org**

Please call member services if you need help filing a grievance.

The Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. If you need help filing a grievance, the Civil Rights Coordinator is available to help you:

Civil Rights Coordinator
Kaiser Permanente
One Kaiser Plaza, 12th Floor, Suite 1223
Oakland, CA 94612

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**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **https://www.hhs.gov/ocr/filing-with-ocr**.

2019 Summary of Changes for Returning Members

If you received a Kaiser Permanente Member Handbook in 2018, the information below gives you a summary of the important changes that are in the 2019 Member Handbook. The most important changes are described in this 2019 Summary of Changes and Clarifications section. Please read the entire Member Handbook to learn more about these changes.

If you are a new Medi-Cal member, you may skip this section.

Important Changes and Clarifications in the 2019 Member Handbook

Health Homes Program

We have added information about the Health Homes Program in Chapter 4 (“Benefits and services”).

Pediatric services

We have added more detail to the description of Pediatric services in Chapter 4.

Schedule II drugs (AB 1048)

We have added language related to a California law. For certain prescription drugs, you or your doctor can tell a pharmacy to give you a smaller amount of the prescription drug than what your doctor prescribed.

State Hearings

The California Department of Social Services has changed the name of State Fair Hearings to State Hearings. We have change the name in your EOC/DF to match the change the State made.

Urgent Care

We have clarified that urgent care services are covered only within the United States.

Words to know

We have added the following terms to the list of Words to Know in Chapter 7.

- Plan Facility
- Plan Hospital
- Plan Pharmacy
- Plan Physician
- Plan Provider

We have changed the definition for the following terms in Chapter 7.

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Medically necessary

Welcome to Kaiser Permanente!

Thank you for choosing Kaiser Permanente as your health care provider through Kern Family Health Care. Kern Family Health Care is a health plan for people who have Medi-Cal. Kern Family Health Care works with the State of California to help you get the health care you need. Kaiser Permanente is your health care provider through Kern Family Health Care.

Member Handbook

This Member Handbook tells you about your coverage through Kaiser Permanente. Please read it carefully and completely. It will help you understand and use your benefits and services. It also explains your rights and responsibilities as a member of Kaiser Permanente. If you have special health needs, be sure to read all sections that apply to you.

This Member Handbook is also called the Combined Evidence of Coverage and Disclosure Form ("EOC/DF"). It is a summary of Kaiser Permanente's rules and policies and based on the contract between Kaiser Permanente and Kern Family Health Care. Your health coverage is determined by our contract with Kern Family Health Care. If you received or downloaded a copy of a Member Handbook directly from Kern Family Health Care, please put that one away and use this one. This Member Handbook will provide you with the most accurate information about your Medi-Cal benefits and coverage. If there are differences between the Member Handbook you received from Kern Family Health Care and this one, this document will the one that we will use to help you.

You may access a sample of the Two-Plan model contract online at **http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.**

You may also ask for another copy of the Member Handbook at no cost to you by calling **1-800-464-4000** (TTY **711**) or visiting our website at **kp.org** to view the Member

Handbook. You may also request, at no cost, a copy of our non-proprietary clinical and administrative policies and procedures, or how to access this information on our website.

Contact us

Kaiser Permanente is here to help. If you have questions, call **1-800-464-4000** (TTY **711**). We are here 24 hours a day, 7 days a week (except closed holidays). The call is toll free.

You can also visit online at any time at **kp.org** or visit the member services department at a Plan Facility (refer to the facility directory on our website at **kp.org/facilities** for addresses). To get a copy of our facility directory, call us.

Thank you,
Kaiser Permanente

Table of contents

1. Getting started as a member

How to get help

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

Kaiser Permanente member services

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

- Answer questions about your covered services
- Help you choose a primary care provider (PCP)
- Tell you where to get the care you need
- Offer interpreter services if you do not speak English
- Offer information in other languages and formats

If you need help, call member services as follows.

- English **1-800-464-4000**
  (and more than 150 languages using interpreter services)
- Spanish **1-800-788-0616**
- Chinese dialects **1-800-757-7585**
- TTY **711**

We are here 24 hours a day, 7 days a week (except closed holidays). The call is toll free. You can also visit online at any time at **kp.org**.

Getting help from Kern Family Health Care

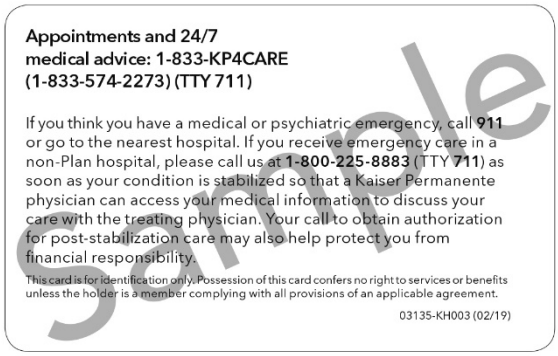
If you have questions about Kern Family Health Care, call them at **1-800-391-2000**, Monday – Friday, 8 a.m. to 5 p.m. (TTY **711**).

Who can be assigned to Kaiser Permanente

Kaiser Permanente does not enroll members directly. To learn more about how to request assignment with Kaiser Permanente, call Kern Family Health Care member services at **1-800-391-2000**.

Identification (ID) cards

As a member of Kaiser Permanente, you will get a Kaiser Permanente ID card. You must show your Kaiser Permanente ID card, your Medi-Cal Benefits Identification Card (BIC), and a photo ID when you get any health care services or prescriptions. You should carry all health cards with you at all times. Here is a sample Kaiser Permanente ID card to show you what yours will look like:



If you do not get your Kaiser Permanente ID card within a few weeks of your assignment to Kaiser Permanente, or if your card is damaged, lost or stolen, call member services right away. We will send you a new card. Call **1-800-464-4000** (TTY **711**).

Ways to get involved as a member

Kern Family Health Care wants to hear from you. Each year, they have meetings to talk about what is working well and how we can improve. Members are invited to attend. Come to a meeting!

2. About your health plan

Health plan overview

Kern Family Health Care is a health plan for people who have Medi-Cal in the Kern Family Health Care Service Area. See the “Kern Family Health Care Service Area” definition in Chapter 7 ("Important phone numbers and words to know”) for a listing of zip codes. Kern Family Health Care works with the State of California to help you get the health care you need.

Kern Family Health Care is your Medi-Cal managed care plan and Kaiser Permanente is your health care provider through Kern Family Health Care. When you choose Kaiser Permanente, you are choosing to get your care through our medical care program. You must get most services from Kaiser Permanente providers. You may talk with one of the Kaiser Permanente member services representatives to learn more about your health care provider. Call us at **1-800-464-4000** (TTY **711**).

If you have questions about Kern Family Health Care, you can call them at **1-800-391-2000** (TTY **711**), Monday through Friday, 8 a.m. to 5 p.m.

When your coverage starts and ends

When you are assigned to Kaiser Permanente through Kern Family Health Care, you should receive a Kaiser Permanente member ID card within two weeks of your assignment to Kaiser Permanente. Please show this card every time you go for any service.

You may start getting Medi-Cal covered services from Kaiser Permanente on the first day of the month following your assignment to Kaiser Permanente. To learn more, call Kern Family Health Care toll free at **1-800-391-2000.**

You may ask at any time to end your assignment to Kaiser Permanente and choose another provider in Kern Family Health Care's network. For help choosing a new provider organization, call Kern Family Health Care at **1-800-391-2000** (TTY **711**) or visit **www.kernfamilyhealthcare.com**. You can also ask to end your Medi-Cal.

We can ask Kern Family Health Care to assign you to a different provider in its network if:

- Your behavior threatens the safety of Kaiser Permanente staff or of any person or property at a network facility; or
- You commit theft from network provider, or a network facility; or
- You intentionally commit fraud, such as presenting a prescription that is not valid or letting someone else use your Medi-Cal or Kaiser Permanente ID card

If Kern Family Health Care reassigns you to a different provider, they will inform you in writing.

Sometimes Kern Family Health Care and Kaiser Permanente can no longer serve you: Kern Family Health Care must end your coverage if:

- You move out of Kern Family Health Care Service Area
- You are in prison
- You no longer have Medi-Cal
- You qualify for certain waiver programs
- You need a major organ transplant (excluding kidneys)
- You need services in a long-term care facility, intermediate care facility, or subacute care facility for longer than the month of admission plus the next month

If your eligibility with Kern Family Health Care and your assignment to Kaiser Permanente end, you may still be able to get services from Fee-For-Service Medi-Cal or other programs. Go to the heading “What Kaiser Permanente does not provide” in this chapter for more information on these services.

If you are an American Indian, you have the right to get health care services at Indian Health Service facilities. You may also stay with or disenroll from Kaiser Permanente while getting health care services from these locations. American Indians have a right to not enroll in a Medi-Cal managed care plan or may leave their health plans and return to regular (fee-for-service) Medi-Cal at any time and for any reason. To find out more,

please call the Indian Health Service at **1-916-930-3927** or visit the Indian Health Service website at **www.ihs.gov**

How your plan works

Kern Family Health Care is a health plan contracted with the California Department of Health Care Services (“DHCS”).). Kern Family Health Care is a managed care health plan and Kaiser Permanente is your health care provider through Kern Family Health Care.

Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. Kaiser Permanente provides services to you through Kaiser Permanente network providers. They work together to give you quality care. When you choose Kaiser Permanente, you are choosing to get your care through our medical care program. You must get most services from Kaiser Permanente network providers. The only services you can get from out of network providers are:

- Care at an Indian Health Service facility
- Covered emergency ambulance services
- Covered emergency services and post-stabilization care
- Covered family planning services
- Covered out-of-area urgent care
- Referrals to out of network providers
- Some covered sensitive services
- Medically necessary immunizations at local health departments

Note: You may be able to receive certain services from a Federally Qualified Health Center (FQHC). Call Kern Family Health Care for more information on FQHC services.

A Kaiser Permanente member services representative can help you understand:

- How Kaiser Permanente works
- How to get the care you need
- How to schedule provider appointments, and
- How to find out if you qualify for transportation services

To learn more, call **1-800-464-4000** (TTY **711**). You can also find member service information online at **kp.org**.

To learn about Kern Family Health Care, call them at **1-800-391-2000** (TTY **711**). You can also find member service information online at **www.kernfamilyhealthcare.com**

Changing provider organizations

You may leave Kaiser Permanente and change to a different Kern Family Health Care provider at any time. Call Kern Family Health Care at **1-800-391-2000** (TTY **711**), Monday through Friday, 8 a.m. to 5 p.m. Tell them you want to change health care providers. This change will not happen right away. Most of the time, it will happen on the first day of the next month. Kern Family Health Care will let you know when your new provider assignment starts. Until then, you must get services from Kaiser Permanente.

If you want to leave Kaiser Permanente sooner, you may ask Kern Family Health Care for an expedited (fast) reassignment. If the reason for your request meets the rules for expedited reassignment, you will get a letter to tell you that you are reassigned.

Changing health plans

You may leave Kern Family Health Care and join another health plan at any time. Call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077**) to choose a new plan. You can call Monday through Friday, 8 a.m. to 5 p.m., or visit **www.healthcareoptions.dhcs.ca.gov**.

It takes up to 45 days to process your request to leave Kern Family Health Care. To find out when Health Care Options has approved your request, call **1-800-430-4263** (TTY 1**-800-430-7077**).

If you want to leave Kern Family Health Care sooner, you may ask Health Care Options for an expedited (fast) disenrollment. If the reason for your request meets the rules for expedited disenrollment, you will get a letter to tell you that you are disenrolled.

Beneficiaries that can request expedited disenrollment include, but are not limited to:

- Children receiving services under the Foster Care or Adoption Assistance Programs

- Members with special health care needs, including, but not limited to major organ transplants
- Members already enrolled in another Medi Cal, Medicare or commercial managed care plan

You may ask to leave Kern Family Health Care in person at your local county health and human services office. Find your local office at **www.dhcs.ca.gov/services/medical/Pages/CountyOffices.aspx** or call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077**).

College students who move to a new county

If you move to a new county in California to attend college, we will only cover emergency services and urgent care in your new county. Emergency services and urgent care are available to all Medi-Cal enrollees statewide regardless of county of residence.

If you are enrolled in Medi-Cal and will attend college in a different county, you do not need to apply for Medi-Cal in that county. There is no need for a new Medi-Cal application as long as you are still under 21 years of age, are only temporarily out of the home and are still claimed as a tax dependent in the household.

When you temporarily move away from home to attend college, there are two options available to you. You may:

- Notify your local county social services office that you are temporarily moving to attend college and provide your address in the new county. The county will update the case records with your new address and county code in the State's database. If Kern Family Health Care does not operate in the new county, you will have to change your health plan to the available options in the new county. For additional questions and to prevent a delay in the new health plan enrollment, you should contact Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077**) for assistance with enrollment.

OR

- Choose not to change your health plan when you temporarily move to attend college in a different county. You will only be able to access emergency room or urgent care in the new county. For routine or preventive health care, you would need to use the Kaiser Permanente provider network in the Kern Family Health Care Service Area. An exception to this is if Kern Family Health Care operates in your new county of residence, as described above, and you

get services from a Kaiser Permanente network provider in your new county of residence.

Continuity of care

If you now see providers who are not in the Kaiser Permanente network, you may be able to keep seeing them for up to 12 months in certain situations.

The types of situations that may qualify you for getting services from an out of network provider include:

- You have a mental health condition that requires services that we are responsible to provide
- You were required to transition from Covered California to Medi-Cal
- You are a new member who qualifies for Medi-Cal as a Senior or Person with Disability ("SPD") and have an active Fee-For-Service Treatment Authorization Request
- You have an existing relationship with a Behavioral Health Treatment provider
- You asked DHCS for a medical exemption and it was denied
- You are taking a single source drug that is a part of a prescribed therapy, if it was prescribed immediately before the date of your enrollment

You may also qualify if you are getting active care for one of the following conditions before you enrolled:

- **An acute condition.** We may cover these services until the acute condition ends
- **A serious chronic condition.** We may cover services until the earlier of (1) 12 months from the date you were enrolled into Kaiser Permanente; or (2) the first day after a course of treatment is complete when it would be safe to transfer your care to a network provider, as determined by Kaiser Permanente after talking with you and the out of network provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - ♦ It persists without full cure
  - ♦ It gets worse over a long period of time
  - ♦ It requires ongoing treatment to maintain remission or prevent the

condition from getting worse

- **Pregnancy (including immediate postpartum care).** We may cover these services while you are pregnant and right after you give birth
- **Terminal illness.** We may cover these services for the duration of the illness. Terminal illnesses are illnesses that cannot be cured or reversed and are likely to cause death within a year or less
- **Care for children under age 3.** We may cover these services until the earlier of (1) 12 months from the date the child was enrolled into Kaiser Permanente; or (2) the child's third birthday
- **Surgery or another procedure that is part of a course of treatment.** The care must be recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or 180 days of the date the provider's contract ended

To find out if you qualify to get services from an out of network provider or want more information, call member services at **1-800-464-4000** (TTY **711**).

Providers who leave Kaiser Permanente

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

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

If you are getting covered services from a network hospital or a network doctor (or certain other providers) when our contract with the provider ends (except if the contract ended for cause), you may be able to keep getting some services from that provider for:

- **Acute conditions**. We may cover these services until the acute condition ends
- **Serious chronic conditions.** We may cover services until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the first day after a course of treatment is complete when it would be safe to transfer your care to a network provider, as determined by Kaiser Permanente after talking with the member and out of network provider and consistent with good professional practice. Serious chronic conditions are illnesses or other

medical conditions that are serious, if one of the following is true about the condition:

- ♦ It persists without full cure
- ♦ It gets worse over a long period of time
- ♦ It requires ongoing treatment to maintain remission or prevent the condition from getting worse

- **Maternity care.** We may cover these services while you are pregnant and right after you give birth
- **Terminal illnesses.** We may cover these services for the duration of the illness. Terminal illnesses are illnesses that cannot be cured or reversed and are likely to cause death within a year or less
- **Care for children under age 3.** We may cover these services until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the child's third birthday
- **Surgery or another procedure that is part of a course of treatment.** The care must be recommended and documented by the provider to occur within 180 days of the date the provider's contract ended

Kaiser Permanente provides continuity of care services if:

- Your Kaiser Permanente coverage is in effect on the date you receive the service
- You are getting services from a provider whose contract has ended on the provider's termination date
- The provider agrees in writing to our contract 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 the services within 30 days (or as soon as you can) from the date the provider's contract ended

Kaiser Permanente does **not** provide continuity of care services if:

- The services are not covered by Medi-Cal
- Your provider won’t work with Kaiser Permanente. You will need to find a new provider

To learn more about continuity of care and eligibility qualifications, call member services at **1-800-464-4000** (TTY **711**).

Costs

Member costs

Kern Family Health Care serves people who qualify for Medi-Cal. Kern Family Health Care members do **not** have to pay for covered services. You will not have premiums or deductibles. For a list of covered services, see Chapter 4 ("Benefits and services").

How a provider gets paid

Kaiser Permanente pays providers in these ways:

- Capitation payment
  - Some providers are paid a set amount of money every month for each member. This is called a capitation payment.
- Fee-for-service
  - Some providers give care to Kaiser Permanente members and then send Kaiser Permanente a bill for the services they provided. This is called a fee-for-service payment.

To learn more about how Kaiser Permanente pays providers, visit our website at **kp.org** or call **1-800-464-4000** (TTY **711)**.

Asking Kaiser Permanente to pay a bill

If you get a bill for a covered service, call member services right away at **1-800-464-4000** (TTY **711**).

If you pay for a service that you think Kaiser Permanente should cover, you can file a claim. Use a claim form and tell us in writing why you had to pay. Call **1-800-464-4000** or **1-800-390-3510** (TTY **711**) to ask for a claim form. Kaiser Permanente will review your claim to see if you can get money back.

To file a claim for payment or to get money back, this is what you need to do:

- As soon as you can, send us a completed claim form. You can get a claim form online the following ways:
  - On our website at **kp.org**
  - In person from any Member Services office at a Plan Facility and from

Plan Providers. You can find addresses in the facility directory on our website at **kp.org**

- By calling our Member Service Contact Center at **1-800-464-4000** or **1-800-390-3510** (TTY **711**)

- We will be happy to help you if you need help completing our claim form
- If you have paid for services, you must include any bills and receipts from the out of network provider with your claim form
- If you want us to pay the out of network provider for services, you must include any bills from the out of network provider with your claim form. If you later get any bills from the out of network provider, please call member services at **1-800-390-3510** (TTY **711**) for help
- You must send us the completed claim form as soon as you can after getting the care

The completed claim form and any bills or receipts must be mailed to:

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

3. How to get care

Getting health care services

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

You can begin to get health care services on the effective date of your assignment to Kaiser Permanente. This is a summary of Kaiser Permanente's rules and policies and based on the contract between Kaiser Permanente and Kern Family Health Care.

Always carry your Kaiser Permanente ID card, your Kern Family Health Care ID Card, and Medi-Cal BIC card with you. Never let anyone else use your ID cards or BIC card.

Kaiser Permanente provides services to members through Kaiser Permanente network providers. They work together to provide you with quality care. When you choose Kaiser Permanente, you are choosing to get your care through our medical care program. To find where Kaiser Permanente network providers are located, visit our website at **kp.org/facilities.**

New members must choose a primary care provider ("PCP") who is in the Kaiser Permanente network and in the Kern Family Health Care Service Area. You must choose a PCP within 30 days from the time you are assigned to Kaiser Permanente. If you do not choose a PCP, we will choose one for you.

You may choose the same PCP or different PCPs for all family members assigned to Kaiser Permanente.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in the Provider Directory. It has a list of all PCPs in the Kaiser Permanente network. The Provider Directory has other information to help you choose. If you need a Provider Directory, call **1-800-464-4000** (TTY **711**). You can also find a Provider Directory on our website at **kp.org/facilities**.

If you cannot get the care you need from a Kaiser Permanente network provider, your PCP must ask the Medical Group for approval to send you to an out-of-network

provider. You do not need approval to go to an out-of-network provider to get sensitive services that are described under the heading “Sensitive care” later in this chapter.

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

Initial health assessment (IHA)

Kaiser Permanente recommends that, as a new member, you see your new PCP in the next 90 days for an initial health assessment (IHA). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP may ask you some questions about your health history or may ask you to complete a questionnaire. Your PCP will also tell you about health education counseling and classes that may help you.

When you call to schedule your IHA, tell the person who answers the phone that you are a member of Kaiser Permanente. Give your Kaiser Permanente medical record number.

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

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

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups, health education, and counseling. In addition to preventive care, routine care also includes care when you are sick. Kaiser Permanente covers routine care from your PCP.

Your PCP will:

- Give you all your routine care, including regular checkups, shots, treatment, prescriptions and medical advice
- Keep your health records
- Refer (send) you to specialists, if needed
- Order X-rays, mammograms or lab work if you need them

When you need routine care, you can call your local Plan Facility or make an appointment online. For appointment phone numbers, please refer to the facility directory on our website at **kp.org**. To request an appointment online, go to our website at **kp.org**.

For an emergency, call **911** or go to the nearest emergency room.

To learn more about health care and services we cover, and what we do not cover, read Chapter 4 ("Benefits and services") in this Member Handbook.

Urgent care

Urgent care is care you need within 24 hours, but it is **not** an emergency or life threatening. Urgent care needs could be a cold or sore throat, fever, ear pain or a sprained muscle.

For urgent care, call your PCP. If you cannot reach your PCP, call **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

If you need urgent care out of the area, go to the nearest urgent care facility. You do not need pre-approval (prior authorization). If you are traveling outside the United States and need urgent care, Medi-Cal will not pay for your care.

If your care is a mental health urgent care concern, contact the county Mental Health Plans toll-free telephone number that is available 24 hours a day, 7 days a week. To locate all counties toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.**

We do not cover follow-up care from out of network providers after you no longer need Urgent Care, except for covered durable medical equipment. If you need durable medical equipment related to your Urgent Care, your out-of-network provider must obtain pre-approval from us.

Emergency care

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

Emergency care is for emergency medical conditions. It is for an illness or injury that a reasonable layperson (not a health care professional) with average knowledge of health

and medicine could expect that, if you don't get care right away, your health (or your unborn baby's health) could be in danger, or a body function, body organ or body part could be seriously harmed. Examples include:

- Active labor
- Broken bone
- Severe pain, especially in the chest
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency condition

Do not go to the ER for routine care. You should get routine care from your PCP, who knows you best. If you are not sure if it is an emergency, call your PCP. You may also call **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in the Kaiser Permanente network. If you go to an ER, ask them to call Kaiser Permanente. You or the hospital to which you were admitted should call Kaiser Permanente within 24 hours after you get emergency care.

If you need emergency transportation, call **911**. You do not need to ask your PCP or Kaiser Permanente first before you go to the ER.

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

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

Post-stabilization care

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

- The DME item is covered under this Member Handbook
- It is medically necessary for you to have the DME item after you leave the hospital
- The DME item is related to the emergency care you received in the hospital

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

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

To request pre-approval for you to receive post-stabilization care from an out of network provider, the provider must call us at **1-800-225-8883** (TTY **711**). 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 needed 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.

Sensitive care

Minor consent services

You can see a doctor without consent from your parents or guardian for these types of care:

- Outpatient mental health (only minors 12 years or older) for:
  - Sexual or physical abuse

    - ♦ When you may hurt yourself or others
- Pregnancy
- Family planning (except sterilization)
- Sexual assault, including rape
- HIV/AIDS testing (only minors 12 years or older)
- Sexually transmitted infections (only minors 12 years or older)
- Substance use disorder treatment services (only minors 12 years or older)

The doctor or clinic does not have to be part of the Kaiser Permanente network and you do not need a referral from your PCP to get these services. For help finding a doctor or clinic giving these services, you can call **1-800-464-4000** (TTY **711**). You may also call **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

Minors can talk to a representative in private about their health concerns by calling **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

Adult sensitive services

As an adult, you may not want to see your PCP for sensitive or private care. If so, you may choose any doctor or clinic for these types of care:

- Family planning
- HIV/AIDS testing
- Sexually transmitted infections

The doctor or clinic does not have to be part of the Kaiser Permanente network. Your PCP does not have to refer you for these types of services. For help finding a doctor or clinic giving these services, you can call **1-800-464-4000** (TTY **711**). You may also call **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

Advance directives

An advance health directive is a legal form. On it you can list what health care you want in case you cannot talk or make decisions later on. You can list what care you do **not**

want. You can name someone, such as a spouse, to make decisions for your health care if you cannot.

You can get an advance directive form at drugstores, hospitals, law offices and doctors' offices. You may have to pay for the form. You can also find and download a free form online. You can ask your family, PCP or someone you trust to help you fill out the form.

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

You have the right to learn about changes to advance directive laws. Kaiser Permanente will tell you about changes to the state law no longer than 90 days after the change.

Where to get care

You will get most of your care from your PCP. Your PCP will give you all of your routine preventive (wellness) care. You will also see your PCP for care when you are sick. Be sure to call your PCP before you get medical care. Your PCP will refer (send) you to specialists if you need them.

To find where Kaiser Permanente network providers are located, visit our website at **kp.org/facilities** or call member services at **1-800-464-4000** (TTY **711**).

To get help with your health questions, you can also call **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

If you need urgent care, call your PCP. Urgent care is care you need soon but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain or sprained muscle.

For emergencies, call **911** or go to the nearest emergency room.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group,

independent practice association, or clinic, or call the health plan at 1-800-464-4000 (TTY 711) to ensure that you can obtain the health care services that you need.

Provider Directory

The Kaiser Permanente Provider Directory lists providers that participate in the Kaiser Permanente network. The network is the group of providers that work with Kaiser Permanente.

The Kaiser Permanente Provider Directory lists hospitals, pharmacies, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, and family planning providers.

The Provider Directory has names, provider addresses, phone numbers, business hours and languages spoken. It tells you whether the provider is taking new patients. It gives the level of physical accessibility for the building.

You can find the online Provider Directory at **kp.org/facilities**.

If you need a printed Provider Directory, call **1-800-464-4000** (TTY **711**).

Provider network

The provider network is the group of doctors, hospitals and other providers that work with Kaiser Permanente. You will get your covered services through the Kaiser Permanente network.

Kaiser Permanente is your health care provider through Kern Family Health Care. When you choose Kaiser Permanente, you are choosing to get your care through our medical care program. You must get most services from our network providers.

If your provider in the network, including a PCP, hospital or other provider, has a moral objection to providing you with a covered service, such as family planning or abortion, call **1-800-464-4000** (TTY **711**). See Chapter 4 ("Benefits and services") for more about moral objections.

If your provider has a moral objection, he or she can help you find another provider who will give you the services you need. Kaiser Permanente can also work with you to find a provider.

In network

You will use providers in the Kaiser Permanente network for your health care needs. You will get preventive and routine care from your PCP. You will also use specialists, hospitals and other providers in the Kaiser Permanente network.

To get a Provider Directory of network providers, call **1-800-464-4000** (TTY **711**). You can also find the Provider Directory online at **kp.org/facilities**.

For emergency care, call **911** or go to the nearest emergency room.

Except for emergency care, you may have to pay for care from providers who are out of network.

Out of network

Out-of-network providers are those that do not have an agreement to work with Kaiser Permanente. Except for covered emergency care and covered urgent care, you may have to pay for care from providers who are out of network. If you need covered health care services, you may be able to get them out of network at no cost to you as long as they are medically necessary, not available in the network, and pre-approved by the Medical Group. You do not need approval to go to an out-of-network provider to get sensitive services that are described under the heading “Sensitive care” earlier in this chapter.

If you need help with out-of-network services, call **1-800-464-4000** (TTY **711**).

If you are outside of the Kern Family Health Care Service Area and need care that is **not** emergency care or urgent care, call your PCP right away. You can also call **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week). If you are traveling outside of the United States and need urgent care, Medi-Cal will not pay for your care.

For emergency care, call **911** or go to the nearest emergency room. Kaiser Permanente covers out-of-network emergency care. If you travel to Canada or Mexico and need emergency services requiring hospitalization, Kaiser Permanente will cover your care. If you are traveling internationally outside of Canada or Mexico and need emergency care, Kaiser Permanente will not cover your care in most cases.

If you have questions about out-of-network or out-of-area care, call **1-800-464-4000** (TTY **711**).

Doctors

You will choose a primary care provider (PCP) from the Kaiser Permanente Provider Directory. Your PCP must be a participating provider. This means the provider is in the Kaiser Permanente network. To get a copy of the Kaiser Permanente Provider Directory, call **1-800-464-4000** (TTY **711**).

You should also call if you want to check to be sure the PCP you want is taking new patients.

If you were seeing a doctor before you were a member of Kaiser Permanente, you may be able to keep seeing that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this Member Handbook. To learn more, call **1-800-464-4000** (TTY **711**).

If you need a specialist, your PCP will give you a referral to a specialist in the Kaiser Permanente network.

Remember, if you do not choose a PCP, we will choose one for you. You know your health care needs best, so it is best if you choose.

If you want to change your PCP, you must choose a PCP from the Kaiser Permanente Provider Directory. Be sure the PCP is taking new patients. To learn how to select or change to a different PCP, please visit our website at **kp.org**, or call member services at **1-800-464-4000** (TTY **711**). You can find a directory of our Plan Physicians on our website at **kp.org/facilities**.

Hospitals

In an emergency, call **911** or go to the nearest hospital.

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in the network. The hospitals in the Kaiser Permanente network are listed in the Provider Directory.

Primary care provider (PCP)

You must choose a PCP within 30 days of being assigned to Kaiser Permanente. Depending on your age and sex, you may choose a general practitioner, Ob/Gyn, family practitioner, internist or pediatrician as your primary care physician. A nurse practitioner

(NP), physician assistant (PA) or certified nurse midwife may also act as your primary care provider. If you choose a NP, PA or certified nurse midwife, you may be assigned a physician to oversee your care.

You can also choose to get your primary health care at a Federally Qualified Health Center ("FQHC") or a Rural Health Clinic ("RHC"). These health centers are located in areas that do not have many health care services. If you want to get your health care at an FQHC on a regular basis you must change your health care provider and choose an FQHC doctor as your PCP through Kern Family Health Care. Call Kern Family Health Care member services at **1-800-391-2000** (TTY **711**) to learn more.

Depending on the type of the provider, you may be able to choose one PCP for your entire family who are members of Kaiser Permanente. If you do not choose a PCP within 30 days, we will assign you to a PCP. If you are assigned to a PCP and want to learn how to change, call member services **at 1-800-464-4000 (**TTY **711).** The change happens the first day of the next month.

Your PCP will:

- Get to know your health history and needs
- Keep your health records
- Give you the preventive and routine health care you need
- Refer (send) you to a specialist if you need one
- Arrange for hospital care if you need it

You can look in the Provider Directory to find a PCP in the Kaiser Permanente network. The Provider Directory has a list of providers that work with Kaiser Permanente.

You can find the Kaiser Permanente Provider Directory online at **kp.org/facilities**. You can also call **1-800-464-4000** (TTY **711**).

Choice of physicians and providers

You know your health care needs best, so it is best if you choose your PCP.

It is best to stay with one PCP so he or she can get to know your health care needs. However, if you want to change to a new PCP, you can change anytime. You must choose a PCP who is in the Kaiser Permanente provider network and is taking new patients.

To learn how to select or change your PCP, call **1-800-464-4000** (TTY **711**).

We may ask you to change your PCP if the PCP is not taking new patients, has left our network, or does not give care to patients your age. We may also ask Kern Family Health Care to reassign you to a different provider in their network if you cannot get along with or agree with your doctor, or if you miss or are late to appointments. If Kern Family Health Care reassigns you to a different provider, they will tell you in writing.

Appointments and visits

When you need health care:

- Call your PCP
- Have your Kaiser Permanente medical record number (located on your Kaiser Permanente ID card) ready when you call
- Leave a message with your name and phone number if the office is closed
- Take your BIC card, Kaiser Permanente ID card, and photo ID to your appointment
- Be on time for your appointment
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

If you have an emergency, call **911** or go to the nearest emergency room.

Telehealth visits

Telehealth visits are designed to make it more convenient for you to get covered Services. If your doctor decides a telehealth visit is appropriate for you, he or she may give you the option of a telehealth visit. Telehealth visits are not available for all medical conditions or for all covered services. You are not required to use Telehealth visits.

Payment

You do **not** have to pay for covered services. In most cases, you will not get a bill from a provider. You may get an Explanation of Benefits (“EOB”) or a statement from Kaiser Permanente. EOBs and statements are not bills.

If you do get a bill, call **1-800-464-4000** (TTY **711**). Tell us the amount charged, the date of service and the reason for the bill. You are **not** responsible to pay a provider for any amount owed by Kaiser Permanente for any covered service.

If you get a bill or are asked to pay a copay when you feel you shouldn't have to, you can also file a claim form. You will need to tell us in writing why you had to pay for the item or service. We will read your claim and decide if you can get money back. You can get a claim form online at **kp.org**. You can also call member services at **1-800-464-4000** (TTY **711)**. We will be happy to help you if you need help completing our claim form.

Referrals

Your PCP will give you a referral to send you to a specialist if you need one. A specialist is a doctor who has extra education in one area of medicine. Your PCP will work with you to choose a specialist. Your PCP's office can help you set up a time to see the specialist.

Examples of specialists that require a referral include:

- Surgery
- Orthopedics
- Cardiology
- Oncology
- Dermatology
- Physical, occupational, and speech therapies

Also, your PCP must refer you before you can get care from qualified autism service providers.

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

If you have trouble getting a standing referral or want a copy of the Kaiser Permanente referral policy, call **1-800-464-4000** (TTY **711**).

You do not need a referral for:

- PCP visits

- Generalists in adult medicine, family practice, and pediatrics
- Specialists in optometry, mental health, and substance use disorder treatment
- Ob/Gyn visits
- Urgent or emergency care visits
- Family planning (To learn more, call California Family Planning Information and Referral Service at 1-800-942-1054)
- HIV testing and counseling (only minors 12 years or older)
- Treatment for sexually transmitted infections (only minors 12 years or older)
- Acupuncture services
- Podiatry services
- Chiropractic services

Minors also do not need a referral for:

- Outpatient mental health (only minors 12 years or older) for:
  - Sexual or physical abuse
  - When you may hurt yourself or others
- Pregnancy care
- Sexual assault care, including rape
- Substance use disorder treatment services (only minors 12 years or older)

Although a referral or pre-approval is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get pre-approval for certain services
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Pre-approval

For some types of care, your PCP or specialist will need to ask the Medical Group for permission before you get the care. This is called asking for prior authorization, prior approval, or pre-approval. It means that the Medical Group must make sure that the care is medically necessary or needed.

Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or alleviates severe pain through the diagnosis or treatment of disease, illness or injury.

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

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from network providers
- Transplants
- Out-of-Network Services, including hospitalization (except for sensitive services)

For the complete list of services that require pre-approval, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call member services at **1-800-464-4000** (TTY **711**).

You never need pre-approval for emergency care, even if it is out of network. This includes having a baby.

For some services, you need pre-approval (prior authorization). Under Health and Safety Code Section 1367.01(h)(1), the Medical Group will decide routine pre-approvals within 5 working days of when the Medical Group gets the information reasonably needed to decide.

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

Kaiser Permanente does **not** pay the reviewers to deny coverage or services. If the Medical Group does not approve the request, we will send you a Notice of Action ("NOA") letter. The NOA letter will tell you how to file an appeal if you do not agree with the decision.

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

Second opinions

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

To get a second opinion, call your PCP. Your PCP can refer you to a network provider who is an appropriately qualified medical professional for your medical condition for a second opinion. You may also call **1-800-464-4000** (TTY **711**) to help you arrange one with a network provider.

We will pay for a second opinion if you or your network provider asks for it and you get the second opinion from a network provider. You do not need permission from us to get a second opinion from a network provider.

If there is no provider in the Kaiser Permanente network to give you a second opinion, we will pay for a second opinion from an out-of-network provider. If there isn't a network provider who is an appropriately qualified medical professional for your condition, member services will help you arrange a consultation with an out of network provider for a second opinion. We will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic illness or could lose your life, limb or major body part, we will decide within 72 hours.

If we deny your request for a second opinion, you may file a complaint (or grievance). To learn more about complaints, see Chapter 6 (“Reporting and solving problems”) in this Member Handbook.

Women’s health specialists

You may go to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive health care services. You do not need a referral from your PCP to get these services. For help finding a women’s health specialist, you can call **1-800-464-4000** (TTY **711**). You may also call **1-833-KP4CARE (1-833-574-2273)** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

Timely access to care

Appointment Type	Must Offer Appointment Within
Urgent care appointments (urgent care appointments do not require pre-approval)	48 hours
Non-urgent primary care appointments	10 business days
Non-urgent specialist	15 business days
Non-urgent mental health provider (non-physician)	10 business days
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	15 business days
Telephone wait times for member services during normal business hours	10 minutes
Triage – 24/7 services	24/7 services – No more than 30 minutes

If you prefer to wait for a later appointment that will better fit your schedule or to see the Kaiser Permanente provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to preventive services. Your doctor may recommend a specific schedule for preventive services, depending on your needs. The standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call our member service contact center.

4. Benefits and services

What your health plan covers

This section explains all your covered services as a member of Kaiser Permanente. Your covered services are free if they are medically necessary. Care is medically necessary if it is reasonable and necessary to protect life, keeps you from becoming seriously ill or disabled, or reduces pain through a diagnosis or treatment of disease, illness or injury.

You must get most services from Kaiser Permanente network providers. The only services you can get from out of network providers are the following:

- Care at an Indian Health Service facility
- Emergency ambulance services
- Emergency services and post-stabilization care
- Family planning services
- Out-of-area urgent care
- Referrals to out of network providers
- Some sensitive services

Note: You may be able to receive certain services from a Federally Qualified Health Center (FQHC). Call Kern Family Health Care for more information on FQHC services.

We offer these types of services:

- Outpatient (ambulatory) services
- Emergency services
- Hospice and palliative care
- Hospitalization
- Maternity and newborn care

- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory and imaging services
- Preventive and wellness services and chronic disease management
- Mental health services
- Substance use disorder services
- Pediatric services
- Vision services
- Investigational services
- Non-emergency medical transportation (“NEMT”)
- Non-medical transportation (“NMT”)
- Reconstructive surgery
- Long-term services and supports (“LTSS”)

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

The health care services provided to members of Kaiser Permanente are subject to the terms, conditions, limitations and exclusions of the contract between Kaiser Permanente and Kern Family Health Care and as listed in this Member Handbook and any amendments.

Medi-Cal benefits

Outpatient (ambulatory) services

- ***Allergy care***

  We cover medically necessary allergy testing and treatment, including allergy desensitization, hyposensitization, or immunotherapy.

- ***Chiropractic services***

  We cover two chiropractic services per month, limited to medically necessary treatment of the spine by manual manipulation for:

  - Children under age 21;

- Pregnant women through the first postpartum visit;
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility; or
- All members when services are provided at an FQHC or RHC

- ***Dialysis/hemodialysis services***

  We cover medically necessary dialysis treatments. We also cover hemodialysis (chronic dialysis) and peritoneal dialysis services. You must meet all medical criteria developed by the Medical Group and by the facility providing the dialysis.

- ***Outpatient surgery and other outpatient procedures***

  We cover medically necessary outpatient surgery and other outpatient procedures.

- ***Anesthesiologist services***

  We cover anesthesia services that are medically necessary when you receive outpatient care.

  For dental procedures, we cover the following services when authorized by the Medical Group:

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

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

- ***Physician services***

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

- ***Podiatry (foot) services***

  We cover podiatry services that are medically necessary. Podiatry services are limited to medical and surgical services to treat disorders of the feet, ankles, or

tendons that insert into the foot, secondary to or complicating chronic medical diseases, or affect your ability to walk.

- ***Treatment therapies***

  We cover medically necessary treatment therapies, including:

  - Chemotherapy
  - Radiation therapy
  - Administered drugs and products

Emergency services

- ***Inpatient and outpatient services needed to treat a medical emergency***

  We cover all services that are needed to treat a medical emergency. 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:

  - Serious risk to your health; ***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, meaning labor at a time when either of the following would occur:
    - ♦ There is not enough time to safely transfer you to another hospital before delivery
    - ♦ The transfer may pose a threat to your health or safety or to that of your unborn child

- ***Emergency transportation services***

  We cover ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life.

- ***Emergency room services***

  We cover emergency room services that are needed to treat a medical emergency. Remember, 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, it could result in serious harm to your health or body.

Hospice and palliative care

- ***Hospice care***

  Members who are dying can choose to get hospice care for their terminal illness. This care helps the discomforts of someone who is dying and also helps that person's caregiver and family.

  If you choose hospice care:

  - Adults age 21 years or older get care to relieve pain and other symptoms of their terminal illness, but not to cure the illness
  - Children under age 21 get care to relieve pain and other symptoms of their terminal illness and can choose to continue to get treatment for their illness

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

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

  - A network doctor has diagnosed you with a terminal illness and determines that your life expectancy is 6 months or less
  - The services are provided in an area where Kaiser Permanente has a license to operate, unless limited by the contract between Kaiser Permanente and Kern Family Health Care
  - The services are provided by a licensed hospice agency that is a network provider
  - A network doctor determines that the services are necessary for the palliation and management of your terminal illness and related conditions

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

  - Services of network doctors
  - Skilled nursing care, including evaluation and case management of nursing needs, treatment for pain and symptom control, emotional support for you and your family, and instruction to caregivers

- Physical, occupational, and speech therapy for symptom control or to help maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and help with eating, bathing, and dressing
- Drugs for pain control and to help with other symptoms of your terminal illness for up to a 100-day supply for each refill in accord with our drug formulary guidelines. You must obtain these drugs from a network pharmacy. For some drugs we cover a 30-day supply in any 30-day period. Call member services at **1-800-464-4000** (TTY **711**) for the current list of these drugs
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five days in a row at one time
- Counseling to help with loss
- Advice about diet

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

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

▪ ***Palliative care***

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.

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.

Hospitalization

- ***Anesthesiologist services***

  We cover medically necessary anesthesiologist services during hospital stays. An anesthesiologist is a provider who specializes in giving patients anesthesia. Anesthesia is a type of medicine used during some medical procedures.

- ***Inpatient hospital services***

  We cover medically necessary inpatient hospital care when you are admitted to the hospital. Services include room and board, drugs, equipment, imaging and laboratory services, and other services that the hospital ordinarily provides.

- ***Surgical services***

  We cover medically necessary surgeries performed in a hospital.

Maternity and newborn care

We cover these maternity and newborn care services when medically necessary:

- ***Breastfeeding education***

  We cover comprehensive lactation support.

- ***Delivery and postpartum care***

  We cover services in the hospital and post-partum care.

- ***Nurse midwife services***

  We cover services of a certified nurse midwife.

- ***Prenatal care***

  We cover a series of prenatal care exams.

- ***Birthing center services***

  We cover services at birthing centers that are a Medi-Cal-approved Comprehensive Perinatal Services Program (CPSP) provider. Birthing center services are an alternative to hospital-based maternity care for women with low-

risk pregnancy. If you want to have your baby at one of these centers and to find out if you qualify, ask your doctor.

Prescription drugs

Covered drugs

We cover medically necessary items that require a prescription and certain items that are available over-the-counter. We cover items prescribed by network providers, within the scope of their license and practice, and in accord with our drug formulary guidelines.

Our drug formulary includes a list of drugs that are approved for our members. This is sometimes called a preferred drug list. Drugs on the formulary are safe and effective. A group of doctors and pharmacists periodically updates this list. Updating this list helps to make sure that the drugs on it are safe and work. We cover a drug that is not on the formulary for your condition if your doctor thinks it is medically necessary for you.

We also cover items prescribed by the following out of network providers:

- Dentists, if the drug is for dental care
- Out of network doctors, if the medical group authorizes a written referral to the out of network doctor and the item is covered as part of that referral
- Out of network doctors, if the item is covered emergency services or out-of-area urgent care
    - ♦ An out of network pharmacist or hospital emergency room may give you up to a 72-hour emergency supply
- Out of network doctors, if the drug is related to Short-Doyle mental health services
- Out of network doctors, if the drug is related to specialty mental health services

To find out if a drug is on the formulary or to get a copy of the formulary, call **1-800-464-4000** (TTY **711**). You may also visit our website at **kp.org/formulary**.

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

Day supply limit

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

- ***Hormonal contraceptives***

  The prescribing doctor determines how much of a contraceptive drug or item to prescribe. For purposes of day supply coverage limits, network doctors determine the amount of contraceptives that constitute medically necessary 30-day or 100-day or 365-day supply for you. The most you may get at one time for hormonal contraceptives is a 365-day supply.

- ***All other items***

  The prescribing doctor or dentist determines how much of a drug, supply, or supplement to prescribe. Network doctors decide the amount of a drug, supply, or supplement that is a medically necessary 30- or 100-day supply for you. The most you may get at one time of a covered item is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. Amounts of drugs or items in excess of the day supply limit are not covered.

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

Pharmacies

You must get your prescriptions filled at a network pharmacy or through our mail order service (unless the item is part of covered emergency services or out-of-area urgent care). See the Provider Directory on our website at **kp.org/facilities** or call member services at **1-800-464-4000** (TTY **711**) for locations and hours of network pharmacies in your area.

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

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

Schedule II drugs

You or your doctor can tell a pharmacy to give you less than the prescribed amount of a covered Schedule II drug at one time. If you do not know if your prescription is for a Schedule II drug, you can ask your pharmacy.

Medicare Part D

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

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

Rehabilitative and habilitative services and devices

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

- The services are medically necessary
- The services are to address a health condition
- The services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the services at a network facility unless a network doctor determines that it is medically necessary for you to receive the services in another location

The plan covers:

- ***Acupuncture***

  We cover acupuncture services medically necessary to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a

generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of the needles) are limited to two services in any one month. If you want more than two visits in a month, you must get pre-approval (prior authorization) for those additional services.

- ***Behavioral health treatments***

  Behavioral health treatment (BHT) includes services and treatment programs, such as applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual.

  We cover BHT services if you are under 21 years of age, have behaviors that significantly interfere with home or community life (some examples include anger, violence, self-injury, running away, or difficulty with living skills, play and/or communication skills), and are medically stable.

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

  BHT services must be medically necessary, prescribed by a licensed doctor or psychologist, approved by the Medical Group, and provided in a way that follows the approved treatment plan. The treatment plan:

  - Must be developed by a network provider who is a qualified autism service provider and may be administered by a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional
  - Has measurable individualized goals over a specific timeline that are developed and approved by the qualified autism service provider for the member being treated
  - Is reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate
  - Ensures that interventions are consistent with evidence-based BHT techniques

- Includes care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable
- Includes parent/caregiver training, support, and participation
- Describes the member's behavioral health impairments to be treated and the outcome measurement assessment criteria used to measure achievement of behavior objectives
- Includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the member's progress is evaluated and reported
- Utilizes evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism

Note: BHT services shall be discontinued when the treatment goals and objectives are achieved or no longer appropriate

We do not cover:

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

If you have any questions call member services at **1-800-464-4000** (TTY **71**1).

- ***Cardiac rehabilitation***

  We cover inpatient and outpatient cardiac rehabilitative services.

- ***Durable medical equipment***

  Durable medical equipment requires pre-approval. We cover the purchase or rental of medical supplies, equipment and other services with a prescription from

a doctor if the item is medically necessary and has been pre-approved for you.

Coverage is limited to the standard item of equipment 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.

- ***Hearing aids***

  We cover hearing aids if you are tested for hearing loss, the hearing aids are medically necessary, and you receive a prescription from your doctor. Coverage is limited to the lowest cost aid that meets your medical needs. We will choose who will supply the 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. We cover ear molds needed for fitting, one standard battery package, visits to make sure the aid is working right, visits for cleaning and fitting, and repair of your hearing aid.

- ***Home health services***

  We cover health services provided in your home, when medically necessary and prescribed by your doctor, when all of the following are true:

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

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

  - Part-time skilled nursing care
  - Part-time home health aide
  - Medical social services
  - Medical supplies

- ***Medical supplies, equipment and appliances***

  We cover medically necessary medical supplies that are approved by a doctor, including implanted hearing devices. Ostomy and urological supplies must be pre-approved for you.

- ***Occupational therapy***

  We cover medically necessary occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction and consultative services.

- ***Orthotics/prostheses***

  We cover medically necessary orthotic and prosthetic appliances and services that are prescribed by your doctor if the items are pre-approved for you. Coverage is limited to the standard item of equipment that adequately meets your medical needs. We select the vendor.

- ***Physical therapy***

  We cover medically necessary physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications.

- ***Pulmonary rehabilitation***

  We cover pulmonary rehabilitation that is medically necessary and prescribed by a doctor.

- ***Skilled nursing facility services***

  We cover skilled nursing facility services as medically necessary, if you are disabled and need a high level of care. These services include room and board in a licensed facility with skilled nursing care on a 24 hour per day basis.

  We cover skilled nursing facility services for the month of admission and the next month.

- ***Speech therapy***

  We cover speech therapy that is medically necessary. You may have limitations on how many visits to a speech therapist you get every month.

Laboratory and imaging services

We cover outpatient and inpatient laboratory and x-ray services. Various advanced imaging procedures are covered based on medical necessity.

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- Health Resources and Service Administration's Bright Futures recommendations
- Preventive services for women recommended by the Institute of Medicine
- Smoking cessation services
- United States Preventive Services Task Force A and B recommended preventive services

Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Food and Drug Administration. As a member, you pick a doctor who is located near you and will give you the services you need.

Kaiser Permanente's PCP and Ob/Gyn specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with Kaiser Permanente without having to get a referral or pre-approval. We will pay that doctor or clinic for the family planning services you get.

Mental health services

The plan covers:

- ***Outpatient mental health services***

  We cover mental health services provided by a network provider. You do not need a referral to see a mental health specialist within the Kaiser Permanente network. A mental health specialist can determine your level of impairment. If your mental health screening results determine you are in mild or moderate distress or have impairment of mental, emotional, or behavioral functioning, we can provide mental health services. We cover these mental health services:

- Outpatient mental health services
  - Individual and group mental health evaluation and treatment (psychotherapy)
  - Psychological testing when necessary to evaluate a mental health condition
  - Outpatient services for the purpose of monitoring drug therapy
  - Psychiatric consultation
- Outpatient drugs to treat your mental health condition (see “Prescription drugs”)
- Imaging and laboratory services related to treatment of your mental health condition (see “Laboratory and imaging services”)

For help finding more information on mental health services provided by Kaiser Permanente you can call **1-800-464-4000** (TTY **711**).

If your mental health screening results determine you need specialty mental health services (SMHS), your doctor will refer you to the county mental health plan to receive an assessment.

- ***Specialty mental health services***

  County mental health plans provide specialty mental health services (SMHS) to Medi-Cal beneficiaries who meet medical necessity criteria. SMHS may include the following inpatient and outpatient services:

  - 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
    - Intensive care coordination (ICC)

- ♦ Intensive home-based services (IHBS)
- ♦ Therapeutic foster care (TFC)

- 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

For help finding more information on specialty mental health services provided by the county mental health plan, you can call the county. To locate all counties toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.**

Substance use disorder treatment services

We cover:

- Outpatient alcohol misuse screenings, brief intervention, and referral to treatment when provided by a PCP
- Care in an inpatient hospital for medically necessary management of withdrawal symptoms

For any other substance use disorder treatment services, including residential services, you must get these services from your county mental health plan. To locate your county's mental health plan's toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx**.

Pediatric services

Kaiser Permanente covers:

- Early and periodic screening, diagnostic and treatment (EPSDT) services.
- If you or your child are under 21 years old, Kaiser Permanente covers well-child visits. Well-child visits are a comprehensive set of preventive, screening, diagnostic, and treatment services.

- We will make appointments and provide transportation to help children get the care they need.
- Preventive care can be regular health check-ups and screenings to help your doctor find problems early. Regular check-ups help your doctor look for any problems with your medical, dental, vision, hearing, mental health, and any substance use disorders. Kaiser Permanente covers screening services any time there is a need for them, even if it is not during your regular check-up. Also, preventive care can be shots you or your child need. Kaiser Permanente must make sure that all enrolled children get needed shots at the time of any health care visit.
- When a problem physical or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem. If the care is medically necessary and we are responsible for paying for the care, then Kaiser Permanente will cover the care at no cost to you. These services include:
  - Doctor, nurse practitioner, and hospital care
  - Shots to keep you healthy
  - Physical, speech/language, and occupational therapies
  - Home health services, which could be medical equipment, supplies, and appliances
  - Treatment for vision and hearing, which could be eyeglasses and hearing aids
  - Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
  - Case management, targeted case management, and health education
  - Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.

If the care is medically necessary and Kaiser Permanente is not responsible for paying for the care, then we will help you get the right care you need. These services include:

- Treatment and rehabilitative services for mental health and substance use disorders
- Treatment for dental issues, which could be orthodontics
- Private duty nursing services

Vision services

We cover:

- Eyeglasses for members who qualify, as determined by Kaiser Permanente :
- Routine eye exam once in 24 months

If you qualify, we cover the following services:

- ***Eyeglasses***
  - Eyeglasses (frame and lenses) every 24 months when you have a prescription of at least 0.75 diopter
  - Replacement eyeglasses within 24 months if you have a change in prescription of at least 0.50 diopter or your eyeglasses are lost, stolen, or broken (and cannot be fixed), and it was not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken. The replacement frames will be the same style as your old frames (up to $80) if less than 24 months have passed since you got your eyeglasses

- ***Lenses***
  - If you are under the age of 21, eyeglass lenses are provided by the state
  - If you are age 21 or older, we cover regular eyeglass lenses when prescribed and obtained from a network provider. Regular eyeglass lenses are lenses that meet all of the following requirements:
    - ♦ They are clear glass, clear plastic, or clear polycarbonate lenses
    - ♦ At least one of the two lenses has a refractive value of .075 diopters or more
    - ♦ They are single vision, flat top multifocal, or lenticular
  - We cover a clear balance lens when only one eye needs correction.
  - If you choose lenses that are not covered by Medi-Cal (for example photochromatic lenses) or lens treatment (such as tints, unless medically necessary, or anti-reflective coating) you must pay the cost of these services.

- ***Frames***

  New or replacement frames that cost $80 or less. If you choose frames that cost more than $80, you must pay the difference between the cost of the frames and $80.

- ***Special Contact Lenses***
  - For aniridia (missing iris), two medically necessary contact lenses (including fitting, and dispensing) per eye every 12 months
  - One pair of medically necessary contact lenses (other than contact lenses for aniridia) every 24 months if a network doctor or optometrist finds that they will give you much better vision than you could get with eyeglasses alone
  - Replacement of medically necessary contact lenses within 24 months if your contact lenses are lost or stolen. You must give us a note that tells us how your contact lenses were lost or stolen

Investigational services

Investigational services are drugs, equipment, procedures or other medical services that are being studied in humans to determine if they are effective and safe. We cover investigational services only when all of the following conditions are met:

- Standard treatment will not adequately treat the condition
- Standard treatment will not prevent progressive disability or premature death
- The provider of the service has a strong safety and success record
- The service is not part of a research study protocol
- There is reasonable expectation that the service will significantly prolong life or will maintain or restore activities of daily living function

All investigational services require pre-approval. See "Independent Medical Review" in Chapter 6 ("Reporting and solving problems") to learn about independent medical review of requests for investigational services.

Non-emergency medical transportation (“NEMT”)

You are entitled to use non-emergency medical transportation (“NEMT”) when you physically or medically are not able to get to your medical appointment by car, bus, train or taxi, and Kaiser Permanente pays for your medical or physical condition. Before getting NEMT, you need to request the service through your doctor and they will prescribe the correct type of transportation to meet your medical condition.

NEMT is an ambulance, litter van, wheelchair van or air transport. NEMT is not a car, bus or taxi. Kaiser Permanente allows the lowest cost NEMT for your medical needs

when you need a ride to your appointment. That means, for example, if you are physically or medically able to be transported by a wheelchair van, we will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation not possible.

NEMT must be used when:

- It is physically or medically needed as determined with a written authorization by a physician; or you are not able to physically or medically use a bus, taxi, car or van to get to your appointment
- You need assistance 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 network doctor determines that you need NEMT, he or she will prescribe the NEMT that best meets your needs. We will call you to schedule your transportation.

Limits of NEMT

There are no limits for receiving NEMT to or from medical appointments covered by Kaiser Permanente when a provider has prescribed it for you. If the appointment type is covered by Medi-Cal but not through Kaiser Permanente, we will refer you and coordinate your transportation (if available).

What does not apply?

Transportation will not be provided if your physical and medical condition allows you to get to your medical appointment by car, bus, taxi, or other easily accessible method of transportation. Transportation will not be provided if the service is not covered by Medi-Cal. A list of covered services is in this Member Handbook.

Cost to member

There is no cost when transportation is authorized by us.

Non-medical transportation (“NMT”)

You can use non-medical transportation (“NMT”) when you are traveling to and from an appointment for a Medi-Cal covered service.

Kaiser Permanente allows you to use a car, taxi, bus or other public/private way of getting to your medical appointment for Medi-Cal-covered services. We allow the lowest cost NMT type that meets your medical needs.

We provide mileage reimbursement when transportation in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers or train tickets. Transport by private vehicle, and mileage reimbursement, is covered (in accord with Medi-Cal guidelines) when it is authorized in advance (before the trip is taken). To request authorization and the criteria used to make authorization decisions call **1-844-299-6230** (TTY **711**). The representative can also answer any questions about mileage reimbursement.

To request NMT services to go to a Medi-Cal covered service, please call Kaiser Permanente's transportation provider at **1-844-299-6230** at least three business days (Monday through Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have all of the following when you call:

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

Limits of NMT

There are no limits for receiving NMT to or from medical appointments covered by Kaiser Permanente. If the appointment type is covered by Medi-Cal but not through the health plan, your health plan will provide for or help you schedule your transportation.

What does not apply?

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.
- You need assistance from the driver to and from the residence, vehicle or place of treatment due to a physical or medical condition.
- The service is not covered by Medi-Cal.

Cost to member

There is no cost when transportation is needed to get to and from a Kaiser Permanente or Medi-Cal covered service.

Reconstructive surgery

We cover:

- Surgery when there is a problem with a part of your body. This problem could be caused by a birth defect, disease or injury. We cover services that are medically necessary to make that part look normal or work better
- After medically necessary removal of all or part of a breast, we cover reconstructive surgery of the breast and reconstructive surgery of the other breast for a more similar look. We cover services for swelling after lymph nodes have been removed

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

Services in connection with a clinical trial

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

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

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

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - The National Institutes of Health
  - The Centers for Disease Control and Prevention
  - The Agency for Health Care Research and Quality
  - The Centers for Medicare & Medicaid Services
  - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

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

Long-term services and supports (LTSS)

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. CBAS centers also offer training and support to your family and/or caregiver.

For information about CBAS services call Kaiser Permanent Care Management at **1-866-551-9619** (TTY **711**) Monday through Friday, 8 a.m. to 6 p.m. to find out if you

qualify. If you qualify to get CBAS, Kern Family Health Care will authorize the services that best meets your needs.

Moral objection

Some providers have a moral objection to some services. This means they have a right to **not** offer some covered services if they morally disagree. These services might include:

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

If your provider has a moral objection, he or she will help you find another provider for the needed services. Kaiser Permanente can also work with you to find a provider. If you need help getting a referral to a different provider, call **1-800-464-4000** (TTY **711**).

Some hospitals and other providers do not offer one or more of the following services that may be covered under your plan contract and that you or your family member might need:

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

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call the Kaiser Permanente member services at **1-800-464-4000** (TTY **711**) to ensure that you can obtain the health care services that you need.

What Kaiser Permanente does not provide

Services you can get through Fee-For-Service (FFS) Medi-Cal

Sometimes Kaiser Permanente does not cover services, but you can still get them through FFS Medi-Cal. This section lists these services. To learn more, call your County Eligibility Worker or Medi-Cal toll free at **1-800-541-5555** (English and Spanish).

Dental services

Medi-Cal covers some dental services, including:

- Services that are normally done by a dentist, orthodontist, or oral surgeon
- Dental appliances

If you have questions or want to learn more about dental services, call Denti-Cal at **1-800-322-6384** (TTY **1-800-735-2922**). You may also visit the Denti-Cal website at **denti-cal.ca.gov**.

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

Institutional long-term care

Kaiser Permanente covers long-term care in a skilled nursing facility, intermediate care facility, or subacute care facility for the month you enter a facility and the month after that. We do **not** cover long-term care if you stay longer.

Regular Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call Kern Family Health Care at **1-800-391-2000** (TTY **711**).

Services you cannot get through Kaiser Permanente or Medi-Cal

There are some services that neither Kaiser Permanente nor Medi-Cal will cover, including:

- California Children's Services (CCS)
- Certain exams and services
- Comfort or convenience items

- Cosmetic services
- Disposable supplies
- Experimental services
- Fertility services (including infertility services, artificial insemination, and assisted reproductive technology services)
- Hair loss or growth treatment
- Items and services that are not health care items and services
- Massage therapy
- Personal care services
- Reversal of sterilization
- Routine foot care items and services

Read each of the sections below to learn more or call **1-800-464-4000** (TTY **711**).

California Children's Services (CCS)

CCS is a state program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems and who meet the CCS program rules. If Kaiser Permanente or your PCP believes your child has a CCS condition, he or she will be referred to the CCS program.

CCS program staff will decide if your child qualifies for CCS services. If your child qualifies to get this type of care, CCS providers will treat him or her for the CCS condition. Kaiser Permanente will continue to cover types of service that do not have to do with the CCS condition such as physicals, vaccines and well-child checkups.

Kaiser Permanente does not cover services provided by the CCS program. For CCS to cover these services, CCS must approve the provider, services and equipment.

CCS does not cover all health conditions. CCS covers most health conditions that physically disable or that need to be treated with medicines, surgery or rehabilitation (rehab). CCS covers children with health conditions such as:

- Congenital heart disease
- Cancers
- Tumors
- Hemophilia

- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts
- Cerebral palsy
- Seizures under certain circumstances
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

The State pays for CCS services. If your child is not eligible for CCS program services, he or she will keep getting medically necessary care from Kaiser Permanente.

To learn more about CCS, call **1-800-464-4000** (TTY **711**).

Certain exams and services

Medi-Cal does not cover exams and services needed:

- To get or keep a job
- To get insurance
- To get any kind of license
- By order of a court, or if for parole or probation

This exclusion does not apply if a network doctor finds that the services are medically necessary.

Comfort or convenience items

Items that are solely for the comfort or convenience of a member, a member's family, or a member's health care provider.

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
- Prostheses to replace all or part of an external facial body part

Disposable supplies

The following disposable supplies for home use: bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages.

This exclusion does not apply to disposable supplies provided as part of the following benefits described in Chapter 4 ("Benefits and services") of this Member Handbook:

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

Experimental services

Experimental services are drugs, equipment, procedures or services that are being tested in a laboratory or on animals, but they are not ready to be tested in humans.

Fertility Services

Services to help someone get pregnant.

Hair loss or growth treatment

Items and services to make hair grow or for hair loss.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play, or swimming, except that this exclusion for "teaching play" does not apply to services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment " in Chapter 4 ("Benefits and services")
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy. This exclusion for aquatic therapy and other water therapy does not apply to therapy services that are part of a physical therapy treatment plan and covered as part of the following benefits in Chapter 4 (“Benefits and services”):
    - ♦ Home health care
    - ♦ Hospice and palliative care

- ♦ Rehabilitative and habilitative services
- ♦ Skilled nursing facility services

Massage therapy

Massage therapy. This exclusion does not apply to therapy services that are part of a physical therapy treatment plan and covered under as part of the following benefits in Chapter 4 (“Benefits and services”) of this Member Handbook:

- Home health care
- Hospice and palliative care
- Rehabilitative and habilitative services
- Skilled nursing facility services

Personal care services

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:

- Hospice and palliative care

Reversal of sterilization

Services to reverse voluntary surgical birth control.

Routine foot care items and services

Foot care items and services that are not medically necessary

Other programs and services for people with Medi-Cal

There are other programs and services for people with Medi-Cal, including:

- Diabetes Prevention Program
- Health Homes Program
- Organ and tissue donation
- Indian Health Service facilities

Read each of the sections below to learn more about other programs and services for people with Medi-Cal.

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The program lasts one year and can continue for an additional year for those members who qualify. The program uses approved lifestyle changes including, but not limited to the following:

- Provides a peer coach;
- Teaches self-monitoring and problem solving;
- Provides encouragement and feedback;
- Provides informational materials to support goals; and
- Tracks routine weigh-ins to help accomplish goals.

Members who are interested in DPP must meet program eligibility requirements. Contact Member Services for additional program and eligibility information.

Health Homes Program

Medi-Cal covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long-term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call Kern Family Health Care, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call Kern Family Health Care to find out the conditions that qualify; and you meet one of the following:
  - ♦ You have three or more of the HHP eligible chronic conditions
  - ♦ You stayed in the hospital in the last year
  - ♦ You visited the emergency department three or more times in the last year; or

- ♦ You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. We provide HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

To learn more, call Complex Case Management at **1-866-551-9619** (TTY **711**).

Organ and tissue donation

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

Indian Health Service facilities

If you are a Native American, you can get health care at an Indian Health Service facility. If you want to get your health care from one of these clinics, please contact your local Indian Health Service facility, listed in your phone book.

Coordination of benefits

Kaiser Permanente offers services to help you coordinate your health care needs at no cost to you. If you have questions or concerns about your health or the health of your child, call **1-800-430-4263** (TTY **711**).

Evaluation of new and existing technologies

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

5. Rights and responsibilities

As a member of Kaiser Permanente, you have certain rights and responsibilities. This chapter will explain those rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of Kaiser Permanente.

Your rights

Kaiser Permanente members have these rights:

- To be treated with respect, 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
- To be able to choose a primary care provider within our network
- To participate in decision making regarding your own health care, including the right to refuse treatment
- 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 received
- To receive care coordination
- To request an appeal of decisions to deny, defer, or limit services or benefits
- To receive oral interpretation services for their language
- To receive free legal help at your local legal aid office or other groups
- To formulate advance directives

- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service facilities, sexually transmitted disease services and emergency services outside the Kaiser Permanente network pursuant to the federal law
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible
- To have access to, and where legally appropriate, receive copies of, amend or correct your medical record
- To disenroll upon request. Beneficiaries that can request expedited disenrollment include, but are not limited to, beneficiaries receiving services under the Foster Care, or Adoption Assistance Programs; and members with special health care needs
- To access Minor Consent Services
- To receive written member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W&I Code Section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- To receive 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

Your responsibilities

Kaiser Permanente members have these responsibilities:

- Reading this Member Handbook to learn what coverage you have and how to get services
- Using your ID cards properly. Bring your Kaiser Permanente ID card, a photo ID, and your Medi-Cal ID card with you when you come in for care
- Keeping appointments
- Telling your PCP about your health and health history

- Following the care plan you and your PCP agree on
- Recognizing the effect of your lifestyle on your health
- Being considerate of network doctors, other health care staff, and members
- Paying for services that are not covered by Medi-Cal
- Solving problems using the ways described in this Member Handbook
- Telling us if you are admitted to an out of network hospital

Notice of Privacy Practices

A STATEMENT DESCRIBING KAISER PERMANENTE'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require all contracting providers to protect the privacy of your PHI. Your PHI is individually identifiable information (oral, written, or electronic) about your health, health care services you received, or payment for your health care.

You can generally see and get a copy of your PHI, fix errors, or update your PHI, and ask us for a list of certain disclosures of your PHI. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

We may use or let others see your PHI for care, health research, payment, or health care operations, such as for research or measuring quality of care and services. Also, by law we may have to give your PHI to the government or provide it in legal actions.

We will not use or disclose your PHI for any other purpose without written authorization from you (or someone you name to act for you), except as described in our Notice of Privacy Practices (see below) and Medi-Cal privacy rules. You do not have to authorize this other use of your PHI.

If you see anyone using your information improperly, contact member services at **1-800-464-4000** (TTY **711**) or the California Department of Health Care Services, Privacy Officer, at **1-866-866-0602** Option 1 (**TTY 1-877-735-2929**). You can also e-mail the California Department of Health Care Services at **privacyofficer@dhcs.ca.gov**.

This is only a short summary of some of our key privacy practices. OUR NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PHI, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To get a copy, call member services at **1-800-464-4000** (TTY **711**). You can also find the notice at a Kaiser Permanente facility or by going online at **kp.org**.

Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this Member Handbook. The main laws that apply to this Member Handbook are state and federal laws about the Medi-Cal program. Other federal and state laws may apply too.

Notice about Medi-Cal as a payer of last resort

Sometimes someone else has to pay first for the services Kaiser Permanente provides you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

The California Department of Health Care Services has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer.

The Medi-Cal program complies with state and federal laws and regulations relating to the legal liability of third parties for health care services to beneficiaries. Kaiser Permanente will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

If you are eligible for Medicare, you must let us know. The Medicare program may have to pay for certain services that you get from us. Medi-Cal always pays last.

Notice about estate recovery

The State of California must seek repayment from the estate of a deceased Kaiser Permanente member for:

- Services the member got on or after his or her 55th birthday

- Any other payments for services the member got from providers not with Kaiser Permanente

To learn more about estate recovery, call **(916) 650-0590**.

Notice of Action

Kaiser Permanente will send you a Notice of Action (NOA) letter any time we deny, delay, terminate or modify a request for health care services. If you disagree with our decision, you can always file an appeal.

Notice about unusual circumstances

If something happens that limits our ability to provide and arrange for care, like a major disaster, we will make a good faith effort to provide you with the care that you need with network providers and network facilities that are available. If you have an emergency medical condition, go to the nearest hospital. You have coverage for emergency services as described in the “Emergency services” section.

Notice about administration of your benefits

You must fill out any forms that we ask for in our normal course of business. Also, we may create standards (policies and procedures) in order to better provide your services.

If we make an exception to the terms of this Member Handbook for you or someone else, we do not have to do the same for you or someone else in the future.

If we do not enforce part of this Member Handbook, this does not mean that we waive the terms of this Member Handbook. We have the right to enforce the terms of this Member Handbook at any time.

Notice about changes to this Member Handbook

We, with the approval of Kern Family Health Care, can make changes to this Member Handbook at any time. We will let you know in writing of any changes 30 days before they happen.

Notice about lawyer and advocate fees and costs

In any dispute between you and us, the Medical Group, or Kaiser Foundation Hospitals, each party will pay their own fees and costs. These include lawyers' fees and advocates' fees.

Notice that Member Handbook is binding on members

The terms of this Member Handbook are binding on you when you choose assignment to Kaiser Permanente through Kern Family Health Care.

Notice that Kern Family Health Care is not our agent

Kern Family Health Care is not an agent or representative of Kaiser Foundation Health Plan, Inc.

Notices about your coverage

We may send you updates about your health care coverage. We will send this to the most recent address we have for you. If you move or have a new address, let us know your new address as soon as you can by calling member services at **1-800-464-4000** (TTY **711**). Also, let your County Eligibility Worker and Kern Family Health Care know your new address.

6. Reporting and solving problems

There are two kinds of problems that you may have with Kaiser Permanente:

- A **complaint** (or **grievance)** is when you have a problem with Kaiser Permanente or a provider, or with the health care or treatment you got from a provider
- An **appeal** is when you don't agree with our decision not to cover or change your services

You can use the Kaiser Permanente grievance and appeal process to let us know about your problem. This does not take away any of your legal rights and remedies. We will not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all members.

You should always contact Kaiser Permanente to let us know about your problem. Call us 24 hours a day, 7 days a week (except closed holidays) at **1-800-464-4000** (TTY **711)** to tell us about your problem. This will not take away any of your legal rights. We will also not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all members.

If your grievance or appeal is still not resolved, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC) at **1-888-HMO-2219** (TTY **1-877-688-9891**).

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

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call **1-800-464-4000** (TTY **711**).

Complaints

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

You can file a complaint with us any time by phone, in writing, in person, or online.

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays). Give your medical record number, your name, and the reason for your complaint
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you. Also, your doctor's office will have complaint forms available. When you get the form, fill it out. Be sure to include your name, medical record number and the reason for your complaint. Tell us what happened and how we can help you. Mail the form to the member service office at a Kaiser Permanente network facility (see Provider Directory for locations)
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a network facility
- **Online:** Use the online form on our website at **kp.org**

If you need help filing your complaint, we can help you. We can give you free language services. Call **1-800-464-4000** (TTY **711**).

Within 5 days of getting your complaint, we will send you a letter letting you know we received it. Within 30 days, we will send you another letter that tells you how we resolved your problem.

If you want or your doctor wants us to make a fast decision because the time it takes to resolve your complaint would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call us at **1-800-464-4000** (TTY **711**). We will make a decision within 72 hours of receiving your complaint.

Appeals

An appeal is different from a complaint. An appeal is a request for Kaiser Permanente to review and change a decision we made about coverage for a requested service. If we sent you a Notice of Action (NOA) letter telling you that we are denying, delaying, changing or ending a service, and you do not agree with our decision, you can file an

appeal. Your PCP can also file an appeal for you with your written permission.

You must file an appeal within 60 calendar days from the date on the NOA you received. If you are currently getting treatment and you want to continue getting treatment, then you must ask for an appeal within 10 calendar days from the date the NOA was delivered to you, or before the date Kaiser Permanente says services will stop. When you request the appeal, please tell us that you want to continue receiving services.

You can file an appeal by phone, in writing, in person, or online:

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays). Give your medical record number, your name, and the service you are appealing
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you. Also, your doctor's office will have appeal forms available. When you get the form, fill it out. Be sure to include your name, medical record number and the service you are appealing. Mail the form to the member service office at a Kaiser Permanente network facility (see Provider Directory for locations)
- **In person:** Fill out an appeal form at a member services office located at a network facility
- **Online**: Use the online form on our website at **kp.org**

If you need help filing your appeal, we can help you. We can give you free language services. Call **1-800-464-4000** (TTY **711**).

Within 5 days of getting your appeal, we will send you a letter letting you know we received it. Within 30 days, we will tell you our appeal decision.

If you or your doctor wants us to make a fast decision because the time it takes to resolve your appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call us at **1-800-464-4000** (TTY **711**). We will make a decision within 72 hours of receiving your appeal.

What to do if you do not agree with an appeal decision

If you filed an appeal and received a letter from us telling you that we did not change our decision, or you never received a letter telling you of our decision and it has been past 30 days, you can:

- Ask for a **State Hearing** from the Department of Social Services (DSS), and a judge will review your case
- Ask for an **Independent Medical Review (IMR)** from DMHC and an outside reviewer who is not part of Kaiser Permanente will review your case

You will not have to pay for a State Hearing or an IMR.

You can ask for both a State Hearing and an IMR at the same time. You can also ask for one before the other to see if it will resolve your problem first. If you ask for an IMR first, but do not agree with the decision, you can still ask for a State Hearing later. 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.

The sections below will provide you with more information on how to ask for a State Hearing or an IMR.

Independent Medical Reviews ("IMR")

An IMR is when an outside reviewer who is not related to the health plan reviews your case. If you want an IMR, you must first file an appeal with Kaiser Permanente or Kern Family Health Care. If you do not hear from your health plan within 30 calendar days, or if you are unhappy with our decision, then you may then request an IMR. You must ask for an IMR within 6 months from the date on the notice telling you of the appeal decision.

You may be able to get an IMR right away without filing an appeal first. This is in cases where your health is in immediate danger or the request was denied because treatment was considered experimental or investigational.

The paragraph below will provide you with information on how to request an IMR. Note that the term "grievance" is talking about both "complaints" and "appeals."

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 toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with people from the Department of Social Services (DSS). A judge will help to resolve your problem. You can ask for a State Hearing only if you have already filed an appeal with Kaiser Permanente. If you are still not happy with the decision, or if you have not received a decision on your appeal after 30 days.

You must ask for a State Hearing within 120 days from the date on the notice telling you of the appeal decision. Your PCP can ask for a State Hearing for you with your written permission and if he or she gets approval from DSS. You can also call DSS to ask the State to approve your PCP’s request for a State Hearing.

You can ask for a State Hearing by phone or mail.

- **By phone:** Call the DSS Public Response Unit at **1-800-952-5253** (TTD **1-800-952-8349**).
- **By mail**: Fill out the form provided with your appeals resolution notice. Send it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call **1-800-464-4000** (TTY **711**).

At the hearing, you will give your side. We will give our side. It could take up to 90 days for the judge to decide your case. We must follow what the judge decides.

If you want the DSS to make a fast decision because the time it takes to have a State Hearing would put your life, health or ability to function fully in danger, you or your PCP can contact the DSS and ask for an expedited (fast) State Hearing. DSS must make a decision no later than 3 business days after it gets your request.

Fraud, waste and abuse

If you suspect that a provider or a person who gets Medi-Cal has committed fraud, waste or abuse, it is your right to report it.

Provider fraud, waste and abuse includes:

- Falsifying medical records
- Prescribing more medication than is medically necessary
- Giving more health care services than medically necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service

Fraud, waste and abuse by a person who gets benefits includes:

- Lending, selling or giving a health plan ID card or Medi-Cal Benefits Identification Card (BIC) to someone else
- Getting similar or the same treatments or medicines from more than one provider
- Going to an emergency room when it is not an emergency
- Using someone else's Social Security number or health plan ID number

To report fraud, waste and abuse, write down the name, address and ID number of the person who committed the fraud, waste or abuse. Give as much information as you can about the person, such as the phone number or the specialty if it is a provider. Give the dates of the events and a summary of exactly what happened.

If you notice potential signs of misconduct, contact member services 24 hours a day, 7 days a week (closed holidays) at **1-800-464-4000** (TTY **711**).

Binding Arbitration

Binding arbitration is a way to solve problems using a neutral third party. This third party hears both sides of the issue and makes a decision that both sides must accept. Both sides give up the right to a jury or court trial. We will use binding arbitration to settle claims that we filed before the effective date of this Member Handbook. The use of binding arbitration for these past claims is binding only on us.

Scope of Arbitration

You must use binding arbitration if the claim is related to this Member Handbook or your membership with us, if all of the following requirements are met:

- The claim is for:
  - Malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered); or
  - Delivery of services or items; or
  - Premises liability
- The claim is brought by:
  - You against us; or
  - Us against you
- Governing law does not prevent the use of binding arbitration to resolve the claim
- The claim cannot be settled through Small Claims Court

Keep in mind:

- You do not have to use binding arbitration for claims that can be settled through a State Hearing
- You cannot use binding arbitration if you have gotten a decision on the claim through a State Hearing

In this "Binding Arbitration" section only, "you" means the party who is asking for binding arbitration:

- You (a member)
- Your heir, relative, or someone you name to act for you

- Someone who claims that a duty to them exists due to your relationship with us

In this "Binding Arbitration" section only, "us" means the party who has a claim filed against them:

- Kaiser Foundation Health Plan, Inc. ("KFHP")
- KP Cal, LLC ("KP Cal")
- Kaiser Foundation Hospitals ("KFH")
- Southern California Permanente Medical Group ("SCPMG")
- The Permanente Medical Group, Inc. ("TPMG")
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any SCPMG or TPMG doctor
- Any person or organization with a contract with any of these parties that requires the use of binding arbitration
- Any employee or agent of any of these parties

Rules of Procedure

Binding arbitrations are conducted using the Rules of Procedure:

- The Rules of Procedure were developed by the Office of the Independent Administrator with input from Kaiser Permanente and from the Arbitration Advisory Committee
- You can get a copy of the Rules of Procedure from member services at **1-800-464-4000** (TTY **711**)

How to Ask for Arbitration

To ask for binding arbitration, you must make a formal request (a Demand for Arbitration), which includes:

- Your description of the claim against us
- The amount of damages you are asking for
- The names, addresses, and phone numbers of all the parties who are making the claim. If any of these parties have a lawyer, include the name, address, and phone number of the lawyer

- The names of the parties whom you are filing the claim against

All claims resulting from the same incident should be included in one request.

Serving the Demand for Arbitration

If you are filing a claim against KFHP, KP Cal, KFH, SCPMG, TPMG, The Permanente Federation, LLC, or The Permanente Company, LLC, mail the Demand for Arbitration to:

Kaiser Permanente
Legal Department
393 E. Walnut St.
Pasadena, CA 91188

If you are filing a claim against any other party, you must give them notice as required by the California Code of Civil Procedure for a civil action.

We are served when we get the Demand for Arbitration.

Filing Fee

The cost of binding arbitration includes a filing fee of $150 that will be waived if you cannot pay your share of the costs.

The filing fee is payable to "Arbitration Account" and is the same amount, no matter how many claims are in your request or the number of parties named. The filing fee is not refundable.

If you are not able to pay your share of the costs of binding arbitration, you can ask the Office of the Independent Administrator to waive the costs. To do this, you must fill out and send in a Fee Waiver Form to:

- The Office of the Independent Administrator; and
- The parties you are filing the claim against

The Fee Waiver Form:

- Tells you how the Independent Administrator decides whether to waive the fees
- Tells you the fees that can be waived

You can get a copy of the Fee Waiver Form from member services at **1-800-464-4000** (TTY **711**).

Number of Arbitrators

Some cases are heard by one arbitrator that both sides agree on (a neutral arbitrator). In other cases, there may be more than one arbitrator. The number of arbitrators may affect whether we pay the cost of the neutral arbitrator.

- Cases that request up to $200,000 in damages go before one arbitrator. The arbitrator must stay neutral. Both sides can agree to have three arbitrators decide the case. The agreement for more than one arbitrator must be made after the Demand for Arbitration has been filed. When there are three arbitrators, one represents each side and the third is neutral. The arbitrator(s) cannot award more than $200,000.
- Cases that request more than $200,000 in damages go before three arbitrators. When there are three arbitrators, there is one for each side in the dispute and a third neutral arbitrator. Either side can waive their right to have an arbitrator represent them. Both sides in a dispute can agree to have the case heard by a single neutral arbitrator. The agreement for a single neutral arbitrator must be made after the Demand for Arbitration has been filed.

Arbitrators' Fees and Expenses

We will pay the fees of the neutral arbitrator in some cases. To find out when we will pay the fees, look in the Rules of Procedure. You can get a copy of the Rules of Procedure from member services at **1-800-464-4000** (TTY **711**). In all other cases, this cost is shared equally by both parties.

If the parties select party arbitrators, each party pays the fees of their party arbitrator.

Costs

Except as set forth above and as allowed by law, each party must pay their own costs of the binding arbitration, no matter the outcome, such as lawyers' fees, witness fees, and other costs.

General Provisions

You cannot ask for binding arbitration if the claim would not meet the statute of limitations for that claim in a civil action.

Your claim will be dismissed if either:

- You have not acted on it with reasonable diligence in accord with the Rules of Procedure, or
- The hearing has not occurred and more than five years have passed after the earlier of:
  - The date you served the Demand for Arbitration; or
  - The date you filed a civil action based on the same incident

A claim may be dismissed on other grounds by the neutral arbitrator. Good cause must be shown for this to happen.

If one of the parties does not attend the hearing, the neutral arbitrator may decide the case in that party's absence.

The California Medical Injury Compensation Reform Act (and any amendments) applies to claims as allowed by law, such as:

- The right to introduce evidence of any insurance or disability benefit payment to you
- Limits on the amount of money you can recover for noneconomic losses
- The right to have an award for future damages made in periodic payments

Arbitrations are governed by this "Binding Arbitration" section. These standards also apply as long as they do not conflict with this section:

- Section 2 of the Federal Arbitration Act
- The California Code of Civil Procedure
- The Rules of Procedure

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a network provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstance prevented timely submission. For more information

on the OCR and how to file a complaint with the OCR, go to **hhs.gov/civil-rights**.

7. Important numbers and words to know

Important phone numbers

- Kaiser Permanente member services:
  - ♦ English **1-800-464-4000**
    (and more than 150 languages using interpreter services)
  - ♦ Spanish **1-800-788-0616**
  - ♦ Chinese dialects **1-800-757-7585**
  - ♦ TTY **711**
- Authorization for post-stabilization care **1-800-225-8883** (TTY **711**)
- Kaiser Permanente appointments and advice **1-833-KP4CARE (1-833-574-2273)** (TTY **711**)
- Kern Family Health Care **1-800-391-2000** (TTY **711**)
- Health Care Options **1-800-430-4263** (TTY **1-800-430-7077**)

Words to know

Active labor: The period of time when a woman is in the three stages of giving birth and either cannot be safely transferred in time to another hospital before delivery or a transfer may harm health and safety of the woman or unborn child.

Acute: A medical condition that is sudden, requires fast medical attention and does not last a long time.

Appeal: A member's request for Kaiser Permanente to review and change a decision made about coverage for a requested service.

Benefits: Health care services and drugs covered under this health plan.

Binding arbitration: A way to solve problems using a neutral third party. For problems that are settled through binding arbitration, the third party hears both sides of the issue and makes a decision that both sides must accept. Both sides give up the right to a jury or court trial.

California Children's Services (CCS): A program that provides services for children up to age 21 with certain diseases and health problems.

California Health and Disability Prevention (CHDP): A public health program that reimburses public and private health care providers for early health assessments to detect or prevent disease and disabilities in children and youth. The program helps children and youth who qualify have access to regular health care. Your PCP can provide CHDP services.

Case manager: Registered nurses or social workers who can help you understand major health problems and arrange care with your providers.

Chronic condition: A disease or other medical problem that cannot be completely cured or that gets worse over time or that must be treated so you do not get worse.

Clinic: Clinic is a facility that members can select as a primary care provider (PCP). It can be either a Federally Qualified Health Center ("FQHC"), community clinic, Rural Health Clinic ("RHC"), Indian Health Service clinic, or other primary care facility.

Community-based adult services (CBAS): Outpatient, facility-based services for skilled nursing care, social services, therapies, personal care, family and caregiver training and support, nutrition services, transportation, and other services for members who qualify.

Complaint: A member's verbal or written expression of dissatisfaction about Kaiser Permanente, a provider, or the quality of care or quality of services provided. A complaint is the same as a grievance.

Continuity of care: The ability of a plan member to keep getting Medi-Cal services from their existing provider for up to 12 months without a break in service, if the provider and Kaiser Permanente agree.

Copayment: A payment you make, generally at the time of service, in addition to the insurer's payment.

Coverage (covered services): The health care services provided to members of Kaiser Permanente, subject to the terms, conditions, limitations and exclusions of the Medi-Cal contract and as listed in this EOC and any amendments.

DHCS: The California Department of Health Care Services. This is the State office that oversees the Medi-Cal program.

Disenroll: To stop using Kern Family Health Care because you no longer qualify or change to a new health plan. You must sign a form that says you no longer want to use Kern Family Health Care or call Health Care Options and disenroll by phone.

DMHC: The California Department of Managed Health Care. This is the State office that oversees managed care health plans.

Durable medical equipment (DME): Equipment that is medically necessary and ordered by your doctor or other provider. We decide whether to rent or buy DME. Rental costs must not be more than the cost to buy. Repair of medical equipment is covered.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT): EPSDT services are a benefit for Medi-Cal members under the age of 21 to keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early.

Emergency medical condition: A medical or psychiatric (mental) condition with such severe symptoms, such as active labor (see definition above) or severe pain, that someone with a reasonable layperson’s knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger
- Cause impairment to a body function
- Cause a body part or organ to not work right

Emergency room care: An exam performed by a doctor (or staff under direction of a doctor as allowed by law) to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.

Emergency medical transportation: Transportation in an ambulance or emergency vehicle to an emergency room to receive emergency medical care.

Enrollee: A person who is a member of a health plan and receives services through the plan.

Excluded services: Services not covered by Kaiser Permanente; non-covered services.

Family planning services: Services to prevent or delay pregnancy.

Federally Qualified Health Center ("FQHC"): A health center in an area that does not have many health care providers. You can get primary and preventive care at an FQHC.

Fee-For-Service (FFS): This means you are not enrolled in a managed care health plan. Under FFS, your doctor must accept "straight" Medi-Cal and bills Medi-Cal directly for the services you got.

Follow-up care: Regular doctor care to check a patient's progress after a hospitalization or during a course of treatment.

Formulary: A list of drugs or items that meet certain criteria and are approved for members.

Fraud: An intentional act to deceive or misrepresent by a person who knows the deception could result in some unauthorized benefit for the person or someone else.

Grievance: A member's verbal or written expression of dissatisfaction about Kaiser Permanente, a provider, or the quality of care or services provided. A complaint is the same as a grievance.

Habilitation services and devices: Health care services that help you keep, learn or improve skills and functioning for daily living.

Health Care Options (HCO): The program that can enroll you in or disenroll you from the health plan.

Health care providers: Doctors and specialists such as surgeons, doctors who treat cancer, or doctors who treat special parts of the body and who work with Kaiser Permanente or are in our network. Our network providers must have a license to practice in California and give you a service we cover.

You usually need a referral from your PCP to see a specialist. For some services, you need pre-approval (prior authorization).

You do **not** need a referral from your PCP for some types of service, such as family planning, emergency care, Ob/Gyn care or sensitive services.

Types of health care providers:

- Audiologist is a provider who tests hearing
- Certified nurse-midwife is a nurse who cares for you during pregnancy and childbirth
- Family practitioner is a doctor who treats common medical issues for people of all ages
- General practitioner is a doctor who treats common medical issues
- Internist is a doctor with special training in internal medicine, including diseases
- Licensed vocational nurse is a licensed nurse who works with your doctor
- A counselor is a person who helps you with family problems
- Medical assistant or certified medical assistant is a non-licensed person who helps your doctors give you medical care
- Mid-level practitioner is a name used for health care providers, such as nurse-midwives, physician's assistants or nurse practitioners
- Nurse anesthetist is a nurse who gives you anesthesia
- Nurse practitioner or physician's assistant is a person who works in a clinic or doctor's office who diagnoses, treats and cares for you, within limits
- Obstetrician/gynecologist (Ob/Gyn) is a doctor who takes care of a woman's health, including during pregnancy and birth
- Occupational therapist is a provider who helps you regain daily skills and activities after an illness or injury
- Pediatrician is a doctor who treats children from birth through the teen years
- Physical therapist is a provider who helps you build your body's strength after an illness or injury
- Podiatrist is a doctor who takes care of your feet
- Psychologist is a person who treats mental health issues but does not prescribe drugs

- Registered nurse is a nurse with more training than a licensed vocational nurse and who has a license to do certain tasks with your doctor
- Respiratory therapist is a provider who helps you with your breathing
- Speech pathologist is a provider who helps you with your speech

Health insurance: Insurance coverage that pays for medical and surgical expenses by repaying the insured for expenses from illness or injury or paying the care provider directly.

Home health care: Skilled nursing care and other services given at home.

Home health care providers: Providers who give you skilled nursing care and other services at home.

Hospice: Care to reduce physical, emotional, social and spiritual discomforts for a member with a terminal illness (not expected to live for more than 6 months).

Hospital: A place where you get inpatient and outpatient care from doctors and nurses.

Hospitalization: Admission to a hospital for treatment as an inpatient.

Hospital outpatient care: Medical or surgical care performed at a hospital without admission as an inpatient.

Indian Health Service: A federal agency within the U.S. Department of Health and Human Services that is responsible for providing health services to American Indians and Alaska Natives.

Inpatient care: When you have to stay the night in a hospital or other place for the medical care you need.

Kaiser Foundation Health Plan, Inc.: A California nonprofit corporation. In this Member Handbook, "we" or "us" means Kaiser Foundation Health Plan, Inc.

Kaiser Permanente: Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals (a California nonprofit corporation), and the Southern California Permanente Medical Group.

Kern Family Health Care: Your Medi-Cal managed care health plan. Kaiser Permanente is your health care provider through Kern Family Health Care.

Kern Family Health Care Service Area: Kern County except for the following ZIP codes:

- Ridgecrest: 93555 and 93556

Long-term care: Care in a facility for longer than the month of admission plus the next month.

Managed care plan: A Medi-Cal plan that uses only certain doctors, specialists, clinics, pharmacies and hospitals for Medi-Cal recipients enrolled in that plan. Kaiser Permanente is a managed care plan.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

Medical home: A model of care that will provide better health care quality, improve self-management by members of their own care and reduce avoidable costs over time.

Medically necessary (or medical necessity): Medically necessary care are important services that are reasonable and protect life. This care is needed to keep patients from getting seriously ill or disabled. This care reduces severe pain by treating the disease, illness or injury. For members under the age of 21, Medi-Cal services includes care that is medically necessary to fix or help a physical or mental illness or condition, including substance use disorders, as set forth in Section 1396d(r) of Title 42 of the United States Code.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

Member: Any eligible Medi-Cal beneficiary assigned to Kaiser Permanente through Kern Family Health Care who is entitled to receive covered services. In this Member Handbook, "you" means a member.

Mental health services provider: Licensed individuals who provide mental health and behavioral health services to patients.

Network: A group of doctors, clinics, hospitals and other providers contracted with Kaiser Permanente to provide care.

Network provider (or in-network provider): See “Participating provider” below.

Non-covered service: A service that Kaiser Permanente does not cover.

Non-emergency medical transportation (NEMT): Transportation when you cannot get to a covered medical appointment by car, bus, train or taxi. We pay for the lowest cost NEMT for your medical needs when you need a ride to your appointment.

Non-formulary drug: A drug not listed in the drug formulary.

Non-medical transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by your provider.

Non-participating provider: A provider not in the Kaiser Permanente network.

Orthotic device: A device used as a support or brace affixed externally to the body to support or correct an acutely injured or diseased body part and that is medically necessary for the medical recovery of the member.

Out-of-area services: Services while a member is anywhere outside of the area in which Kaiser Permanente has a license to operate. To get more information on where Kaiser Permanente has a license to operate, call member services at **1-800-464-4000** (TTY **711**).

Out-of-network provider: A provider who is not part of the Kaiser Permanente network.

Outpatient care: When you do not have to stay the night in a hospital or other place for the medical care you need.

Outpatient mental health services: Outpatient services for members with mild to moderate mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory, supplies and supplements

Palliative care: Care to reduce physical, emotional, social and spiritual discomforts for a member with a serious illness.

Participating hospital: A licensed hospital that has a contract with Kaiser Permanente to provide services to members at the time a member receives care. The covered services that some participating hospitals may offer to members are limited by our utilization review and quality assurance policies or our contract with the hospital.

Participating provider (or participating doctor): A doctor, hospital or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with Kaiser Permanente to offer covered services to members at the time a member receives care.

Physician services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while you are admitted in a hospital that are charged in the hospital bill.

Plan: See managed care plan.

Plan Facility: Any facility listed on our website at **kp.org/facilities** that is part of our network. Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call Member Services.

Plan Hospital: Any hospital listed on our website at **kp.org/facilities** that is part of our network. Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call Member Services.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to Your Guidebook or the facility directory on our website at **kp.org** for a list of Plan Pharmacies in your area. Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call Member Services.

Plan Physician: Any licensed physician who is an employee of the Medical Group, or any licensed physician who contracts to provide covered services to Members. Physicians who contract with us only to provide referral services are not considered Plan Physicians.

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Kaiser Permanente designates as a Plan Provider.

Post-stabilization services: Services you receive after an emergency medical condition is stabilized.

Pre-approval (or prior-authorization): Your PCP must get approval from the Southern California Permanente Medical Group before you get certain services. The Southern California Permanente Medical Group will only approve the services you need. They will not approve services by non-participating providers if they believe you can get comparable or more appropriate services through Kaiser Permanente providers. A referral is not an approval. You must get approval from the Southern California Permanente Medical Group.

Premium: An amount paid for coverage; cost for coverage.

Prescription drug coverage: Coverage for medications prescribed by a provider.

Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed, unlike over-the-counter (OTC) drugs that do not require a prescription.

Preferred drug list (PDL): A chosen list of drugs approved by this health plan from which your doctor may order for you. Also called a formulary.

Primary care: See routine care.

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need. Some care needs to be approved first, unless:

- You have an emergency
- You need Ob/Gyn care
- You need sensitive services
- You need family planning care

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- Ob/Gyn
- FQHC or RHC
- Nurse practitioner
- Physician assistant

- Clinic

Prior authorization (pre-approval): A formal process requiring a health care provider to get approval to provide specific services or procedures.

Prosthetic device: An artificial device attached to the body to replace a missing body part.

Provider Directory: A list of providers in the Kaiser Permanente network.

Psychiatric emergency medical condition: A mental disorder where the symptoms are serious or severe enough to cause either an immediate danger to yourself or others or you are immediately unable to provide for or use food, shelter or clothing due to the mental disorder.

Psychiatric emergency services may include moving a member to a psychiatric unit inside a general hospital or to an acute psychiatric hospital. This move is done to avoid or lessen a psychiatric emergency medical condition. In addition, the treating provider believes the move would not result in making the member's condition worse.

Public health services: Health services targeted at the population as a whole. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified provider: Doctor qualified in the area of practice appropriate to treat your condition.

Reconstructive surgery: Surgery when there is a problem with a part of your body. This problem could be caused by a birth defect, disease or injury. It is medically necessary to make that part look normal or work better.

Referral: When your PCP says you can get care from another provider. Some covered care and services require a referral and pre-approval. See Chapter 3 ("How to get care") for more about services that require referrals or pre-approval.

Routine care: Medically necessary services and preventive care, well child visits, or care such as routine follow-up care. The goal of routine care is to prevent health problems.

Rural Health Clinic (RHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an RHC.

Sensitive services: Medically necessary services for family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions.

Serious illness: A disease or condition that must be treated and could result in death.

Skilled nursing care: Covered services provided by licensed nurses, technicians and/or therapists during a stay in a Skilled Nursing Facility or in a member's home.

Skilled nursing facility: A place that gives 24-hour-a-day nursing care that only trained health professionals may give.

Specialist (or specialty physician): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a referral from your PCP to see a specialist.

Specialty mental health services:

- 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
  - Intensive care coordination (ICC)
  - Intensive home-based services (IHBS)
  - Therapeutic foster care (TFC)
- 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

Telehealth visits: Interactive video visits and scheduled telephone visits between you and your provider.

Terminal illness: A medical condition that cannot be reversed and will most likely cause death within one year or less if the disease follows its natural course.

Triage (or screening): The evaluation of your health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of your need for care.

Urgent care (or urgent services): Services provided to treat a non-emergency illness, injury or condition that requires medical care. You can get urgent care from an out-of-network provider if network providers are temporarily not available or not accessible.

KAISER PERMANENTE®

Member Service Contact Center
1-800-464-4000 (TTY users call **711**), 24 hours a day, seven days a week (except closed holidays).

kp.org

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Pasadena, CA 91188

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