Important Information Inside

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KAISER PERMANENTE®

Alameda Alliance for Health

Member Handbook

What you need to know about your benefits

2022 Combined Evidence of Coverage and Disclosure Form (EOC/DF)

Effective January 1, 2022
Kaiser Foundation Health Plan, Inc.
Northern California Region

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Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. We provide written translations from qualified translators. Call **1-800-464-4000** (TTY **711**). The call is toll-free. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

Other formats

You can get this information in other formats, such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call **1-800-464-4000** (TTY **711**). The call is toll-free.

Interpreter services

We provide oral interpretation services from a qualified interpreter. You do not have to use a family member or

friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. Interpreter, linguistic and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this Member 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. You can also request auxiliary aids and devices at our facilities. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Պարզապես զանգահարեք մեզ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。您還可以在我們的場所內申請使用輔助工具和設備。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه مدارک به زبان شما و یا به صورتهای دیگر درخواست کنید. شما همچنین می توانید کمکهای جانبی و وسایل . کمکی برای محل اقامت خود درخواست کنید کافیست در 24 ساعت. شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران ناشنوا (TTY) با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muaj kec pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。補助サービスや当施設の機器についてもご相談いただけます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺឥតគិតថ្លៃថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែឯកសារដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ 711។

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스,귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일휴무). TTY 사용자번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັຽຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ທ່ານສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ອຸປະກອນຕ່າງໆໃນສະຖານບໍລິການຂອງພວກເຮົາໄດ້.ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

Mien: Mbenc nzoih liouh wang-henh tengx nzie faan waac bun muangx maiv zuqc cuotv zinh nyaanh meih, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. Meih se haih tov heuc tengx lorx faan waac mienh tengx faan waac bun muangx, dorh nyungc horngh jaa-sic mingh faan benx meih nyei waac, a'fai liouh ginv longc benx haaix hoc sou-guv daan yaac duqv. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Kungx douc waac mingh lorx taux yie mbuo yiem njiec naaiv **1-800-464-4000**, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. (hnoi-gec se guon gorn zangc oc). TTY nyei mienh nor douc waac lorx **711**.

Navajo: Doo bik'é asíníłáágóó saad bee ata' hane' bee áká e'elyeed nich'į' ąą'át'é, t'áá áłahjį' jíį̨go dóó tł'ée'go áádóó tsosts'ijí ąą'át'é. Ata' hane' yídííkił, naaltsoos t'áá Diné bizaad bee bik'i' ashchíigo, éí doodago hane' bee didíits'íílígíí yídííkił. Hane' bee bik'i' di'díítíílígíí dóó bee hane' didíits'íílígíí bína'ídíłkidgo yídííkił. Kojį hodiilnih **1-800-464-4000**, t'áá áłahjį', jíį̨go dóó tł'ée'go áádóó tsosts'ijí ąą'át'é. (Dahodílzingóne' doo nida'anish dago éí da'deelkaal). TTY chodayooł'ínígíí kojį dahalne' **711**.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (excepto los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Maaari ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: มีบริการช่วยเหลือด้านภาษาฟรีตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ คุณสามารถ ขอใช้บริการล่าม แปลเอกสารเป็นภาษาของคุณ หรือในรูปแบบอื่นได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการให้ความช่วยเหลือของเรา โดยโทรหา เราที่ **1-800-464-4000** ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ (ยกเว้นวันหยุดราชการ) ผู้ใช้ TTY ให้โทร **711**

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача, отримання матеріалів у перекладі мовою, якою володієте, або в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Просто зателефонуйте нам за номером **1-800-464-4000**. Ми працюємо цілодобово, 7 днів на тиждень (крім святкових днів). Номер для користувачів телетайпа: **711**.

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

Welcome to Kaiser Permanente!

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

Member Handbook

This Member Handbook tells you about your coverage under the Health Plan. 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 the Health Plan. If you have special health needs, be sure to read all sections that apply to you.

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

This Member Handbook is also called the Combined Evidence of Coverage and Disclosure Form (“EOC/DF”). It is a summary of our rules and policies and is based on the contract between the Health Plan and Alameda Alliance for Health. Your health coverage is determined by our contract with Alameda Alliance for Health. If you received or downloaded a copy of a Member Handbook directly from Alameda Alliance for Health, please put that one away and use this one. This Member Handbook will provide you with the most accurate information about the services you can get from us. If there are differences between the Member Handbook you received from Alameda Alliance for Health and this one, this document will the one that we will use to help you. Call **510-747-4567** (TTY **711 or 1-800-735-2929**) to ask for a copy of the contract between Alameda Alliance for Health and DHCS.

Welcome to Kaiser Permanente!

You may 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/medi-cal/documents** to view the Member Handbook. You may also request, at no cost to you, a copy of our non-proprietary clinical and administrative policies and procedures, or how to access this information on our website. To learn more about our clinical and administrative procedures, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Contact us

We are 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 locations on our website at **kp.org/facilities** for addresses). For more information on our providers and locations, call our Member Service Contact Center or go to **kp.org/facilities**.

Thank you,
Kaiser Foundation Health Plan, Inc.

1. Getting started as a Member

How to get help

We want you to be happy with your health care. If you have 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 services covered by us
- Help you choose or change a primary care provider ("PCP")
- Tell you where to get the care you need
- Help you get interpreter services if you do not speak English
- Help you get information in other languages and formats

If you need help, call our Member Service Contact Center as follows:

- English (and more than 150 languages using interpreter services) **1-800-464-4000**
- 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. We must make sure that you wait less than 10 minutes when calling our Member Service Contact Center. You can also visit online at any time at **kp.org.**

Getting help from Alameda Alliance for Health

If you have questions about Alameda Alliance for Health, call them at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

Transitional Medi-Cal

Transitional Medi-Cal is also called "Medi-Cal for working people." You may be able to get Transitional Medi-Cal if you stop getting Medi-Cal because:

- You started earning more money
- Your family started receiving more child or spousal support

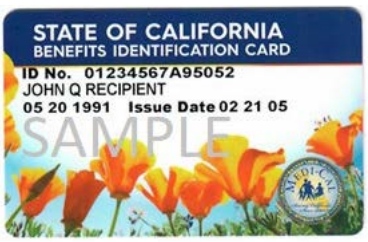
You can ask questions about qualifying for Transitional Medi-Cal at your local county health and human services office at **http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.**
You can also call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077** or **711**).

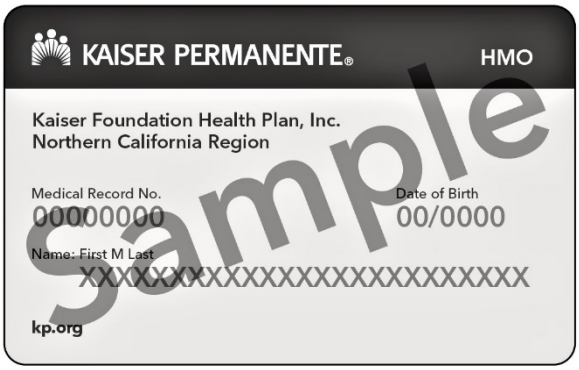
Who can be assigned to us

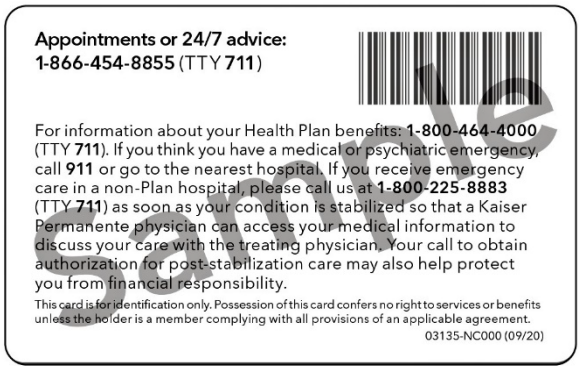
We do not enroll Members directly. To learn more about how to request assignment with us, call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**).

Identification ("ID") cards

As a Member of Health Plan, you will get a Kaiser Permanente ID card. You should also have a Medi-Cal Benefits Identification Card ("BIC") that the State of California sent to you. You must show your Kaiser Permanente ID card, your Alameda Alliance for Health ID Card, your Medi-Cal 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 BIC and a 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 us or if your card is damaged, lost or stolen, call our Member Service Contact Center right away. We will send you a new card at no cost to you. Call **1-800-464-4000** (TTY **711**).

2. About your health plan

Health Plan overview

Alameda Alliance for Health is a health plan for people who have Medi-Cal in Alameda County. Alameda Alliance for Health works with the State of California to help you get the health care you need.

Alameda Alliance for Health is your Medi-Cal managed care plan and Kaiser Permanente is your health care provider network through Alameda Alliance for Health. 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.

You may talk with one of Kaiser Permanente's Member Services representatives to learn more about Kaiser Permanente and how to make it work for you. Call **1-800-464-4000** (TTY **711**).

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

If you have questions about Alameda Alliance for Health, you can call them at **510-747-4567** (TTY 711 or 1-800-735-2929), Monday through Friday, 8 a.m. to 5 p.m.

When your coverage starts and ends

When you are assigned to us through Alameda Alliance for Health, we will send you a Kaiser Permanente Member ID card within two weeks of your assignment date. Please

show your Kaiser Permanente ID card, your BIC, and your Alameda Alliance for Health ID card when you get any health care services or prescriptions.

Your Medi-Cal coverage will need to be renewed every year. If your local county office cannot renew your Medi-Cal coverage using electronic sources, the county will send you a Medi-Cal renewal form. Complete this form and return it to your local county human services agency. You can return your information online, in person, or by phone or other electronic means if available in your county.

You may ask at any time to end your assignment to Kaiser Permanente and choose another provider network that works with Alameda Alliance for Health. For help choosing a new provider network, call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**) or visit **www.alamedaalliance.org**. You can also ask to end your Medi-Cal.

We can ask Alameda Alliance for Health to assign you to a different provider network if any of the following occurs:

- Your behavior threatens the safety of Kaiser Permanente staff or of any person or property at a Plan Facility
- You commit theft from a Network Provider, or a Plan Facility
- 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 Alameda Alliance for Health reassigns you to a different provider network, they will inform you in writing.

Your Medi-Cal eligibility with Alameda Alliance for Health may end if any of the following is true:

- You move out of the Alameda Alliance for Health Service Area
- You are in jail or in prison
- You no longer have Medi-Cal
- You become eligible for a waiver program that requires you to be enrolled in FFS Medi-Cal
- You are 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 Alameda Alliance for Health and your assignment to Kaiser Permanente end, you may still be eligible for Fee-for-Service ("FFS") Medi-Cal coverage. If you are not sure if you are still covered by us for your Medi-Cal, please call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Special considerations for American Indians in managed care

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

If you are an American Indian, you have the right to get health care services at an Indian Health Care Provider ("IHCP"). You may also stay with or disenroll from Alameda Alliance for Health while getting health care services from these locations. For more information on enrollment and disenrollment, call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**).

How your plan works

Alameda Alliance for Health is a managed care health plan contracted with the California Department of Health Care Services ("DHCS") for Medi-Cal. Kaiser Permanente is your health care provider network through Alameda Alliance for Health.

Kaiser Permanente provides health care services directly to Members through an integrated medical care program. Our medical care program gives you access to most of the covered services you may need, such as Routine Care, hospital care, laboratory and services, Emergency Care, Urgent Care, and other benefits described in this Member Handbook. Plus, our health education programs offer you great ways to protect and improve your health.

Benefit policies and the processes for how to get covered services may vary among Alameda Alliance for Health's provider networks. If you would like information on how to change provider networks, please call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

While you are a Medi-Cal Member of Kaiser Permanente, you may be eligible to get some additional services provided through FFS Medi-Cal. These include outpatient prescription drugs, over-the-counter drugs, some medical supplies, and supplements that are available through the Medi-Cal Rx program. The services you can get from FFS Medi-Cal are described in Chapter 4 ("Benefits and services").

To learn more, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). You can also find Member Services information online at **kp.org**.

To learn about Alameda Alliance for Health call them at **510-747-4567** (TTY **711 or 1-800-735-2929**). You can also find Member Services information online at **www.alamedaalliance.org**.

Changing provider networks

You may leave Kaiser Permanente and change to a different Alameda Alliance for Health provider network at any time. Call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m. Tell them you want to change provider networks. This change will not happen right away. Alameda Alliance for Health will let you know when your new provider assignment starts. Until then, you must get services from Kaiser Permanente.

Benefit policies and the processes for how to get covered services may vary among Alameda Alliance for Health's provider networks. If you would like information on how to change provider networks, please call Alameda Alliance for Health's Member Services at **510-747-4567** (TTY 711 or 1-800-735-2929), Monday through Friday, 8 a.m. to 5 p.m.

If you want to leave Kaiser Permanente sooner, you may ask Alameda Alliance for Health 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 Alameda Alliance for Health and join another Medi-Cal managed care plan in the county where you live 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 6 p.m., or visit **https://www.healthcareoptions.dhcs.ca.gov/**.

It takes up to 30 days to process your request to leave Alameda Alliance for Health and enroll in another managed care plan in your county, if there are no issues with the request. Until then, you must get services from us. To find out the status of your request, call Health Care Options at **1-800-430-4263** (TTY 1**-800-430-7077**).

If you want to leave Alameda Alliance for Health 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.

Members who 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
- Members already enrolled in Medicare, another Medi-Cal, or commercial managed care plan

You may ask to leave Alameda Alliance for Health in person at your local county health and human services office. Find your local office at **https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx**. Or call Health Care Options at **1-800-430-4263** (TTY **1-800-430-7077**).

College students who move to a new county or out of California

If you move to a new county in California that is outside your Home Region to attend college, we will only cover Emergency Care and Urgent Care in your new county. Emergency Care and Urgent Care are available to all Medi-Cal enrollees statewide regardless of county of residence. Routine Care, including preventive care, is covered only in your Home Region.

Going to college outside your Home Region in California

If you are enrolled in Medi-Cal and will attend college outside of your Home Region in California, you do not need to apply for Medi-Cal in that county. When you temporarily move away from home to attend college outside your Home Region, there are two options available to you.

You may do either of the following:

- Notify your home county 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. Use this option if you want to get Routine Care, including preventive care, in your new county. You may have to change your Medi-Cal

managed care plan. 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 managed care plan when you temporarily move to attend college in a different county that is outside your Home Region. You may only be able to access Emergency Care or Urgent Care in the new county. For Routine Care, including preventive care, you will need to use the Kaiser Permanente provider network in your Home Region. To learn more, go to Chapter 3 ("How to get care") for information on Emergency Care and Urgent Care.

Going to college outside of California

If you are leaving California temporarily to attend college in another state and you want to keep your Medi-Cal coverage, contact your eligibility worker at your home county office. As long as you are eligible, Medi-Cal will cover Emergency Care and Urgent Care in another state. We will also cover Emergency Care that results in hospitalization in Canada and Mexico if the services are approved, and the doctor and hospital meet Medi-Cal rules. If you want to get Routine Care, including preventive care, in another state, you will need to apply for Medicaid in that state. If you sign up for Medicaid in another state, you will no longer be eligible for Medi-Cal in California and we will not pay for your health care. Medi-Cal Rx does not cover outpatient prescription drugs outside of California, except for prescriptions that are given to you as part of covered Emergency Care or covered Urgent Care.

Continuity of care

Completion of Covered Services from non–Plan Providers

New Members

If you are a new Member and have been getting care from providers who are not in the Kaiser Permanente network, you may be able to keep seeing them for up to 12 months or more in certain situations. If your medical situation falls under one of the cases listed below under the heading "Eligibility", you can ask to continue care with that provider.

Existing Members

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

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

Eligibility

This section describes the medical conditions for which you can ask for Continuity of Care. There are additional criteria that must be met in order for us to approve your request. Those additional criteria are listed later in this section. If we approve your request for Completion of Covered Services, we will cover the services listed below. For new members, approved services are covered for up to 12 months from your enrollment date, unless otherwise specified below.

- **Acute conditions**. Covered Services until the acute condition ends
- **Serious chronic conditions**. Covered Services until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the first day after a course of treatment is complete when it would be safe to transfer your care to a Network Provider, as determined by Kaiser Permanente after 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.** Covered Services while you are pregnant and for up to a year after you give birth
- **Services for women who have a mental health condition** while pregnant or right after birth. Covered Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever is later
- **Terminal illnesses**. Covered 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 in most cases

- **Care for children under age 3**. Covered Services until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the child's third birthday
- **Surgery or another procedure that is part of a course of treatment.**
  - If you are a new Member, the surgery or procedure must be recommended and documented by the provider to occur within 180 days of your effective date of coverage
  - If your provider’s contract with Kaiser Permanente ends, the surgery or procedure must be recommended and documented by the provider to occur within 180 days of the end date of the contract between Kaiser Permanente and the provider

To qualify for this completion of services coverage, all the following requirements must be met:

- Your Medi-Cal coverage is in effect on the date you receive the services
- For new Members, your prior plan's coverage of the provider's services has ended or will end when your coverage with us becomes effective
- You are receiving services in one of the cases listed above from a non-Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the services of your current non-Plan Provider
- For new Members, you must have an existing relationship with the provider you are asking to keep going to.
  - For behavioral health treatment services for children under age 21, an existing relationship means you were seen by the provider in the six months prior to your enrollment in a Medi-Cal managed care plan
- For all other services, an existing relationship means that you were seen by the provider within the past 12 months for a non-emergency visit
- The provider agrees to our standard contractual terms and conditions
- The services are Medically Necessary and would be covered services under this Member Handbook if you got them from a Network Provider

- You request completion of services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider
- Kaiser Permanente does not have a documented quality of care concern with the non-plan provider

Kaiser Permanente does **not** cover completion of covered services from non-Plan Providers if either of the following is true:

- The services are not covered by Medi-Cal managed care
- Your provider won't work with Kaiser Permanente. You will need to find a new provider
- We are not required to provide Continuity of Care for services not covered by Medi-Cal, durable medical equipment, transportation, other ancillary services and carved-out service providers.

More information

For more information about this provision, or to request the services or a copy of our "Completion of Covered Services" policy, please call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). Our Member Service Contact Center can also tell you if you qualify to get services from an Out-of-Network Provider.

Costs

Member costs

Alameda Alliance for Health serves people who qualify for Medi-Cal. Alameda Alliance for Health Members do **not** have to pay for covered services received from Network Providers. For a list of covered services, see Chapter 4 ("Benefits and services").

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

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

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

When you are inside the United States, we cover Urgent Care services. If you are inside your Home Region, you must have pre-approval to go to an Out-of-Network Urgent Care provider. You do not need pre-approval for Urgent Care if you are outside your Home Region. If you are outside of the United States, Urgent Care services are **not** covered, and you will have to pay for your care. Your Home Region is the Kaiser Permanente Northern California Region.

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

You may have to pay a share of cost each month for your long-term care services. The amount of your share of cost depends on your income and resources. Each month you will pay your own medical bills including, but not limited to, Managed Long-term Support Services ("MLTSS") bills, until the amount that you have paid equals your share of cost. After that, your long-term care will be covered by Alameda Alliance for Health for that month. For more information on share of cost, call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

How a provider gets paid

Kaiser Permanente pays providers in these ways:

- Capitation payments
  - We pay some providers a set amount of money every month for each Member. This is called a capitation payment. We work with providers to decide on the payment amount
- FFS payments
  - Some providers give care to Medi-Cal Members and then send us a bill for the services they provided. This is called a FFS payment. We work with providers to decide how much to pay for each service

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

Asking us to pay a bill

Covered Services are services that we are responsible to pay for. If you get a bill for a Covered Service, do not pay the bill. Call our Member Service Contact Center right away at **1-800-464-4000** (TTY **711**).

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

If you pay for a service that you think we 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** (TTY **711**) to ask for a claim form. We 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 facility locations on our website at **kp.org/facilities**
  - By calling our Member Service Contact Center at **1-800-464-4000** or (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 our Member Service Contact Center at **1-800-464-400** (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 - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

3. How to get care

Getting health care services

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

The coverage information in this Member Handbook applies when you get health care services in your Home Region. Your Home Region is the Kaiser Permanente Region where you live. Your Home Region is Northern California and is identified on the cover of this Member Handbook and on your Kaiser Permanente ID Card. If you visit another Kaiser Permanente Region, you are covered only for Emergency Care or Urgent Care, unless we pre-approve the services for you. For more information on how to find Network Providers in your Home Region, go to our provider listings on **kp.org/facilities** or call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

You can begin to get health care services on your effective date of your assignment to us. This is a summary of our rules and policies and based on the contract between Kaiser Foundation Health Plan, Inc. and Alameda Alliance for Health.

Always carry your Kaiser Permanente ID card, Alameda Alliance for Health ID Card, Medi-Cal BIC, and any other health insurance cards you have with you. Never let anyone else use your ID cards or BIC.

We provide services to Members through our Network Providers. They work together to provide you with quality care. When you choose Kaiser Permanente as your provider network, you are choosing to get your care through our medical care program. To find where our Network Providers are located, visit our website at **kp.org/facilities**. For more information, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

New Members must choose a primary care provider ("PCP") who is in our provider network and in the Alameda Alliance for Health Service Area. You must choose a PCP within 30 days from the time you are assigned to us. 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 find our searchable Provider Directory at **kp.org/facilities**. You can also download a Provider Directory from our website at **kp.org/Medi-Cal/documents.** For more information, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

If you cannot get the care you need from a Kaiser Permanente Network Provider, your PCP must ask The Permanente Medical Group for approval to send you to an Out-of-Network Provider. This is called an Out-of-Network Referral. You do not need approval to go to an Out-of-Network Provider to get Sensitive Care, which is 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.

Pharmacy benefits are now administered through the Fee-For-Service ("FFS") Medi-Cal Rx program. To learn more, read the "Other Benefits and Programs Covered by Kaiser Permanente" section in Chapter 4.

Primary Care Provider ("PCP")

You must choose a PCP within 30 days of being assigned to Kaiser Permanente.

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

Adults can choose a PCP from the following:

- Adult medicine/internal medicine
- Family medicine
- Specialists in OB/GYN whom The Permanente Medical Group ("Medical Group") designates as PCPs

For children up to age 18, you can choose a doctor from Pediatrics/adolescent medicine or Family medicine to be their child's PCP. Each covered family member may choose their own personal doctor. 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 are in both Medicare and Medi-Cal, or if you have other health care insurance, you do not have to choose a PCP.

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

Note: American Indians may choose an IHCP as their PCP, even if the IHCP is not in our provider network.

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

You can change to another available Kaiser Permanente doctor at any time, for any reason. You can change your doctor online anytime at **kp.org** or you can call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

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

You can look in the Medi-Cal Provider Directory to find a PCP in the Kaiser Permanente network. The Medi-Cal Provider Directory has a list of providers that work with Kaiser Permanente to provide Medi-Cal Covered Services.

You can find the Kaiser Permanente Provider Directory online at **kp.org/facilities**. You can also request a Provider Directory to be mailed to you by calling **1-800-464-4000** (TTY **711**).

Choice of doctors and other 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 they 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 our Member Service Contact Center at **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 Alameda Alliance for Health to reassign you to a different provider network if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If Alameda Alliance for Health reassigns you to a different provider network, they will tell you in writing.

Some things to think about when picking a PCP:

- Does the PCP take care of children?
- Does the PCP work at a Plan Facility I like to use?
- Is the PCP's office close to my home, work or children's school?
- Does the doctor speak my language?
- Do the PCP's office hours fit my schedule?

Initial Health Assessment ("IHA")

We recommend that, as a new Member, you visit your new PCP within the first 120 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.

Take your BIC, your Alameda Alliance for Health ID Card, your Kaiser Permanente ID card, and your photo ID 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.

If you have questions about the IHA, call our care coordination team at **510-618-5800** (TTY **711**), Monday through Friday, 8:30 a.m. to 5 p.m.

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. Children are able to receive much needed early preventive services like hearing and vision screenings, assessments of developmental process, and many more services that are recommended by pediatricians' Bright Futures guidelines. In addition to Preventive Care, Routine Care also includes care when you are sick. Kaiser Permanente covers Routine Care from your Network Providers.

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 **1-866-454-8855** (TTY **711**) to schedule an appointment or you can make an appointment online. To request an appointment online, go to our website at **kp.org**.

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

To learn more about health care and services we cover, and what we do not cover, read Chapter 4 ("Benefits and services") and Chapter 5 ("Child and youth well care") in this Member Handbook.

All Network Providers can use aids and services to communicate with Members and caregivers with disabilities. They can also communicate with you in another language or format. Tell your provider or call us to tell us what you need.

Medi-Cal provider network

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

Kaiser Permanente is your health care provider network through Alameda Alliance for Health. 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.

You can go to an Out-of-Network Provider without a referral or pre-approval for emergency services or for family planning services. You can also go to an Out-of-Network Provider for out-of-area Urgent Care when you are in an area where we do not operate. You must have a referral or pre-approval for all other out-of-network services, or they will not be covered.

Note: American Indians may choose an Indian Health Care Provider ("IHCP") as their PCP, even if the IHCP is not a Network Provider.

If your PCP, hospital or other provider has a moral objection to providing you with a covered service, such as family planning or abortion, they can help you find another Network Provider who will give you the services you need. You can also call our Member Service Contact Center at **1-800-464-4000** (TTY **711**) to ask for help finding another Network Provider. For more about moral objections, read the "Moral objection" section later in this chapter.

Network Providers

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

For more information on our Network Providers, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). You can also find Kaiser Permanente Network Providers and locations online at **kp.org/facilities**. You can download a copy of the Provider Directory at **kp.org/Medi-Cal/documents.**

To get a copy of the Medi-Cal Rx Contract Drug List, call Medi-Cal Rx Customer Service at **1-800-977-2273,** 24 hours a day, 7 days a week. TTY users can call **1-800-977-2273** and press 5 or call **711,** Monday through Friday, 8 a.m. to 5 p.m. You can also visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/**.

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

Except for Emergency Care, Urgent Care outside your Home Region, or Sensitive Care, you must get pre-approval from Kaiser Permanente before you see a provider outside the Kaiser Permanente network. If you do not get pre-approval and you go to a provider outside of the network for care that is not emergency care, Urgent Care outside your

Home Region, or Sensitive Care, you may have to pay for the services you get from that Out-of-Network Provider. Kaiser Permanente providers who are outside your Home Region are Out-of-Network Providers.

Out-of-Network Providers inside your Home Region

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

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

- Emergency Care
- Sensitive Care

For Urgent Care inside the Home Region, you must see a Kaiser Permanente Network Provider. You do not need pre-approval to get Urgent Care from a Network Provider.

You must approval from us to get Urgent Care from an Out-of-Network Provider who is inside your Home Region. If you do not get pre-approval, you may have to pay for the Urgent Care you get from Out-of-Network Provider inside your Home Region. For more information on Emergency Care, Urgent Care, and Sensitive Care, go to those headings in this chapter.

Note: If you are an American Indian, you can get care at an IHCP outside of our provider network without a referral.

If you need Medically Necessary Covered Services that are not available in the Kaiser Permanente network, we will approve and refer you to an Out-of-Network Provider to get those services. If we give you a referral to an Out-of-Network Provider, we will pay for your care.

Your Urgent Care provider might give you medication as part of your Urgent Care visit. If you get medications as part of your visit, we will cover the medications as part of your covered Urgent Care. If your Urgent Care provider gives you a prescription to take to a pharmacy, the medications prescribed for you will be covered by the Medi-Cal Rx program. For more information on Medi-Cal Rx, go to the “Medi-Cal Rx” heading in the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” in Chapter 4.

If you need help with Out-of-Network services, talk with your PCP, or call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Providers outside your Home Region

Routine Care, including preventive care, is not covered outside your Home Region.

If you are outside of your Home Region and need care that is **not** Emergency Care or Urgent Care, call **1-866-454-8855** (TTY **711**) and talk to a licensed health care professional, 24 hours a day, 7 days a week.

Your Urgent Care provider might give you medication as part of your Urgent Care visit. If you get medications as part of your visit, we will cover the medications as part of your covered Urgent Care. If your Urgent Care provider gives you a prescription to take to a pharmacy, the medications prescribed for you will be covered by the Medi-Cal Rx program. For more information on Medi-Cal Rx, go to the “Medi-Cal Rx” heading in the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” in Chapter 4.

For Emergency Care, call **911** or go to the nearest hospital. Kaiser Permanente covers Out-of-Network Emergency Care. If you travel to Canada or Mexico and need Emergency Care that requires hospitalization, Kaiser Permanente will cover your care. If you are traveling internationally outside of Canada or Mexico and need Emergency Care, we **will not** cover your care.

If you pay for Emergency Care requiring hospitalization in Canada or Mexico, you can ask us to pay you back. Submit a claim form and we will review your request. For more information on filing a claim, see the “Ask us to pay a bill” section in Chapter 2.

If you are in another State, including US territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the US Virgin Islands), you are covered for Emergency Care. Not all hospitals and doctors accept Medicaid (Medicaid is what Medi-Cal is called in other States). If you need Emergency Care outside of California, tell the hospital or emergency room doctor as soon as possible that you have Medi-Cal and are a Kaiser Permanente member. Ask the hospital to make copies of your Kaiser Permanente ID card. Tell the hospital and the doctors to bill us. If you get a bill for services you received in another State, call us immediately. We will work with the hospital and/or doctor to arrange to pay for your care.

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

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

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

If you have questions about services available from Out-of-Network Providers or outside your Home Region, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Doctors

You will choose your primary care provider ("PCP") from our provider network. To find a PCP near you, you can look on our website at **kp.org/facilities**. You can download a copy of our Provider Directory at **kp.org/Medi-Cal/documents**, You can also call our Member Service Contact Center at **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 had a doctor before you were a Member of Kaiser Permanente, and that doctor is not part of our provider network, you may be able to keep that doctor for a limited time. This is called Continuity of Care. You can read more about Continuity of Care in Chapter 2 of this Member Handbook. To learn more, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

If you need a specialist, your PCP will refer you to a specialist in the Kaiser Permanente network. Some specialties do not require a referral. For more information on referrals, go to the heading "Referrals" later in this chapter 3.

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 are in both Medicare and Medi-Cal, or if you have other health care insurance, you do not have to choose a PCP.

If you want to change your PCP, you must choose a PCP from the Kaiser Permanente network. Be sure the PCP is taking new patients. To learn how to select or change to a different PCP, please visit our website at **kp.org**, or call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Hospitals

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

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in our network. To find our network hospitals, you can look on our website at **kp.org/facilities**. You can also call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Women's health specialists

You may go to a women's health specialist within the Kaiser Permanente 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 **1-866-454-8855** (TTY **711**) and talk to a licensed health care professional, 24 hours a day, 7 days a week.

Provider Directory

The Kaiser Permanente Medi-Cal Provider Directory ("Provider Directory") lists providers that participate in the Kaiser Permanente Medi-Cal provider network. The network is the group of providers that work with Kaiser Permanente.
The Kaiser Permanente Medi-Cal Provider Directory lists the following types of providers that are in our network:

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

The Provider Directory has Kaiser Permaente Network Provider names, specialties, addresses, phone numbers, business hours and languages spoken. It tells you if the

provider is taking new patients. It also gives the level of physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars. If you want information about a doctor's education, training, and board certification, please call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

You can find the online, searchable, Provider Directory at **kp.org/facilities**. You can download a copy at **kp.org/Medi-Cal/documents**. If you need a printed Provider Directory, call **1-800-464-4000** (TTY **711**).

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

Timely access to care

Your provider must offer you an appointment within the time frames listed below.

Appointment Type	Must Offer Appointment Within
Urgent Care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent Care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent (routine) primary care appointments	10 business days
Non-urgent (routine) specialist care appointments	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days
Non-urgent (routine) appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness, or other health condition	15 business days

Appointment Type	Must Offer Appointment Within
Telephone wait times for Member Services during normal business hours	10 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. Sometimes waiting longer for care is not a problem. Your provider may give you a longer wait time if it would not be harmful to your health. If must be noted in your record that a longer wait time will not be harmful to your health.

The standards for appointment availability do not apply to Preventive Care. 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. We highly discourage the use of minors or family members as interpreters. For more information on the interpreter services we offer, please call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

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

Travel time or distance to care

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

If you need care from a specialist and that provider is located far from where you live, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). They can help you find a provider located closer to you. If we cannot find care for you with a closer provider, you can request that we arrange transportation for you to see a provider even if that provider is located far from where you live.

It is considered far if you cannot get to that specialist within the travel time and distance standards for your county, regardless of any alternative access standard that may be in place for your ZIP Code.

If you need help with pharmacy providers, please call Medi-Cal Rx at **1-800-977-2273** (TTY **1-800-977-2273** and press 5 or **711**).

Appointments

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, Alameda Alliance for Health ID card, Kaiser Permanente ID card, and photo ID to your appointment
- Ask for transportation to your appointment, if needed
- Ask for language assistance or interpreter services, if needed
- Be on time for your appointment, arriving a few minutes early to sign in, fill out forms and answer any questions your provider may have
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

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

Getting to your appointment

If you don’t have a way to get to and from your health care services and appointments, we can help arrange transportation for you. Transportation help is available for services and appointments that are not related to Emergency Care and you may be able to get a ride at no cost to you. This service, called Medical Transportation, is **not** for emergencies. If you are having a medical emergency, call **911**.

Go to the section “Transportation services for situations that are not emergencies” in Chapter 4 (“Benefits and services”) for more information.

Canceling and rescheduling

If you can’t make your appointment, call your provider’s office right away. Most doctors ask you to call 24 hours (1 business day) before your appointment if you have to cancel. If you miss repeated appointments, your doctor may not want to see you as a patient anymore.

Payment

You do **not** have to pay for covered services. In most cases, you will not get a bill from a provider. You must show your Kaiser Permanente ID card, your Alameda Alliance for Health ID Card, and your Medi-Cal BIC when you get any health care services or prescriptions. Your ID Card will tell your doctor where to send the bill. You may get an Explanation of Benefits (“EOB”) from us or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call our Member Service Contact Center at **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 from a pharmacy for a prescription drug, supplies, or supplements, call Medi-Cal Rx Customer Service at **1-800-977-2273**, 24 hours a day, 7 days a week. TTY users can call **711**, Monday through Friday, 8 a.m. to 5 p.m. You can also visit the Medi-Cal Rx website for information at **https://medi-calrx.dhcs.ca.gov/home/.**You must get pre-approval (prior authorization) before you go to an Out-of-Network Provider, except when you need:

- Emergency Care
- Urgent Care outside your Home Region
  - Inside your Home Region, you need pre-approval to see an Out-of-Network Provider for Urgent Care
- Sensitive Care

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

If you need Medically Necessary services that are covered by Medi-Cal that are not available in the Kaiser Permanente network, we will approve and refer you an Out-of-Network Provider to get those services.

If you get a bill or are asked to pay a copay that you think you did not have to pay, 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 our Member Service Contact Center at **1-800-464-4000** (TTY **711**). We will be happy to help you if you need help completing our claim form.

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

Referrals

Your doctor 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 doctor will work with you to choose a specialist. Your doctor's office can help you set up a time to see the specialist.

Examples of services that require a referral include:

- Hospital stays that are not part of emergency care
- Surgery
- Orthopedics
- Cardiology
- Oncology
- Dermatology
- Physical, occupational, and speech therapies
- Stays at the following types of facilities:
  - Skilled nursing facility
  - Subacute facility

    - Pediatric subacute facility
    - Intermediate care facility
- Specialized treatments

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 go to the same specialist more than once without getting a referral each time.

If you have trouble getting a standing referral or want a copy of 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 services for mild to moderate conditions, including initial mental health assessments
- Obstetrics/Gynecology ("OB/GYN") visits
- Urgent Care
- Adult sensitive services, such as sexual assault care
- Emergency Care
- Family planning services (To learn more, call Office Family Planning Information and Referral Service at **1-800-942-1054**)
- HIV testing and counseling (12 years or older)
- Services for sexually transmitted infections (12 years or older)
- Chiropractic services (a referral may be required by out-of-network FQHCs and RHCs, and IHCPs)

Minors can also get certain outpatient mental health services, Sensitive Care services, and substance use disorder treatment services without their parents' consent. Substance use disorder treatment services are not covered under this Member Handbook. They are covered by county mental health plans.

Not all outpatient mental health services are covered under this Member Handbook. See the heading “Mental health services” in Chapter 4 for more information on what services are covered.

Although a referral or pre-approval is not required to receive most care from these providers, you may need a referral 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

Ready to quit smoking? Call **800-NO-BUTTS** (800-662-8887) to find out how. Or go to **www.nobutts.org**.

Pre-approval (Prior Authorization)

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

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

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

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

- Transplants
- Out-of-network services, including hospitalization after your condition is stable

For some services, you need pre-approval (prior authorization). Under Health and Safety Code Section 1367.01(h)(1), The Permanente Medical Group will decide routine pre-approvals (prior authorizations) within 5 working days of when The Permanente 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 endanger your life or health or ability to attain, maintain, or regain maximum function, The Permanente Medical Group will make an expedited (fast) authorization decision. We will give notice as quickly as your health condition requires and no later than 72 hours after getting the request for services. Pre-approval (prior authorization) requests are reviewed by clinical or medical staff, such as doctors and nurses.

Kaiser Permanente does **not** pay the reviewers to deny coverage or services. We will send you a Notice of Action ("NOA") letter if The Permanente Medical Group does not approve your request. 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 Permanente Medical Group needs more information or more time to review your request.

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

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

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 our Member Service Contact Center at **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 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. If we refer you to an Out-of-Network Provider for a second opinion, we will pay for the second opinion. We will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic, severe or serious illness, or face an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, we will decide within 72 hours.

If we deny your request for a second opinion, you may file a grievance. To learn more about grievances, go to the "Complaints" heading in Chapter 6 ("Reporting and Solving Problems") in this Member Handbook.

Sensitive Care

Minor consent services

You may only get the following services without your parent or guardian's permission if you are 12 years old or older:

- Outpatient mental health for:
  - Sexual assault (no lower age limit)
  - Incest
  - Physical assault
  - Child abuse
  - When you have thoughts of hurting yourself or others

- HIV/AIDS prevention/testing/treatment
- Sexually transmitted infections prevention/testing/treatment
- Substance use disorder treatment services
  - Substance use disorder treatment is not covered under this Member Handbook. You have to get services from the county mental health plan in the county where you live. Go to the heading “Substance use disorder treatment services” under the Section “Other Medi-Cal programs and services not covered by Kaiser Permanente” for more information.

If you are under 18 years old, you can go to a doctor without permission from your parents or guardian for these types of care:

- Pregnancy testing and counseling
- Family planning/birth control (including sterilization)
- Abortion services
- Sexual assault care

For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be part of the Kaiser Permanente network. You can choose any Medi-Cal provider and go to them without a referral or prior authorization. You can also get services related to sexually transmitted infections from Medi-Cal family planning providers.

For minor consent services that are not specialty mental health services, you can see a Network Provider without a referral and without prior authorization. Your PCP does not have to refer you and you do not need to get pre-approval (prior authorization) from us to get minor consent services that are covered under this Member Handbook. Minors can talk to a representative in private about their health concerns by calling **1-866-454-8855** (TTY **711**).

Minor consent services that are specialty mental health services are not covered under this Member Handbook. Specialty mental health services are covered by the county mental health plan for the county where you live.

Services from an Out-of-Network Provider that are not related to Sensitive Care may not be covered. For help finding a Medi-Cal provider who is outside the Kaiser Permanente network, or to ask for transportation help to get to a provider, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Minors can talk to a representative in private about their health concerns by calling **1-866-454-8855** (TTY **711**) and talk to a licensed health care professional, 24 hours a day, 7 days a week.

Adult Sensitive Care

As an adult (18 years or older), you may not want to go to your PCP for certain sensitive or private care. If so, you may choose any doctor or clinic for the following types of care:

- Family planning/birth control (including sterilization services)
- Pregnancy testing and counseling
- HIV/AIDS prevention/testing/treatment
- Sexually transmitted infections prevention/testing/treatment
- Sexual assault care
- Outpatient abortion services

For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be part of the Kaiser Permanente network. You can choose any Medi-Cal provider and go to them without a referral or prior authorization. For help finding a Medi-Cal provider who is outside the Kaiser Permanente network, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

For all other adult Sensitive Care, you can see a Network Provider without a referral and without prior authorization. Your PCP does not have to refer you and you do not need to get pre-approval (prior authorization) from us to get adult Sensitive Care that is covered by us.

Services from an Out-of-Network Provider that are not related to Sensitive Care may not be covered. For help finding a doctor or clinic giving these services, or for transportation help getting to these services, you can call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). You may also call **1-866-454-8855** and talk to a licensed health care professional, 24 hours a day, 7 days a week.

Moral objection

Some providers have a moral objection to some covered services. This means they have a right to **not** offer some covered services if they morally disagree with the services. If your provider has a moral objection, they 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 our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

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**
- **abortion**

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

These services are available to you and we must ensure you or your family member sees a provider or is admitted to a hospital that will perform the covered services. Call our Member Service Contact Center at **1 800-464-4000** (TTY **711**) if you have questions or need help finding a provider.

Urgent Care

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

Urgent Care needs could be a cold, sore throat, fever, ear pain, sprained muscle or maternity services. For Urgent Care, call **1-866-454-8855** (TTY **711**) and talk to a licensed health care professional, 24 hours a day, 7 days a week.

You must obtain Urgent Care services from a Network Provider when you are inside your Home Region. You do not need pre-approval (prior authorization) for Urgent Care from Network Providers inside your Home Region.

If you are outside your Home Region, but inside the United States, you do not need pre-approval (prior authorization) to get Urgent Care. Go to the nearest Urgent Care facility. Medi-Cal does not cover Urgent Care services outside the United States. If you are traveling outside the United States and need Urgent Care, we will **not** cover your care.

Your Urgent Care provider might give you medication as part of your Urgent Care visit. If you get medications as part of your visit, we will cover the medications as part of your covered Urgent Care. If your Urgent Care provider gives you a prescription to take to a pharmacy, the medications prescribed for you will be covered by the Medi-Cal Rx program. For more information on Medi-Cal Rx, go to the “Medi-Cal Rx” heading in the section “Other Medi-Cal programs and services not covered by Kaiser Permanente” in Chapter 4.

If your care is a mental health Urgent Care concern, contact the county Mental Health Plan’s 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. After your Urgent Care issue has resolved, you must see a Network Provider for any needed follow-up care. If you need durable medical equipment related to your Urgent Care, your Out-of-Network Provider must obtain pre-approval (prior authorization) from us.

Emergency Care

For Emergency Care, call **911** or go to the nearest hospital. For Emergency Care, you do **not** need pre-approval (prior authorization) from us. You have the right to use any hospital or other setting for emergency care including in Canada and Mexico. Emergency care and other care in other countries are not covered.

Emergency Care is for emergency medical conditions. It is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don’t get care right away, you would place your health (or your unborn baby’s health) in serious danger, or risk serious harm to your

body functions, body organs or body parts. Examples of emergency medical conditions include, but are not limited to:

- Active labor
- Broken bone
- Chest pain
- Drug overdose
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts (covered by county mental health plans)
- Severe bleeding
- Severe burn
- Severe pain
- Trouble breathing
- Fainting

Do not go to the ER for Routine Care or care that is not needed right away. You should get Routine Care from your PCP, who knows you best. If you are not sure if you have an emergency, call your PCP. You may also call **1-866-454-8855** (TTY **711**) and talk to a licensed health care professional, 24 hours a day, 7 days a week.

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 us. You or the hospital to which you were admitted should call Kaiser Permanente within 24 hours after you get emergency care. If you are traveling outside the U.S., other than to Canada or Mexico, and need Emergency Care, Kaiser Permanente will **not** cover your 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 hospital.

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 Necessary to get you to the provider. This may include special transport services that we would not normally cover.

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

The Appointment and Advice Line gives you free medical information and advice 24 hours a day, every day of the year. Call **1-866-454-8855** (TTY **711**).

Appointment and Advice Line

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

- Talk to a healthcare professional who will answer medical questions, give care advice, and help you decide if you should see a provider right away
- Get help with medical conditions such as diabetes or asthma, including advice about what kind of provider may be right for your condition
- Get help on what to do if you need care and a Plan Facility is closed or you are outside your Home Region

You can reach one of these licensed health care professionals by calling **1-866-454-8855** (TTY **711**). When you call, a trained support person may ask you questions to help determine how to direct your call.

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 about your health care if you cannot.

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

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

You have the right to learn about changes to advance directive laws. Kaiser Permanente will tell you about changes to the state law no longer than 90 days after the change. For more information, you can call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Organ and tissue donation

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

4. Benefits and services

What your health plan covers

This chapter explains your Covered Services as a Member of Kaiser Foundation Health Plan, Inc. Your Covered Services are no cost to you as long as they are Medically Necessary and provided according to the rules outlined in this Member Handbook. Most services must be provided by a Network Provider. We may cover Medically Necessary services from an Out-of-Network Provider in some cases. You must ask us for pre-approval (prior authorization) if the care is out-of-network, except for Sensitive Care, Emergency Care or Urgent Care services.

Medically Necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness or injury. For Members under the age of 21, Medically Necessary services include care that is needed to fix or help relieve a physical or mental illness or condition. Members under 21 years old are able to get extra benefits and services. Read Chapter 5 (“Child and youth well care”) for more information.

For more information on your Covered Services, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

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 Care

The following are examples of the services we cover:

- Ambulatory (outpatient) services
- A limited number of outpatient prescription drugs, supplies, and supplements. Most outpatient prescription drugs, supplies, and supplements are covered under the Medi-Cal Rx Program under Fee-for-Service Medi-Cal
- Emergency services, including emergency ambulance services
- Hospice and palliative care
- Hospitalization
- Investigational services
- Laboratory and radiology services, such as X-rays
- Long-term services and supports ("LTSS")
- Maternity and newborn care
- Mental health services for mild to moderate conditions, including initial mental health assessments
- Non-emergency medical transportation ("NEMT")
- Non-medical transportation ("NMT")
- Pediatric services
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative (therapy) services and devices
- Reconstructive surgery
- Substance use disorder screening services
- Telehealth services from Kaiser Permanente Network Providers
- Vision services

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

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

Benefit policies and the processes for how to get covered services may vary among Alameda Alliance for Health's provider networks. If you would like information on how to

change provider networks, please call Alameda Alliance for Health's Member Services at **510-747-4567**, (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

Medically Necessary are services that will (or are reasonably expected to) prevent, diagnose, cure, correct or improve the following and that are provided in a manner consistent with accepted standards of medical practice:

- Pain and suffering
- Physical, mental, cognitive or developmental effects of an illness, injury or disability

For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), these services may also include treatment that is observation only and services that would correct or improve defects and physical and mental illnesses discovered by screening services.

Medically Necessary services do not include:

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

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

Medically Necessary services include Covered Services that are reasonable and necessary to:

- Protect life
- Prevent significant illness or significant disability
- Alleviate severe pain
- Achieve age-appropriate growth and development
- Attain, maintain, and regain functional capacity

For Members under the age of 21, Medically Necessary services include all Covered Services, identified above, and any other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions, as required by the federal Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") benefit.

EPSDT provides a broad range of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. The EPSDT benefit is more robust than the benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

We will coordinate with other programs to ensure that you receive all Medically Necessary services, even if those services are covered by another program and not by Kaiser Permanente.

Medi-Cal benefits covered by Kaiser Permanente

Outpatient (ambulatory) services

Adult Immunizations

You can get adult immunizations (shots) from a Network Provider without pre-approval (prior authorization0. We cover those shots recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"), including shots you need when you travel. For information on immunizations for children, go to chapter 5 ("Child and youth well care").

You can also get some adult immunization (shots) services in a pharmacy through Medi-Cal Rx. To learn more about the Medi-Cal Rx program, go to that heading under the section "Other programs and services not covered by Kaiser Permanente" later in this chapter 4.

Allergy care

We cover Medically Necessary allergy testing and treatment, including allergy desensitization, hyposensitization, or immunotherapy.

Anesthesiologist services

We cover anesthesia services that are Medically Necessary when you get outpatient care. These services may include anesthesia for dental procedures when provided by a medical anesthesiologist.

For dental procedures, we cover the following services when authorized by The Permanente 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 Center ("FQHC"), dental office, or hospital setting

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

Chiropractic services

We cover chiropractic services, limited to the treatment of the spine by manual manipulation. You may get up to two visits per month without prior authorization. Additional visits may be approved when Medically Necessary.

- ***Chiropractic services from American Specialty Health network providers***
  We work with American Specialty Health to arrange chiropractic services. For more information on chiropractic services, please call American Specialty Health at **1-800-678-9133** (TTY **711**). The following Members are eligible to get chiropractic services from American Specialty Health network providers:
  - Children under age 21
  - Pregnant women through the postpartum period
  - Residents in a skilled nursing facility, intermediate care facility, or subacute care facility

- ***Chiropractic services from County facilities, FQHCs, and RHCs***
  Medi-Cal may cover chiropractic services for Members of all ages when received at county hospital outpatient departments, county outpatient clinics, FQHCs, or RHCs that are in Alameda Alliance for Health's network. FQHCs and RHCs may require a referral to get services. Not all county facilities, FQHCs or RHCs offer outpatient chiropractic services. To get more information, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Dialysis and hemodialysis services

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

We do not cover

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Outpatient surgery and other outpatient procedures

We cover Medically Necessary outpatient surgery and other outpatient procedures.

Physician services

We cover physician services that are Medically Necessary. Some services may be provided as a group appointment.

Dyadic services

Starting on July 1, 2022, we will cover dyadic behavioral health services provided by your PCP or your child's PCP. Dyadic services are family-focused screening and counseling services. They identify physical health, mental health, and social determinants of health concerns early and provide referrals to community resources as needed.

Podiatry (foot) services

We cover podiatry services as Medically Necessary for diagnosis and medical, surgical, mechanical, manipulative, and electrical treatment of the human foot. This includes the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg controlling the functions of the foot.

Treatment therapies

We cover Medically Necessary treatment therapies, including:

- Chemotherapy
- Radiation therapy
- Administered drugs and products. These are medications and products that require administration or observation by a health care provider. We cover these items when a Network Provider prescribes them for you, in accordance with our drug formulary guidelines. Items must be administered in a Plan

Facility or during home visits to be covered. Examples of administered drugs we cover include, but are not limited to:

- Whole blood, red blood cells, plasma, and platelets
- Cancer chemotherapy drugs
- Allergy antigens
- Drugs and products that are administered via intravenous therapy or injection

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

Maternity and newborn care

Breastfeeding education

We cover comprehensive lactation support.

Breast pumps and supplies

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

Delivery and postpartum care

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

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.

Certified Nurse Midwife (“CNM”) services

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

Licensed Midwife ("LM") services

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

Testing and counseling for genetic disorders

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

Newborn care

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

The Provisional Postpartum Care Extension Program *(effective until April 1, 2022)*

The Provisional Postpartum Care Extension ("PPCE") Program provides extended coverage for Medi-Cal members who have a maternal mental health condition during pregnancy or the time period after pregnancy.

We cover maternal mental health care for women during pregnancy and for up to two months after the end of pregnancy. The PPCE Program extends that coverage for up to 12 months after the diagnosis or from the end of the pregnancy, whichever is later.

To qualify for the PPCE program, your doctor must confirm your diagnosis of a maternal mental health condition within 150 days after the end of pregnancy. Ask your doctor about these services if you think you need them. If your doctor thinks you should have the services from PPCE, your doctor completes and submits the forms for you.

To learn about the mental health services we cover, go to the heading "Mental health services" in this Chapter 4.

The Postpartum Care Extension Program *(effective starting April 1, 2022)*

The Postpartum Care Extension Program provides extended coverage for Medi-Cal members during both the pregnancy and after pregnancy.

The Postpartum Care Extension Program extends Medi-Cal coverage for up to 12 months after the end of the pregnancy regardless of income, citizenship, or immigration status and no additional action is needed.

Telehealth services

Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider. Or telehealth may involve sharing information with your provider without a live conversation. You can receive many services through telehealth. However, telehealth may not be available for all covered services. You can contact your provider to learn which types of services may be available through telehealth. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. You have the right to in-person services and are not required to use telehealth even if your provider agrees that it is appropriate for you.

Mental health services

Mental health assessments

You do not need a referral or pre-approval to get an initial mental health assessment from a Network Provider. You may get a mental health assessment at any time from a licensed mental health provider who is a Network Provider. You can look at our online provider listings at **kp.org/facilities** to find a mental health provider in our network or call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). If your mental health provider decides you need specialty mental health services ("SMHS"), your doctor will refer you to the county mental health plan to receive an assessment.

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

Outpatient mental health services for mild to moderate conditions

If your mental health provider determines that you have a mild or moderate mental health condition or have impairment of mental, emotional or behavioral functioning, we cover the following outpatient mental health services:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when necessary to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purpose of monitoring drug therapy

- Psychiatric consultation
- Imaging and laboratory services related to treatment of your mental health condition (see “Laboratory and radiology services” in this chapter 4)

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

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

Emergency Services

Inpatient and outpatient services needed to treat a medical emergency

We cover all services that are needed to treat a medical emergency that happens in the U.S. (including territories such as Puerto Rick, U.S. Virgin Islands, etc.) or requires you to be in a hospital in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent (reasonable) layperson (not a health care professional) with an average knowledge of health and medicine could expect it to result in any of the following:

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

Covered Emergency Care services include up to a 72-hour emergency supply of outpatient prescription drugs if a pharmacist or hospital emergency department gives you the medication as part of your Emergency Care.

If a hospital emergency department provider gives you a prescription that you have to take to an outpatient pharmacy to be filled, Medi-Cal Rx will be responsible for the coverage of that prescription. If a pharmacist at an outpatient pharmacy gives you an emergency supply of a medication, that prescription will also be covered by Medi-Cal Rx and not by us. If the pharmacy needs help to process your prescription, they can call Medi-Cal Rx Customer Service at **1-800-977-2273**, 24 hours a day, 7 days a week.

Emergency transportation services

We cover ambulance services to help you get to the nearest place of care in 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. No services are covered outside the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico. If you receive emergency ambulance services in Canada and Mexico and you are not hospitalized during that episode of care, we will not cover your ambulance services.

Health education

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

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). These programs and materials are available at no cost to you.

For more information about our health education counseling, programs, and materials, please contact the health education department at your local Plan Facility. You can also call our Member Service Contact Center at **1-800-464-4000** (TTY **711**) or go to our website at **kp.org**.

Hospice and palliative care

Hospice care

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

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

- A 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 your Home Region

- 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

With hospice care:

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

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

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

- Services of 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.
    - We cover administered drugs in accordance with our drug formulary guidelines
    - We cover outpatient drugs that are directly related to your covered hospice services. You must obtain these drugs from a Kaiser Permanente network pharmacy. For some drugs, we cover a 30-day supply in any 30-day period
    - Outpatient prescription drugs that are not part of your hospice care are

covered by Medi-Cal Rx. You can learn more about Medi-Cal Rx by going to the heading "Medi-Cal Rx" under the section "Other benefits and programs not covered by Kaiser Permanente" later in this Chapter 4

- 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. Palliative care may be provided at the same time as curative care.

Palliative care includes the following:

- Advance care planning
- Palliative care assessment and consultation
- A plan of care including, but not limited to the following, as needed:
  - Services of a doctor of medicine or osteopathy
  - Services of a physician assistant
  - Services of a registered nurse
  - Services of a licensed vocational nurse or nurse practitioner
  - Services of a social worker
  - Services of a chaplain
  - Care coordination
  - Pain and symptom management

- Mental health and medical social services

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

Surgical services

We cover Medically Necessary surgeries performed in a hospital.

Rapid Whole Genome Sequencing

Rapid Whole Genome Sequencing ("rWGS"), including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal member who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. rWGS is an emerging method of diagnosing conditions in time to affect ICU care of children one year of age or younger. If your child is eligible for California Children's Services ("CCS"), CCS may be responsible for covering the hospital stay and the rWGS.

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.

Drugs that are covered as part of investigational services are covered by Kaiser Permanente and not Medi-Cal Rx. You must go to a Kaiser Permanente network pharmacy to fill prescriptions related to investigational services for them to be covered.

Outpatient prescription drugs, supplies, and supplements covered by Kaiser Permanente

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

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

Enteral and parenteral nutrition

These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. We cover enteral and parenteral nutrition products when Medically Necessary.

Contraceptive drugs and devices

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

Diabetic Testing Supplies

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

Other prescription drug items we cover

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

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

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

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 Providers determine what is the Medically Necessary supply for you for 30 days or 100 days or 365 days. The most you may get at one time for hormonal contraceptives is a 365-day supply.

- ***All other items***

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

  The most you may get at one time of a covered item is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. Amounts of drugs or items 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).

Drug formulary for prescription items covered by Kaiser Permanente

We cover certain Medically Necessary items that require a prescription and certain items that are available over the counter ("OTC"). We cover these items when you receive them as part of a covered hospital stay or when you receive them as part of a medical visit. We also cover certain items required under state law when those items are dispensed from a network outpatient pharmacy. We cover items prescribed by 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 our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee is a group of network doctors and pharmacists the reviews drugs for their safety and effectiveness. The Pharmacy and Therapeutics Committee decides which drugs will be on the Kaiser Permanente drug formulary. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available.

To find out if a drug is on the formulary or to get a copy of the formulary, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

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

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

You can learn more about Medi-Cal Rx by going to the heading "Medi-Cal Rx" under the section "Other Medi-Cal programs and services not covered by Kaiser Permanente" later in this Chapter 4.

Pharmacies

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

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

  You can find locations for our pharmacies on our website at **kp.org/facilities** or call our Member Service Contact Center at **1-800-464-4000** (TTY **711**) for locations and hours of network pharmacies in your area.

  Once you choose a pharmacy, take your prescription to the pharmacy. Give the pharmacy your prescription with your Kaiser Permanente ID card. Make

sure the pharmacy knows about all medications you are taking and any allergies you have. If you have any questions about your prescription, make sure you ask the pharmacist.

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

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

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

Medicare Part D

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

To learn more about Medicare Part D (including how to enroll in Part D), please call 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 ('therapy") services and devices

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

- The services are Medically Necessary
- The services are to address a health condition
- The services are to help you keep, learn, or improve skills and functioning for daily living

- You receive the services at a Plan Facility, unless a network doctor determines that it is Medically Necessary for you to receive the services in another location

Acupuncture

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

Acupuncture services are covered when obtained through our Network Providers or American Specialty Health network providers. For more information on acupuncture services, please call American Specialty Health at **1-800-678-9133** (TTY **711**).

Audiology (hearing)

We cover Medically Necessary audiology services.

Behavioral health treatment

We cover behavioral health treatment ("BHT") services for members under 21 years of age under the federal Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") benefit. BHT includes services and treatment programs, such as applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual under 21 years old.

BHT services teach skills using behavioral observation and reinforcement, or through prompting to teach each step of a targeted behavior. BHT services are based on reliable evidence 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 Permanente 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

Medi-Cal coverage does not include:

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

If you have any questions call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Cardiac rehabilitation

We cover Medically Necessary inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment

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

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

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

Medi-Cal Plan coverage does not include the following:

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

- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse, except when Medically Necessary for a Member under age 21
- Other items that are generally not used for a health care purpose

Note: The services that are subject to prior authorization (pre-approval) may vary among Alameda Alliance for Health's provider networks. If you would like information on how to change provider networks, please call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

Hearing aids

We cover hearing aids as described in this section if:

- You are tested for hearing loss
- The hearing aids are Medically Necessary
- You receive a prescription from your doctor.
- Coverage is limited to the lowest cost aid that meets your medical needs. We will choose who will supply the hearing aid. We cover one hearing aid unless an aid for each ear is needed for results significantly better than you could get with one aid.

- ***Hearing aids for Members under the age of 21***
  State law requires children who need hearing aids to be referred to the California Children's Services ("CCS") program to determine if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for Medically Necessary hearing aids. If the child is not eligible for CCS, we will cover Medically Necessary hearing aids as part of Medi-Cal coverage.

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

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

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

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

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

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

- Replacement hearing aid batteries

Home health services

We cover Medically Necessary health services provided in your home, prescribed by your doctor, if all of the following are true:

- You are housebound (substantially confined to your home or a friend's or family member's home)
- Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist
- A network doctor finds that it is possible to monitor and control your care in your home
- A network doctor finds that the services can be provided in a safe and effective way in your home
- You get the services from 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 equipment, appliances, and supplies that are prescribed by a Network Provider, including implanted hearing devices. Some medical supplies are covered by Medi-Cal Rx and not by us. You can ask your pharmacy for more information about what supplies are covered by Medi-Cal Rx. To learn more about Medi-Cal Rx, see the Medi-Cal Rx heading under the “Other benefits and programs not covered by Kaiser Permanente” later in this chapter 4.

Medi-Cal coverage does not include the following:

- Common household items including, but not limited to
  - Adhesive tape (all types)
  - Rubbing alcohol
  - Cosmetics
  - Cotton balls and swabs
  - Q-tips, dusting powders
  - Tissue wipes
  - Witch hazel
- Common household remedies including, but not limited to, the following:
  - White petrolatum
  - Dry skin oils and lotions
  - Talc and talc combination products
  - Oxidizing agents such as hydrogen peroxide
  - Carbamide peroxide and sodium perborate
  - Non-prescription shampoos
- Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid and zinc oxide paste
- Other items not generally used primarily for health care and which are regularly and primarily used by persons who do not have a specific medical need for them

Occupational therapy

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

Note: The services that are subject to prior authorization (pre-approval) may vary among Alameda Alliance for Health's provider networks. If you would like information on how to change provider networks, please call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

Orthotics/prostheses

We cover prosthetics and orthotic devices if all the following conditions are met:

- The item is Medically Necessary to restore how a body part works (for prosthetics only)
- The item is prescribed for you
- The item is Medically Necessary to support a body part (for orthotics only)
- The item is Medically Necessary for you to perform activities of daily living
- The item makes sense for your overall medical condition

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

Note: The services that are subject to prior authorization (pre-approval) may vary among Alameda Alliance for Health's provider networks. If you would like information on how to change provider networks, please call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

Ostomy and urological supplies

Ostomy and urological supplies must be pre-approved for you.

We cover ostomy bags, urinary catheters, draining bags, irrigation supplies and adhesives. We do not cover supplies that are for comfort or convenience purposes. We also do not cover luxury equipment or features.

Note: The services that are subject to prior authorization (pre-approval) may vary among Alameda Alliance for Health's provider networks. If you would like information on how to change provider networks, please call Alameda Alliance for Health Member Services at **510-747-4567** (TTY 711 or 1-800-735-2929), Monday through Friday, 8 a.m. to 5 p.m.

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 Network Provider.

Skilled nursing facility services

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

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

Speech therapy

We cover speech therapy that is Medically Necessary.

Transgender services

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

Clinical Trials

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

- We would have covered the services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to 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 a life-threatening condition. The clinical trial must meet one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration

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

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

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

Laboratory and radiology services

We cover outpatient and inpatient laboratory and X-ray services when Medically Necessary. Various advanced imaging procedures, such as CT scans, MRI, and PET scans, are covered based on medical necessity.

Preventive and wellness services and chronic disease management

Preventive services

We cover the following preventive services:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- American Academy of Pediatrics' Bright Futures recommendations
- Preventive services for women recommended by the Institute of Medicine, the Health Services Resources Administration, and the American College of Obstetrics and Gynecologists
- 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 FDA. 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 Medi-Cal 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.

Note: For more information on preventive services for children, go to the section "Pediatric services" in this Chapter 4.

Diabetes Prevention Program ("DPP")

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. It can last for second year for those Members who qualify. The program uses approved lifestyle supports and techniques including, but not limited to, the following:

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

Members who are interested in DPP must meet program eligibility requirements. Contact our Member Service Contact Center at **1-800-464-4000** (TTY **711**) for additional program and eligibility information.

Reconstructive surgery

We cover:

- Surgery when there is a problem with a part of your body. This problem could be caused by congenital defects, a developmental abnormality, trauma, infection, tumors, disease or injury. We cover surgery to correct or repair abnormal structures of the body to create a normal appearance to the extent possible.
- After Medically Necessary removal of all or part of a breast, we cover reconstructive surgery of the breast and reconstructive surgery of the other breast for a more similar look. We cover services for swelling after lymph nodes have been removed

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

Substance use disorder screening services

We cover screening and counseling services for alcohol misuse and illegal drug use. We do not cover substance use disorder treatment services.

For more information on substance use disorder treatment services, go to the heading "Substance use disorder treatment services" under the section "Other benefits and programs not covered by Kaiser Permanente" later in this chapter.

Vision services

Routine eye exams

We cover one routine eye exam every 24 months. Additional eye exams are covered if Medically Necessary.

Eyeglasses

We cover the following:

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

  We cover one complete pair of eyeglasses every 24 months when you have a prescription of at least 0.75 diopter.

- ***Eyeglass lenses***
  We will order new or replacement eyeglasses for you from DHCS's eyeglass lens vendor. If DHCS's vendor cannot provide you with the lenses you need, we will arrange for your lenses to be made at another optical lab. You will not have to pay extra if we have to make arrangements because DHCS's vendor cannot make your eyeglass lenses.

  If you want eyeglasses lenses or features that are not covered by Medi-Cal, then you may have to pay extra for those upgrades.

- ***Eyeglass Frames***
  We cover new or replacement frames that cost $80 or less. If you choose frames that cost more than $80, you must pay the difference between the cost of the frames and $80.

- ***Replacement eyeglasses within 24 months***

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

Low vision devices

Low vision devices are covered by Medi-Cal when the following conditions are met:

- The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point.
- The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means.
- The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient.

Coverage is limited to the lowest cost device that meets the Member's needs. Medi-Cal coverage does not include electronic magnification devices and devices that do not incorporate a lens for use with the eye.

Special Contact Lenses

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

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

Note: Lens replacement policies may vary among Alameda Alliance for Health's provider networks. If you would like information on how to change provider networks, please call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m.

Transportation services for situations that are not emergencies

For information on emergency transportation services, see the heading "Emergency services" earlier in this chapter 4.

Medical Transportation for situations that are not emergencies

You are entitled to Medical Transportation in non-emergency situations if you have medical needs that don't allow you to use a car, bus, train, or taxi to get to your Medi-Cal appointments. Medical Transportation can be provided for Medi-Cal services, such as medical, dental, mental health, substance use, and pharmacy appointments. Your doctor will decide the correct type of transportation that you need. Medical Transportation can be an ambulance, litter van, wheelchair van or air transport.

Medical Transportation must be used when:

- You are not able to physically or medically use a bus, taxi, car or van to get to your appointment
- You need help from the driver to and from your residence, vehicle or place of treatment due to a physical or mental disability
- It is requested by a network doctor and authorized in advance

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

Limits of Medical Transportation

In non-emergency situations, we cover the lowest cost medical transportation for your medical needs to the closest provider where an appointment is available. That means, for example, if you can physically or medically be transported by a wheelchair van, we will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

We will not arrange for Medical Transportation if the service is not covered by Medi-Cal. If the service is covered by Medi-Cal, but not by us, we can still help you arrange Medical Transportation. If you need Medical Transportation outside your Home Region or to go to an Out-of-Network Provider, we will cover Medical Transportation only if we have authorized it for you.

Cost to Member for non-emergency Medical Transportation

There is no cost to you when non-emergency Medical Transportation is authorized by us.

Non-Medical Transportation

Your Medi-Cal benefits include getting a ride to your appointments or to the pharmacy for Medi-Cal Covered Services. You can get a ride, at no cost to you, when you are:

- Traveling to and from an appointment for a Medi-Cal covered service
- Picking up prescriptions and medical supplies

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

Please call Kaiser Permanente's transportation provider at **1-844-299-6230** (TTY **711**) at least three business days (Monday 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)

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

Limits of NMT

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

NMT does not apply if:

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

Cost to Member for Non-Medical Transportation

There is no cost when Non-Medical Transportation is arranged by us.

Other Benefits and Programs Covered by Kaiser Permanente

Long-term Services and Supports ("LTSS")

We cover these LTSS benefits for members who qualify:

- Skilled nursing facility services as described under the heading "Skilled nursing facility services" in the section "Rehabilitative and habilitative ("therapy") services and devices" earlier in this Chapter 4.

Community Based Adult Services

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 Alameda Alliance for Health Member Services at **510-747-4567** If you qualify to get CBAS, Alameda Alliance for Health will authorize the services that best meet your needs.

Care coordination

We offer services to help you coordinate your health care needs at no cost to you. We will coordinate with other programs to ensure that you receive all Medically Necessary services covered by Medi-Cal, even if those services are covered by another program and not us. If you have questions or concerns about your health or the health of your child, call **510-618-5800** and leave a message. A Care Coordinator will call you back Monday through Friday, 8:30 a.m. to 5 p.m.

Enhanced Care Management

We cover Enhanced Care Management ("ECM") services for members with highly complex needs. ECM is a benefit that provides extra care coordination services to help you get the care you need to stay healthy. It coordinates the care you get from different doctors. ECM helps coordinate primary care, acute care, behavioral health, developmental services, oral health, and community-based long-term services and supports ("LTSS"), and referral to available community resources.

If you qualify for ECM, you may be contacted about ECM services that are available to you. You can also call us, or talk to your doctor or clinic staff, to find out if you can receive ECM.

Covered ECM services

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

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care

- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

To find out if ECM may be right for you, talk to your doctor.

Cost to member

There is no cost to you for ECM services.

Community Supports ("CS") program

Community Supports may be available to you under your individualized care plan. Community Supports are suitable and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. Community Supports are optional to Members; you do not have to accept them. If you qualify, Community Supports may help you live more independently. Community Supports do not replace benefits you already get under Medi-Cal. Community Supports are not available in all areas. Not all Members qualify to receive Community Supports. To qualify, you must meet specific criteria.

For more information on Community Supports, call **510-618-5800** and leave a message. A Care Coordinator will call you back Monday through Friday, 8:30 a.m. to 5 p.m.

Major Organ Transplants

Transplants for children under age 21

State law requires children who need transplants to be referred to the California Children's Services ("CCS") program to see if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for the transplant and related services. If the child is not eligible for CCS, then we will refer the child to a qualified transplant center for evaluation. If the transplant center confirms the transplant would be needed and safe, we will cover the transplant and related services.

Transplants for adults age 21 and older

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

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

- Bone marrow
- Heart
- Heart/Lung
- Kidney
- Kidney/Pancreas
- Liver
- Liver/Small bowel
- Lung
- Small bowel

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

Sometimes Kaiser Permanente does not cover services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. This section lists some of these services. To learn more, call your County Eligibility Worker or Medi-Cal toll-free at **1-800-541-5555** (English and Spanish). We will coordinate with other programs to ensure you receive all Medically Necessary services covered by Medi-Cal, even if those services are not covered by us.

Medi-Cal Rx

Most outpatient prescription drugs are covered by Medi-Cal Rx as a service through FFS Medi-Cal. To be covered by Medi-Cal Rx, the item must be on the Medi-Cal Contract Drug List ("CDL") or must be pre-approved for you by Medi-Cal Rx. Your provider can tell you if a drug is on the Medi-Cal Rx CDL.

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

The Medi-Cal Contract Drug List is the list of drugs that do not require pre-approval from Medi-Cal Rx. Your provider can tell you if a drug is on the Medi-Cal Rx Contract Drug List.

Sometimes, you may need an item that is not on the Contract Drug List. In such cases, Medi-Cal Rx will need to approve these items first before the pharmacy can give them to you. Medi-Cal Rx will review the request from your provider and make a decision within 24 hours.

- A pharmacist at your outpatient pharmacy or hospital emergency room may give you a 72-hour emergency supply if they think you need it. Medi-Cal Rx will pay for the emergency medication supply given by an outpatient pharmacy.

- Medi-Cal Rx may say no to a non-emergency request. If they say no, they will send you a letter to tell you why. They will tell you what your choices are. See the “Complaints” section in Chapter 6 (“Reporting and solving problems”) for more information.

To find out if a drug is on the Contract Drug List or to get a copy of the Contract Drug List, call Medi-Cal Rx Customer Service at **1-800-977-2273**, 24 hours a day, 7 days a week. TTY users can call **711**, Monday through Friday, 8 a.m. to 5 p.m. You can also visit the Medi-Cal Rx website at **https://www.Medi-CalRx.dhcs.ca.gov/home/**.

Medi-Cal Rx Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with Medi-Cal Rx. All Kaiser Permanente outpatient pharmacies in your Home Region work with Medi-Cal Rx. You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at **https://www.Medi-CalRx.dhcs.ca.gov/home/**. You can also call Medi-Cal Rx Customer Service at **1-800-977-2273**, 24 hours a day, 7 days a week. TTY users can call **711**, Monday through Friday, 8 a.m. to 5 p.m.

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

You can get transportation help from us to get to the pharmacy to pick up your prescription. For more information, go to the heading “Transportation services for situations that are not emergencies” earlier in this chapter 4.

Dental services

Medi-Cal covers some dental services, including:

- Diagnostic and preventive dental hygiene (such as examinations, X-rays and teeth cleanings)
- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)

- Scaling and root planning
- Periodontal maintenance
- Complete and partial dentures
- Orthodontics for children who qualify
- Topical fluoride

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.

Specialty mental health services

County mental health plans provide Medically Necessary specialty mental health services ("SMHS") to Medi-Cal Members. Specialty mental health services include the following:

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") (for beneficiaries up to age 21)
- Intensive home-based services ("IHBS") (for beneficiaries up to age 21)
- Therapeutic foster care ("TFC") (for beneficiaries up to age 21)

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

To learn more about specialty mental health services the county mental health plan provides, you can call the county. To locate all counties' toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.**

California Children's Services ("CCS")

CCS is a Medi-Cal 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-eligible condition, your child will be referred to the CCS county program to be assessed for eligibility.

County CCS program staff will decide if your child qualifies for CCS services. We do not decide CCS eligibility. If your child qualifies to get this type of care, CCS providers will treat your child for the CCS condition. Kaiser Permanente will continue to cover the types of services 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

County 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. DHCS will pay for qualifying CCS services.

If your child is not eligible for CCS program services, they will keep getting Medically Necessary care from Kaiser Permanente. To learn more about CCS, you can visit the CCS web page at **www.dhcs.ca.gov/services/ccs** or call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Substance use disorder treatment services

The county provides substance use disorder services to Medi-Cal members who meet medical necessity rules. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. To find all counties' telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx**.

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. If you are getting covered hospice care, this exclusion doesn't apply to you.

Fee-for-Service ("FFS") Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call **1-800-464-4000** (TTY **711**).

Prayer or spiritual healing

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

Local Education Agency ("LEA") assessment services

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

LEA services as specified in Title 22 CCR Section 51360

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

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

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

Pediatric Day Health Care

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

Targeted case management services as specified in Title 22 CCR Sections 51185 and 51351

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

Services you cannot get through Kaiser Permanente or Medi-Cal

This section describes the services that neither we nor Medi-Cal will cover. Read each of the sections below to learn more or call **1-800-464-4000** (TTY **711**).

Certain exams and services

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

- To get or keep a job
- To get insurance

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

This exclusion does not apply if a network doctor finds that the services are Medically Necessary.

Comfort or convenience items

Medi-Cal coverage does not include comfort, convenience, or luxury equipment or features. These include items that are solely for the comfort or convenience of a Member, a Member's family, or a Member's health care provider. This exclusion does not apply to retail-grade breast pumps that are provided to women after a pregnancy. This exclusion also does not apply to items approved for you under the Community Supports program. For more information on Community Supports, go to that heading earlier in this chapter 4.

Cosmetic services

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

- Testicular implants implanted as part of a covered reconstructive surgery
- Breast prostheses needed after a mastectomy or lumpectomy
- Prostheses to replace all or part of an external facial body part

Disposable supplies

Medi-Cal coverage does not include the following disposable supplies for home use: bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages. This exclusion does not apply to disposable supplies provided as part of the following benefits described in Chapter 4 ("Benefits and services") of this Member Handbook:

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

Experimental services

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

Fertility services

Medi-Cal coverage does not include services to help someone get pregnant, including infertility services, artificial insemination, and assisted reproductive technology services. Fertility preservation services are not covered by Medi-Cal.

Hair loss or growth treatment

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

Items and services that are not health care items and services

Medi-Cal coverage does not include items that are not health care items or services unless they are approved for you under the Community Supports program or approved for you under Durable Medical Equipment. For example, we do not cover:

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

- Training for a specific job or employment counseling
- Modifications to your home or car, unless they are temporary changes that are determined to be Medically Necessary or approved for you under Community Supports
- Aquatic therapy and other water therapy. This exclusion for aquatic therapy and other water therapy does not apply to therapy services that are part of a physical therapy treatment plan and covered as part of the following benefits in Chapter 4 ("Benefits and services"):
  - Home health care
  - Hospice and palliative care
  - Rehabilitative and habilitative services
  - Skilled nursing facility services

Massage therapy

Medi-Cal coverage does not include massage therapy. This exclusion does not apply to therapy services that are part of a physical therapy treatment plan and covered as part of the following benefits in Chapter 4 ("Benefits and services") of this Member Handbook:

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

Personal care services

Medi-Cal coverage does not include services that are not Medically Necessary, such as help with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of coverage described under the following sections:

- Hospice and palliative care
- Skilled nursing/intermediate/subacute facility care
- Community Supports Program

Reversal of sterilization

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

Routine foot care items and services

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

Services not approved by the federal Food and Drug Administration

Medi-Cal coverage does not include drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion does not apply to the following situations:

- Covered emergency services received in Canada or Mexico
- Services covered under "Cancer clinical trials" in Chapter 4 of this Member Handbook
- Services provided as part of covered investigational services as described in Chapter 4 of this Member Handbook

Services performed by unlicensed people

Medi-Cal coverage does not include services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to services covered under "Behavioral health treatments" heading under "Rehabilitative and habilitative services" in Chapter 4 of this Member Handbook. This exclusion also does not apply to Community Supports approved for you.

Services related to a noncovered service

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

Childhood lead poisoning case management provided by county health departments

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

Evaluation of new and existing technologies

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

5. Child and youth well care

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

Pediatric services (Children under age 21)

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

- Well-child visits and teen check-ups (Important visits children need)
- Immunizations (shots) s
- Mental health services for mild to moderate conditions (specialty mental health services are covered by the county)
- Hearing services (covered by CCS for children who qualify. We will cover Medically Necessary hearing services that CCS does not cover)
- Lab tests, including blood lead poisoning testing
- Health and preventive education
- Vision services
- Dental services (covered by FFS Medi-Cal Dental)

These services are called Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. EPSDT services that are recommended by pediatricians' Bright Futures guidelines to help you or your child stay healthy are covered at no cost to you.

Well-child health check-ups and preventive care

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

Preventive care also includes shots you or your child need. We must make sure that all enrolled children get needed shots at the time of any health care visit. Preventive care services and screenings are available at no cost and without pre-approval (prior authorization).

Your child should get check-ups at these ages:

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

Well-child health check-ups include:

- A complete history and head-to-toe physical exam
- Age-appropriate shots (California follows the American Academy of Pediatrics Bright Futures Periodicity schedule)
- Lab tests, including blood lead poisoning testing
- Health education
- Vision and hearing screening
- Oral health screening
- Behavioral health assessment

When a physical problem 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 we 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 problems, including eyeglasses
- Treatment for hearing problems, including hearing aids when they are not covered by CCS
- Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
- Case management and health education
- Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance

Blood lead poisoning testing

All children assigned to Kaiser Permanente should get blood lead poisoning testing at 12 and 24 months or between the ages of 36 and 72 months if they were not tested earlier.

Help getting child and youth well care services

We will help members under 21 years old and their families get the services they need. A Kaiser Permanente care coordinator can:

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

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

Other services children can get through Fee-For-Service ("FFS") Medi-Cal or other programs

Dental check-ups

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

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

Babies ages 1 to 4

- Baby's first dental visit
- Baby's first dental exam
- Dental exams (every 6 months; every 3 months from birth to age 3)
- X-rays
- Teeth cleaning (every 6 months)
- Fluoride varnish (every 6 months)
- Fillings
- Tooth removal
- Emergency services
- Outpatient services
- Sedation (if Medically Necessary)

Kids ages 5-12

- Dental exams (every 6 months)
- X-rays
- Fluoride varnish (every 6 months)
- Teeth cleaning (every 6 months)
- Molar sealants
- Fillings
- Root canals
- Emergency services
- Outpatient services
- Sedation (if Medically Necessary)

Kids ages 13-17

- Dental exams (every 6 months)
- X-rays
- Fluoride varnish (every 6 months)
- Teeth cleaning (every 6 months)
- Orthodontics (braces) for those who qualify
- Fillings
- Crowns
- Root canals
- Tooth removal
- Emergency services
- Outpatient services
- Sedation (if Medically Necessary)

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

Additional preventive education referral services

If you are worried that your child is having a hard time taking part and learning at school, talk to your child's Primary Care Doctor, teachers or administrators at the school. In

addition to your medical benefits covered by us, there are services that the school must provide to help your child learn and not fall behind.

Examples of services that may be provided to help your child learn include:

- Speech and Language Services
- Psychological Services
- Physical Therapy
- Occupational Therapy
- Assistive Technology
- Social Work Services
- Counseling Services
- School Nurse Services
- Transportation to and from school

These services are provided by and paid for by the California Department of Education. Together with your child's doctors and teachers, you can make a custom plan that will best help your child.

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 appeals process to let us know about your problem. You may also contact Alameda Alliance for Health instead of Kaiser Permanente. Call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m. to tell them about your problem. Using the Kaiser Permanente or Alameda Alliance for Health's grievance process will not take away any of your legal rights. Neither Kaiser Permanente nor Alameda Alliance for Health will 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 after 30 days, or you are unhappy with the result, you can ask the DMHC to review your complaint or conduct an Independent Medical Review ("IMR"). You can call the California Department of Managed Health Care ("DMHC") at **1-888-466-2219** (TTY **1-877-688-9891 or 711**) or visit the DMHC website at www.dmhc.ca.gov.

The California Department of Health Care Services ("DHCS") Medi-Cal Managed Care Ombudsman can also help. They can help if you have problems joining, changing, or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman 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 our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

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

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.

If you have a complaint about outpatient prescription drugs you got through Medi-Cal Rx, submit your complaint to Medi-Cal Rx. You can submit a complaint either in writing or by telephone by going to **www.Medi-CalRx.dhcs.ca.gov** or calling Medi-Cal Rx Customer Service at **1-800-977-2273**, 24 hours a day, 7 days a week. TTY users can call **711**, Monday through Friday, 8 a.m. to 5 p.m.

Complaints related to Medi-Cal Rx pharmacy benefits are not subject to our grievance process and are not eligible for Independent Medical Review. Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling **1-800-977-2273** (TTY **800-977-2273 and press 5** or **711**) or going to **www.Medi-CalRx.dhcs.ca.gov**. If your doctor refused to prescribe a drug you think you need, you can request an Independent Medical Review of your doctor's decision. DMHC's toll-free telephone number is **1-888-466-2219** and the TTY line is **1-877-688-9891**. You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: **www.dmhc.ca.gov**.

For all other issues, you can file a complaint through Kaiser Permanente or Alameda Alliance for Health any time by phone, in writing, or online.

- **By phone:**
  - Call Kaiser Permanente Member Services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays). Give us your medical record number, your name, and the reason for your complaint
  - Call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m. Give them your Alameda Alliance for Health ID number, your name, and the reason for your complaint
- **By mail**:
  - Call Kaiser Permanente Member Services 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 Services office at a Kaiser Permanente network facility (see **kp.org/facilities** for locations)

- Call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the reason for your complaint. Tell them what happened and how they can help you. Mail the form to:

  Alameda Alliance for Health
  Attn: Member Grievances
  1240 South Loop Road
  Alameda, CA 94502

- **In person:**
  - Fill out a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility
- **Online:**
  - Use the online form on our website at **kp.org**
  - Visit the Alameda Alliance for Health website at **www.alamedaalliance.org**

If you need help filing your complaint, we can help you. We can give you no-cost language services. Call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). You can also get help from Alameda Alliance for Health. They can also give you no-cost language services.

If you filed your complaint with Alameda Alliance for Health, they will work with you and Kaiser Permanente to solve the problem. To learn more about the Alameda Alliance for Health grievance process, call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**).

Within 5 days of getting your complaint, we will send you a letter letting you know we got it. Within 30 days, we will send you another letter that tells you how we resolved your problem. If you filed your grievance with Alameda Alliance for Health, they will respond within the same timeframes. If you call us about a grievance that is not about health care

coverage, medical necessity, or experimental or investigational treatment, and your grievance is resolved by the end of the next business day, you may not receive a letter.

If you want or your doctor wants Kaiser Permanente or Alameda Alliance for Health 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 our Member Service Contact Center at **1-800-464-4000** (TTY **711**) or Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**). Within 72 hours of receiving your complaint, we or Alameda Alliance for Health will make a decision about how we will handle your complaint and whether we will expedite your complaint. If we or Alameda Alliance for Health determine that we will not expedite your complaint, we will let you know that we will resolve your complaint within 30 days.

Appeals

An appeal is different from a complaint. An appeal is a request for Kaiser Permanente or Alameda Alliance for Health 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 or other provider can also file an appeal for you with your written permission.

You must file an appeal within 60 calendar days from the date on the NOA you received. If we decided to reduce, suspend, or stop a service(s) you are getting now, you can continue getting that service(s) while you wait for your appeal to be decided. This is called Aid Paid Pending. To receive Aid Paid Pending, you must ask us for an appeal within 10 days from the date on the NOA or before the date we said your service(s) will stop, whichever is later. When you request an appeal under these circumstances, the service(s) will continue. We may require you to pay for the cost of services if the final decision denies or changes a service.

If you want to appeal a decision made by Medi-Cal Rx, you can request a State Hearing. The California Department of Social Services has a State Hearing process if you want to appeal a Medi-Cal Rx decision. This process is different from the appeals process you use for your other benefits. In a State Hearing, a judge reviews your request with clinical input from DHCS pharmacists to make sure the decision aligns with Medi-Cal pharmacy policy.

For all other issues, you can file an appeal through Kaiser Permanente or Alameda Alliance for Health anytime by phone, in writing, in person, or online:

- **By phone:**
  - Call Kaiser Permanente Member Services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays). Give us your medical record number, your name, and the service you are appealing
  - Call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 5 p.m. Give them your Alameda Alliance for Health ID number, your name, and the service you are appealing. They will send you a form to fill out to confirm that you asked for an appeal.
- **By mail:**
  - Call Kaiser Permanente Member Services 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 Services office at a Kaiser Permanente Plan Facility (see **kp.org/facilities** for locations)
  - Call Alameda Alliance for Health Member Services at **510-747-4567** (TTY **711 or 1-800-735-2929**) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, Alameda Alliance for Health ID number, and the service you are appealing. Mail the form to:

    Alameda Alliance for Health
    Attn: Member Grievances
    1240 South Loop Road
    Alameda, CA 94502
- **In person**
  - Fill out an appeal form at a Member Services office located at a Plan Facility
- **Online:**
  - Use the online form on our website at **kp.org**
  - Visit the Alameda Alliance for Health website at **www.alamedaalliance.org**

If you need help filing your appeal or with Aid Paid Pending, we can help you. We can give you no-cost language services. Call our Member Service Contact Center at **1-800-464-4000** (TTY **711**). You can also get help from Alameda Alliance for Health by calling **510-747-4567** (TTY **711 or 1-800-735-2929**). They can also give you no-cost language services.

If you file your appeal with Alameda Alliance for Health, they will work with you and Kaiser Permanente on your appeal. To learn more about the Alameda Alliance for Health appeal process, call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**).

Within 5 days of getting your appeal, we will send you a letter letting you know we got it. Within 30 days, we will tell you our appeal decision and send you a Notice of Appeal Resolution ("NAR") letter. If you filed your appeal with Alameda Alliance for Health, they will respond within the same timeframes. If we do not tell you our appeal decision within 30 days, you can request a State Hearing and an Independent Medical Review. 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 final say.

If you want or your doctor wants Kaiser Permanente or Alameda Alliance for Health 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**) or call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**). We or Alameda Alliance for Health will make a decision within 72 hours of receiving your appeal about whether we will expedite your appeal.

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

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

- Ask for a **State Hearing** from the California Department of Social Services ("CDSS"), and a judge will review your case
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have our decision reviewed or ask for an **Independent Medical Review** ("IMR") from DMHC. During DMHC's IMR, an outside doctor who is not part of Kaiser Permanente or Alameda Alliance for Health will review your case. DMHC's toll-free telephone number is (**1-888-466-2219**) and the TTY line for the hearing and speech impaired is (**1-877-**

688-9891). You can find the Independent medical Review/Complaint form and instructions online at the DMHC's website at **www.dmhc.ca.gov**.

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

You are entitled to both a State Hearing and an IMR. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say. Medi-Cal Rx pharmacy benefit decisions are not subject to the IMR process.

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

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by Kaiser Permanente. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling **800-977-2273** (TTY **800-977-2273 and press 5** or **711**). However, complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing.

Note: Items and services you receive under the Community Supports Program do not qualify for IMR.

Complaints and Independent Medical Reviews ("IMR") with the Department of Managed Health Care

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 us or Alameda Alliance for Health. If you do not hear from us 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 only have 120 days to request a State Hearing so if you want an IMR and a State hearing file your complaint as soon as you can. Remember, if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say.

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

If your complaint to DMHC does not qualify for an IMR, DMHC will still review your complaint to make sure we made the correct decision when you appealed our denial of services. We have to comply with DMHC's IMR and review decisions.

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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with people from the California Department of Social Services ("CDSS"). A judge will help to resolve your problem. You have the right to ask for a State Hearing only if you have already filed an appeal with either Kaiser Permanente or Alameda Alliance for Health and 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 calendar 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. However, if we gave you Aid Paid Pending during your appeal, and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 days of our Notice of Appeal Rights ("NAR") letter, or before the date we said your service(s) will stop, whichever is later. If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, call

our Member Service Contact Center at **1-800-464-4000** (TTY **711**). Your PCP can ask for a State Hearing for you with your written permission.

Sometimes you can ask for a State Hearing without completing our appeal process. For example, you can request a State Hearing without having to complete our appeal process, if we did not notify you correctly or on time about your service(s). This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- We did not make a Notice of Action ("NOA") letter available to you in your preferred language.
- We made a mistake that affects any of your rights.
- We did not give you a NOA letter.
- We made a mistake in our NAR letter.
- We did not decide your appeal within 30 days.
- We decided your case was urgent, but did not respond to your appeal within 72 hours.

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

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

  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 no-cost language services. Call our Member Service Contact Center at **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 CDSS to make a fast decision because the time it takes to have a State Hearing would put your life, health or ability to function fully in danger, you or your PCP can contact the CDSS and ask for an expedited (fast) State Hearing. CDSS must make

a decision no later than 3 business days after it gets your complete case file from Kaiser Permanente and Alameda Alliance for Health.

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 by calling the confidential toll-free number **1-800-822-6222** or submitting a complaint online at **https://www.dhcs.ca.gov**.
Provider fraud, waste and abuse includes:

- Falsifying medical records
- Prescribing more medication than is Medically Necessary
- Giving more health care services than Medically Necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service
- Offering free or discounted items and services to members in an effort to influence which provider is selected by the member
- Changing member's primary care physician without the knowledge of the member

Fraud, waste and abuse by a person who gets benefits includes, but is not limited to:

- Lending, selling or giving a health plan ID card or Medi-Cal Benefits Identification Card (BIC) to someone else
- Getting similar or the same treatments or medicines from more than one provider
- Going to an emergency room when it is not an emergency
- Using someone else's Social Security number or health plan ID number
- Taking Medical Transportation and Non-Medical Transportation rides for non-healthcare related services or for services not covered by Medi-Cal, or when you do not have a medical appointment or prescriptions to pick up

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 our Member Service Contact Center at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (closed holidays).

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”)
- 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 our Member Service Contact Center 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, KFH, SCPMG, TPMG, The Permanente Federation, LLC, or The Permanente Company, LLC, mail the Demand for Arbitration to:

Kaiser Permanente
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

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

We are served when we get 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 our Member Service Contact Center 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 our Member Service Contact Center 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 of the following occurs:

- You have not acted on it with reasonable diligence in accord with the Rules of Procedure
- The hearing has not occurred and more than five years have passed after the earlier of:

- ♦ The date you served the Demand for Arbitration; or
- ♦ The date you filed a civil action based on the same incident

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

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

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

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

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

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

7. Rights and responsibilities

As a Member of Kaiser Permanente, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a Member of Kaiser Permanente.

Your rights

These are your rights as a Member of Kaiser Permanente:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information
- To be provided with information about the plan and its services, including covered services, Network Providers, and member rights and responsibilities
- To make recommendations about our member rights and responsibilities policy
- To be able to choose a primary care provider within our network
- To have timely access to Network Providers
- 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 you got
- To get care coordination
- To ask for an appeal of decisions to deny, defer, or limit services or benefits

- To get no-cost interpreter services in your language
- To get no-cost legal help at your local legal aid office or other groups
- To formulate advance directives
- To ask for a State Hearing if a service or benefit is denied. You can ask for a State hearing if you have already filed an appeal with us and you are not happy with the decision. You can also ask for a State Hearing if you did not get a decision within 30 days on the appeal you filed with us. This includes information on the circumstances under which an expedited hearing is possible
- To have access to, and where legally appropriate, receive copies of, amend or correct your medical record
- To disenroll from Alameda Alliance for Health and change to another managed care plan in the county where you live
- To access Minor Consent services
- To get no-cost written member information in other formats, such as braille, large-size print, audio and accessible electronic formats, upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions Code Section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To discuss truthfully information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage
- To get a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how you are treated by Kaiser Permanente, providers, or the State
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside our network pursuant to the federal law

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 Nondiscrimination

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

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

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)

- No-cost language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call **711**.

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

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your Evidence of Coverage or Certificate of Insurance for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- **By phone**: Call Member Services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays)
- **By mail**: Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you
- I**n person**: Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online**: Use the online form on our website at **kp.org**

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

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

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

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

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

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

  Complaint forms are available at:
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- **Online:** Send an email to CivilRights@dhcs.ca.gov

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

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

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

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  Complaint forms are available at:
  http://www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/cp

Ways to get involved as a Member

Alameda Alliance for Health wants to hear from you. They have meetings to talk about what is working well and how they can improve. Members are invited to attend. Come to a meeting!

Member Advisory Committee

Alameda Alliance for Health ("Alliance") has a group called the Member Advisory Committee. This group is made up of Alliance members, community advocates, and providers.

The group talks about how to improve Alliance policies and is responsible for:

- Giving feedback on programs and policies
- Making recommendations on member outreach, education, and meeting member needs

If you would like to be a part of this group, call **510-747-4567** or toll-free at **1-877-932-2738** (CRS/TTY **711** or **1-800-735-2929**).

The Alliance wants to hear from you! You may receive a survey or phone call asking for your ideas on how they are doing. Please take a few minutes to respond so they can improve programs for all members.

Play an active role in your health. Alliance Health Education has handouts, tools, classes and programs to help you reach your health goals. Call Alliance Health Programs at **510-747-4577** to learn more.

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 our Member Service Contact Center 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 our Member Service Contact Center 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, other health coverage, and tort recovery

Sometimes someone else has to pay first for the services Kaiser Permanente provided or arranged for 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.

Medi-Cal members may also have other health coverage ("OHC") provided to them at no cost. By law, members are required to exhaust all services provided by the OHC before using services through Medi-Cal. If you do not apply for or keep no-cost OHC or state-paid OHC, your Medi-Cal benefits and/or eligibility will be denied or stopped. Federal and state laws require Medi-Cal members to report private health insurance. To report or change private health insurance, go to **http://dhcs.ca.gov/mymedi-cal**. You can also call Alameda Alliance for Health at **510-747-4567** (TTY **711 or 1-800-735-2929**). Or call DHCS at **1-800-541-5555** (TTY **1-800-430-7077** or **711**). Outside of California, call **1-916-636-1980**. If you do not report changes to your OHC promptly, and because of this, get Medi-Cal benefits that you are not eligible for, you may have to repay DHCS.

If you are injured, and another party is liable for your injury, you or your legal representative must notify DHCS within 30 days of filing a legal action or a claim. Submit your notification online:

- Personal Injury Program at http://dhcs.ca.gov/PI
- Workers Compensation Recovery Program at http://dhcs.ca.gov/WC

To learn more, call **1-916-445-9891.**

Notice about estate recovery

The Medi-Cal program must seek repayment for the estates of certain deceased Medi-Cal members from payments made, including managed care premiums for nursing facility services, home and community-based services, and related hospital and prescription drug services provided to the deceased Medi-Cal member on or after the member's 55th birthday. If a deceased member does not leave an estate or owns nothing when they die, nothing will be owed.

To learn more about estate recovery, call **(916) 650-0590** or go online at **http://dhcs.ca.gov/er**. You can also get legal advice.

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. See the Appeals section in Chapter 6 for important information on filing your Appeal. When we send you an NOA, it will inform you of all rights you have if you disagree with a decision we made.

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 Alameda Alliance for Health, can make changes to this Member Handbook at any time. We will let you know in writing of any changes 30 days before they happen.

Notice about lawyer and advocate fees and costs

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

Notice that this Member Handbook is binding on Members

The terms of this Member Handbook are binding on you when you choose assignment in Kaiser Permanente through Alameda Alliance for Health.

Notice that Alameda Alliance for Health is not our agent

Alameda Alliance for Health 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 our Member Service Contact Center at **1-800-464-4000** (TTY **711**). Also, let your County Eligibility Worker and Alameda Alliance for Health know your new address

8. 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 1-866-454-8855 (TTY **711**)
- Alameda Alliance for Health **510-747-4567** (TTY 711 or 1-800-735-2929)
- Health Care Options **1-800-430-4263**
  (TTY **1-800-430-7077**)
- Medi-Cal Rx **1-800-977-2273**
  (TTY **711**)

Words to know

Active labor: The 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 the 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.

Alameda Alliance for Health: Your Medi-Cal managed care health plan. Kaiser Permanente is your provider network through Alameda Alliance for Health.

Alameda Alliance for Health Service Area: Alameda County.

American Indian: An individual, defined at Title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

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 Medi-Cal 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, licensed vocational nurses, social workers, or other designated staff who can help you understand major health problems and arrange care with your providers.

Certified Nurse Midwife ("CNM"): An individual licensed as a Registered Nurse and certified as a nurse midwife by the California Board of Registered Nursing. A certified nurse midwife is permitted to attend cases of normal childbirth.

Chiropractor: A provider who treats the spine by means of manual manipulation

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

Clinic: A facility that Members can select as a primary care provider (PCP). It can be either a Federally Qualified Health Center (FQHC), community clinic, Rural Health Clinic (RHC), Indian Health 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.

Contract Drugs List ("CDL"): The approved drug list for Medi-Cal Rx from which your doctor may order covered drugs you need.

Coordination of Benefits ("COB"): The process of determining which insurance coverage (Medi-Cal, Medicare, commercial insurance or other) has primary treatment and payment responsibilities for Members with more than one type of health insurance coverage.

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

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 Member Handbook 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 Alameda Alliance for Health as your Medi-Cal managed care plan 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 Alameda Alliance for Health 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, diagnostic and treatment ("EPSDT"): EPSDT services are a benefit for Medi-Cal Members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early as well as any treatment to take care of or help the conditions that may be found in the check-ups.

Emergency medical condition: A medical or mental condition with such severe symptoms, such as active labor (go to definition above) or severe pain, that someone with a prudent layperson's 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 Care: An exam performed by a doctor (or staff under direction of a doctor as allowed by law) to find out if an emergency medical condition exists. Medically Necessary services needed to make you clinically stable within the capabilities of the facility.

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

Enrollee: A person who is a Member of a health plan and gets services through the plan.

Established patient: A patient who has an existing relationship with a provider and has seen that provider within a specified amount of time established by the Plan.

Excluded services: Services not covered by Kaiser Permanente by the California Medi-Cal program; non-covered services

Experimental treatment: Drugs, equipment, procedures or services that are in a testing phase with laboratory and/or animal studies prior to testing in humans. Experimental services are not undergoing a clinical investigation.

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"): Sometimes your Medi-Cal plan does not cover services but you can still get them through Medi-Cal FFS, such as many pharmacy services. through FFS Medi-Cal Rx.

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.

Freestanding Birth Centers ("FBCs"): Health facilities where childbirth is planned to occur away from the pregnant woman's residence that are licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan. These facilities are not hospitals.

Grievance: A Member's verbal or written expression of dissatisfaction about Kaiser Permanente, a provider, or the quality of care or services provided. A complaint is an example of 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 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 services, such as family planning, emergency care, OB/GYN care or Sensitive Care.

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.

Home Region: The Northern California Kaiser Foundation Health Plan, Inc. Region.

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 Clinic ("IHC"): A health clinic operated by the Indian Health Service (HIS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization.

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.

Investigational treatment: A treatment drug, biological product or device that has successfully completed phase one of a clinical investigation approved by the FDA but that has not been approved for general use by the FDA and remains under investigation in an FDA approved clinical investigation.

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

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

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

Medi-Cal Rx: A FFS Medi-Cal pharmacy benefit service known as “Medi-Cal Rx” that provides pharmacy benefits and services, including prescription drugs and some medical supplies to all Medi-Cal beneficiaries.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

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 describes 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.

Medical Transportation: Transportation when you cannot get to a covered medical appointment by car, bus, train or taxi. We pay for the lowest cost form of transportation for your medical needs when you need a ride to your appointment. Medical Transportation must be prescribed by a licensed doctor, dentist, podiatrist, mental health, or substance use disorder provider.

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 Alameda Alliance for Health 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.

Midwifery services: Prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn, provided by certified nurse midwives (CNM) and licensed midwives (LM).

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

Network Provider (or In-Network Provider): See “Participating provider” below.

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

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 and when picking up prescriptions and medical supplies.

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

Other health coverage (“OHC”): Private health insurance and service payers other than Medi-Cal. Services may include medical, dental, vision, pharmacy and/or Medicare supplemental plans (Part C & D).

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 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 our Member Service Contact Center 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. Palliative care does not require the member to have a life expectancy of 6 months or less.

Participating hospital: A licensed hospital that has a contract with Kaiser Permanente to provide services to Members at the time a Member 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: Go to the definition for “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 our Member Service Contact Center.

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 our Member Service Contact Center.

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

Plan Provider: A Plan Hospital, a Plan Physician, The Permanente Medical Group, a Plan Pharmacy, or any other provider Health Plan designates as a Plan Provider.

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

Pre-approval (or prior-authorization): Your PCP must get approval from The Permanente Medical Group before you get certain services. The 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 Permanente Medical Group.

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

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

Primary care: Go to the definition of "Routine care".

Primary care provider ("PCP"): The licensed provider 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 Care
- You need family planning services

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner

- OB/GYN
- Indian Health Care Provider (“IHCP”)
- Federally Qualified Health Center (“FQHC”)
- Rural Health Clinic (“RHC”)
- Nurse practitioner
- Physician assistant
- Clinic

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 in which the symptoms are serious or severe enough to cause 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 to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors, or disease.

Referral: When 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.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call our Member Service Contact Center.

Rehabilitative and habilitative therapy services and devices: Services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

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

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

Sensitive Care: 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: Services for members who have mental health services needs that are a higher level of impairment than mild to moderate.

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.

2022 Member Handbook Addendum

This is important information about changes to your
2022 Kaiser Foundation Health Plan, Inc. Medi-Cal Member Handbook

Your Member Handbook is also called the Combined Evidence of Coverage and Disclosure Form ("EOC/DF"). This Addendum lets you know about updates to your 2022 Member Handbook. Please keep this document with your 2022 Member Handbook.

New benefit description added to Chapter 4 (Benefits and services)

The following benefit description for cognitive health assessments is added to your Member Handbook. Coverage for cognitive health assessments begins on July 1, 2022.

Cognitive health assessments

We cover an annual brief cognitive health assessment for members 65 years of age or older, and are otherwise not eligible for a similar assessment as part of an annual wellness visit under the Medicare Program. A cognitive health assessment looks for signs of Alzheimer's disease or dementia.

Kaiser Foundation Health Plan, Inc.
393 E. Walnut St.
Pasadena, CA 91188

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