Important Information Inside

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KAISER PERMANENTE®

Health Plan of San Mateo Member Handbook

What you need to know about your benefits

2021 Combined Evidence of Coverage and Disclosure Form (EOC/DF)

Effective January 1, 2021

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. 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, 18-point font large print and audio at no cost to you. Call **1-800-464-4000** (TTY **711**). The call is toll-free.

Interpreter services

You do not have to use a family member or friend as an interpreter. For no-cost interpreter, linguistic and cultural services and help 24 hours a day, 7 days a week, 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. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

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

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

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

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

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

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

Other languages and formats

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

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សឹងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន sម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

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

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທຣ **711**.

Navajo: Saad bee áká’a’ayeed náhólǫ́ t’áá jiik’é, naadiin doo bibąą’ dį́į’ ahéé’iikeed tsosts’id yiskąąjį́ damoo ná'ádleehjį́. Atah halne’é áká’adoolwołígíí jóki, t’áadoo le’é t’áá hóhazaadjį́ hadilyąą’go, éí doodaii’ náánáá lá ał’ąą ádaat’ehígíí bee hádadilyaa’go. Kojį́ hodiilnih **1-800-464-4000**, naadiin doo bibąą’ dį́į’ ahéé’iikeed tsosts’id yiskąąjį́ damoo ná’ádleehjį́ (Dahodiyin biniiyé e’e’aahgo éí da’deelkaal). TTY chodeeyoolínígíí kojį́ hodiilnih **711**.

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

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

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Other languages and formats

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

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทรหาเราที่หมายเลข **1-800-464-4000** ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ **711**

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

Notice of non-discrimination

Discrimination is against the law. Kaiser Permanente follows state and federal civil rights laws. Kaiser Permanente does not unlawfully discriminate, exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

Kaiser Permanente provides:

- 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).

How to file a grievance with Kaiser Permanente

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical

condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance.

You may submit a grievance in the following ways:

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

Please call Member Services if you need help filing a grievance.

The Kaiser Permanente Civil Rights Coordinators will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinators directly at:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

How to file a grievance with the California Department of Health Care Services Office of Civil Rights

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

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights 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

Welcome to Kaiser Permanente!

Thank you for choosing Kaiser Permanente as your health care provider network through Health Plan of San Mateo (“HPSM”). HPSM is a health plan for people who have Medi-Cal. HPSM works with the State of California to help you get the health care you need. Kaiser Permanente is your health care provider network through HPSM. In this Member Handbook, we will use the term “Health Plan” to describe Kaiser Foundation Health Plan, Inc.

Member Handbook

This Member Handbook tells you about your coverage through Kaiser Foundation Health Plan, Inc. (“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 7 ("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 Kaiser Foundation Health Plan, Inc. and HPSM. Your health coverage is determined by our contract with Health Plan of San Mateo. If you received or downloaded a copy of a Member Handbook directly from HPSM, 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 HPSM and this one, this document will the one

that we will use to help you. Call **1-800-750-4776** (TTY **711 or 1-800-735-2929**) to ask for a copy of the contract between Health Plan of San Mateo and DHCS.

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.

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 your covered services
- 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. You can also visit online at any time at **kp.org.**

Getting help from Health Plan of San Mateo

If you have questions about Health Plan of San Mateo, call them at **1-800-750-4776** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 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

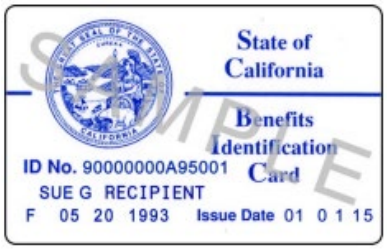
You can ask questions about qualifying for Transitional Medi-Cal at your local county health and human services office at **www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx**

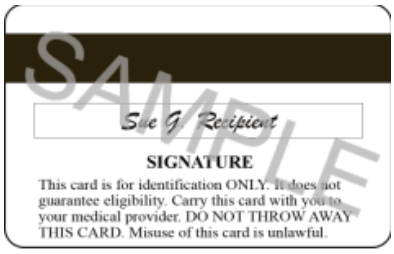
Who can be assigned to us

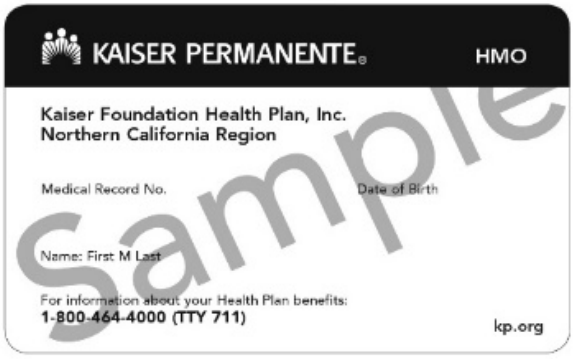
We do not enroll Members directly. To learn more about how to request assignment with us, call Health Plan of San Mateo at **1-800-750-4776** (TTY **711 or 1-800-735-2929**).

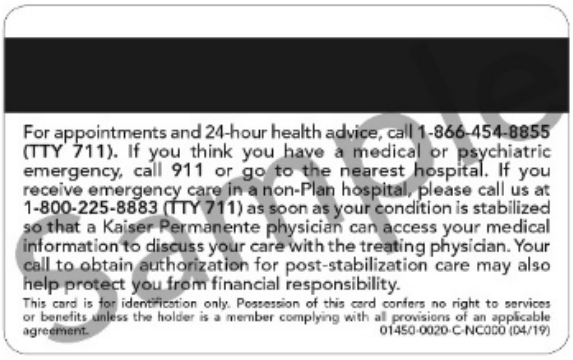
Identification (“ID”) cards

As a Member of Health Plan, you will get a Kaiser Permanente ID card. You must show your Kaiser Permanente ID card, your HPSM ID Card, your Medi-Cal Benefits Identification Card (“BIC”), and a photo ID when you get any health care services or prescriptions. You should carry all health cards with you at all times. Here is a sample 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**).

Ways to get involved as a Member

Health Plan of San Mateo 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!

Consumer Advisory Committee

Health Plan of San Mateo (“HPSM”) has a group called Consumer Advisory Committee. This group is made up of HPSM members, community advocates and staff from agencies who work with HPSM members. The Consumer Advisory Committee meets four times a year. The group talks about how to improve HPSM policies and is responsible for:

- Providing advice to HPSM staff on improving the quality of HPSM services and care.

If you would like to be a part of this group, call **1-800-750-4776** (TTY **711** or **1-800-735-2929**).

2. About your health plan

Health plan overview

Health Plan of San Mateo (“HPSM”) is a health plan for people who have Medi-Cal in San Mateo County. HPSM works with the State of California to help you get the health care you need.

Health Plan of San Mateo is your Medi-Cal managed care plan and Kaiser Permanente is your health care provider network through HPSM. 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.

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 services, 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 HPSM, you can call them at **1-800-750-4776** (TTY **711** or **1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m.

When your coverage starts and ends

When you are assigned to us through HPSM, you should receive a Kaiser Permanente Member ID card within two weeks of your assignment to Kaiser Permanente. Please show your Kaiser Permanente ID card, your BIC, and your HPSM ID card when get any health care services or prescriptions.

Your Medi-Cal coverage will need to be renewed every year. The county will send you a Medi-Cal renewal form. Complete this form and return it to your local county human services agency.

You may ask at any time to end your assignment to Kaiser Permanente and choose another provider in HPSM's network. For help choosing a new provider, call HPSM at **1-800-750-4776** (TTY **711 or 1-800-735-2929**) or visit **www.hpsm.org**. You can also ask to end your Medi-Cal.

We can ask HPSM 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 network facility
- You commit theft from a Network Provider, or a network 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 HPSM reassigns you to a different provider network, they will inform you in writing.

Sometimes HPSM and Kaiser Permanente can no longer serve you. HPSM must end your Medi-Cal managed care enrollment if any of the following is true:

- You move out of the Health Plan of San Mateo Service Area
- You are in prison
- You no longer have Medi-Cal
- You qualify for certain waiver programs that require you to be enrolled in Fee-for-Service Medi-Cal

If your eligibility with HPSM and your assignment to Kaiser Permanente end, you may still be able to get services from Fee-for-Service Medi-Cal or other programs. Go to the heading “Services you can get through Fee-For-Service (“FFS”) Medi-Cal or other programs” in Chapter 4 for more information on these services.

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 Fee-For-Service ("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 Indian Health Clinics ("IHC"). To find out more, please call the Indian Health Service at **1-916-930-3927** or visit the Indian Health Service website at **www.ihs.gov**.

How your plan works

Health Plan of San Mateo 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 HPSM.

Kaiser Permanente provides health care services directly to Members through an integrated medical care program. Our medical care program gives you access to covered services you may need, such as routine care, hospital care, laboratory and services, emergency services, 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 HPSM's provider networks. If you would like information on how to change provider networks, please call HPSM Member Services at **1-800-750-4776** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m.

As a Medi-Cal Member, you can also get additional services through Fee-for-Service ('FFS") Medi-Cal. The services you can get from FFS Medi-Cal are described in Chapter 4 "Benefits and Services".

A Kaiser Permanente Member Services representative can help you understand:

- How Kaiser Permanente works
- How to get the care you need
- How to schedule provider appointments within standard access times, and

- How to find out if you qualify for transportation services

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

To learn about HPSM call them at **1-800-750-4776**, (TTY **711 or 1-800-735-2929**). You can also find Member Services information online at **www.hpsm.org**.

Changing provider networks

You may leave Kaiser Permanente and change to a different Health Plan of San Mateo provider network at any time. Call HPSM at **1-800-750-4776**, (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m. Tell them you want to change provider networks. This change will not happen right away. HPSM 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 HPSM's provider networks. If you would like information on how to change provider networks, please call HPSM's Member Services at **1-800-750-4776**, (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m.

If you want to leave Kaiser Permanente sooner, you may ask HPSM 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.

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 services and Urgent Care in your new county. Emergency services and Urgent Care are available to all Medi-Cal enrollees statewide regardless of county of residence. Routine and preventive care are covered only in your Home Region.

Going to college in a new county in California

If you are enrolled in Medi-Cal and will attend college in a different county in California, you do not need to apply for Medi-Cal in that county. When you temporarily move away from home to attend college, 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 or preventive care in your new county. You may have to change health plans. 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. You may only be able to access emergency care or Urgent Care in the new county, if your new county is outside your Home Region. For routine or preventive health care, you will need to use the Kaiser Permanente provider network your Home Region.

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 emergencies and Urgent Care in another state. Medi-Cal will also cover emergencies requiring hospitalization in Canada and Mexico, if the service is approved and the doctor and hospital meet Medi-Cal rules. If you want to get routine or preventive care in another state, you will need to apply for Medicaid in that state. If you sign up for Medicaid in another state, you will no longer be eligible for Medi-Cal in California and we will not pay for your health care.

Continuity of care

Completion of Services from Non–Plan Providers

New Member

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 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.

Terminated provider

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.

Eligibility

The cases that are subject to this Completion of Services provision are:

- **Acute conditions**. We may cover these services until the acute condition ends
- **Serious chronic conditions**. We may cover services until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the first day after a course of treatment is complete when it would be safe to transfer your care to a Network Provider, as determined by Kaiser Permanente after talking with the Member and Out-of-Network Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
    - ♦ It persists without full cure
    - ♦ It gets worse over a long period of time

  - ♦ It requires ongoing treatment to maintain remission or prevent the condition from getting worse

- **Maternity care.** We may cover these services while you are pregnant and right after you give birth
- **Services for women who have a mental health condition while pregnant or right after birth**
- **Terminal illnesses.** We may cover these services for the duration of the illness. Terminal illnesses are illnesses that cannot be cured or reversed and are likely to cause death within a year or less
- **Care for children under age 3.** We may cover these services until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the child's third birthday
- **Surgery or another procedure that is part of a course of treatment.**
  - ♦ 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
- You are receiving long term care under Managed Long-term Services and Supports (MLTSS)

To qualify for this completion of services coverage, all of 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
- 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** cover completion of covered services from non-Plan Providers if either of the following is true:

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

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. To find out if you qualify to get services from an Out-of-Network Provider or want more information, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**).

Costs

Member costs

Health Plan of San Mateo serves people who qualify for Medi-Cal. HPSM Members do **not** have to pay for covered services received from -Network Providers. You will not have premiums or deductibles. 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 services without pre-approval. For information on what sensitive services are covered, go to the heading "Sensitive care" later in this Chapter 3.

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

When you are outside your Home Region, but still inside the United States, we cover Urgent Care services. 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 a share of cost

You may have to pay a share of cost each month. The amount of your share of cost depends on your income and resources. Each month you will pay your own medical bills until the amount that you have paid equals your share of cost. After that, your care will be covered by Health Plan of San Mateo for that month. For more information on share of cost, call HPSM's Member Services at **1-800-750-4776**, (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m.

How a provider gets paid

Kaiser Permanente pays providers in these ways:

- Capitation payments
    - ♦ Some providers are paid 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
- Fee-for-service payments
    - ♦ Some providers give care to Medi-Cal Members and then send us a bill for the services they provided. This is called a fee-for-service 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

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 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** or **1-800-390-3510** (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 **1-800-390-3510** (TTY **711**)

We will be happy to help you if you need help completing our claim form.

If you have paid for services, you must include any bills and receipts from the Out-of-Network Provider with your claim form.

If you want us to pay the Out-of-Network Provider for services, you must include any bills from the Out-of-Network Provider with your claim form. If you later get any bills from the Out-of-Network Provider, please call our Member Service Contact Center at **1-800-390-3510** (TTY **711**) for help.

You must send us the completed claim form as soon as you can after getting the care.

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

Kaiser Permanente

Claims Administration - 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 Health Plan of San Mateo.

Always carry your Kaiser Permanente ID card, HPSM 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 Health Plan of San Mateo 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 at our online listing of providers and locations at **kp.org/facilities**. You can also 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. You do not need approval to go to an Out-of-Network Provider to get sensitive services that are described under the heading “Sensitive care” later in this chapter.

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

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 HPSM 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.

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 can get much needed early preventive services like hearing and vision screening, 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 PCP.

Your PCP will:

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

When you need routine care, you can call **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 an emergency, call **911** or go to the nearest emergency room.

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

Urgent Care

Urgent Care is **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. Urgent Care appointments that do not need pre-approval (prior authorization) are available within 48 hours of your request for an appointment. 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.

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 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.

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).

Emergency care

For emergency care, call **911** or go to the nearest emergency room ("ER"). For emergency care, you do **not** need pre-approval (prior authorization) from us. You have the right to use any hospital or other setting for emergency care.

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, your health (or your unborn baby's health) could be in danger, or a body function, body organ or body part could be seriously harmed. Examples of emergency medical conditions include, but are not limited to:

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

- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts (covered by county mental health plans)

Do not go to the ER for routine care. You should get routine care from your PCP, who knows you best. If you are not sure if 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 emergency room.

Post-stabilization care

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

- The DME item is covered under this Member Handbook

- It is medically necessary for you to have the DME item after you leave the hospital
- The DME item is related to the emergency care you received in the hospital.

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

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

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

When the provider calls, we will talk to the doctor who is treating you about your health issue. If we determine you need post-stabilization care, we will authorize the covered services. In some cases, we may arrange to have a Network Provider provide the care.

If we decide to have a network hospital, skilled nursing facility, or other provider provide the care, we may authorize transport services that are medically needed to get you to the provider. This may include special transport services that we would not normally cover.

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

Sensitive care

Minor consent services

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

- Outpatient mental health services for:
  - Sexual assault

    - ♦ Physical assault
    - ♦ 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.

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, or birth control services, 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 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**).

For minor consent services that are not specialty mental health services, you can see an -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.

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 doctor or clinic giving these services, or to get transportation help, 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).

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 services

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

- Family planning/birth control (except sterilization)
- 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, or birth control services, 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 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 services, you can see an 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 services that are 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, you can call **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).

Advance directives

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

You can get an advance directive form at Kaiser Permanente Plan Facilities at no cost to you. You can also get a form at drugstores, 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 Health Resources Services Administration organ donor website at **organdonor.gov**.

Where to get care

You will get most of your care from your PCP. Your PCP will provide your routine preventive (wellness) care. You will also see your PCP for care when you are sick. Be

sure to call your PCP before you get medical care. Your PCP will refer (send) you to specialists if you need them.

To find where Kaiser Permanente Network Providers are located, visit our website at **kp.org/facilities** or call our Member Service Contact Center at **1-800-464-4000** (TTY **711**)

To get help with your health questions, you can 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 Urgent Care, call **1-866-454-8855** (TTY **711**). Urgent Care is care you need soon but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain or sprained muscle.

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

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at 1-800-464-4000 (TTY 711) to ensure that you can obtain the health care services that you need.

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 HPSM. 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 IHC as their PCP, even if the IHC is not in the Kaiser Permanente network.

If your Network Provider, including a PCP, hospital or other provider, has a moral objection to providing you with a covered service, such as family planning or abortion, call **1-800-464-4000** (TTY **711**). See the Moral Objection heading earlier in this chapter for more about moral objections.

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

Network Providers

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

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**.

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

Except for emergency care, Urgent Care, 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, 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 or Outside your Home Region

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.

You must get pre-approval (prior authorization) 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 get pre-approval 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 services, go to those headings in this chapter. If you are an American Indian, you can get care at an IHC outside of our provider network without a referral.

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 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 you need health care services for a California Children's Services (CCS) eligible medical condition and we do not have a CCS-paneled specialist in the network who can provide the care you need, you may be able to go to a provider outside of the provider network at no cost to you. To learn more about the CCS program, read the Benefits and Services chapter of this handbook.

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

Outside your Home Region

Routine care is not covered outside your Home Region.

If you are outside of your Home Region and need care that is **not** an emergency 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.

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.

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

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

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

Doctors

You will choose your doctor or a 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 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, 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 **1-800-464-4000** (TTY **711**).

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

Remember, if you do not choose a PCP, we will choose one for you. You know your health care needs best, so it is best if you choose. If you are in both Medicare and Medi-Cal, 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

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

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in 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**).

Timely access to care

Appointment Type	Must Offer Appointment Within
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointment that do require pre-approval (prior authorization)	96 hours
Non-urgent primary care appointments	10 business days
Non-urgent specialist	15 business days
Non-urgent mental health provider (non-doctor)	10 business days
Non-urgent appointment for ancillary (supporting) services for the diagnosis or treatment of injury, illness or other health condition	15 business days
Telephone wait times during normal business hours	10 minutes
Triage – 24/7 services	24/7 services – No more than 30 minutes

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

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

Interpreter services

If you need interpreter services when you call us or when you get covered services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. 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.

Travel time and distance to care

Kaiser Permanente must follow travel time and 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 and distance standards are different depending on the county you live in.

If you need care from a provider and that provider is located far from where you live, you can call our Member Service Contact Center at **1-800-464-4000** (TTY **711**) to get help finding care with 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 provider 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.

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

- Adult medicine/internal medicine
- Family medicine

- Specialists in OB/GYN whom The Permanente Medical Group (“Medical Group”) designates as PCPs

Parents can choose a doctor from Pediatrics/adolescent medicine or Family medicine (for children up to age 18) 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.

You can also choose to get your primary health care at a Federally Qualified Health Center (“FQHC”) or a Rural Health Clinic (“RHC”). These health centers are located in areas that do not have many healthcare services. If you want to get your health care at an FQHC or RHC on a regular basis you must change your health care provider network and choose an FQHC or RHC as your PCP through HPSM. Call HPSM Member Services at **1-800-750-4776** (TTY **711 or 1-800-735-2929**) to learn more.

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
- Arrange for hospital care if you need it

To find a PCP near you, 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**).

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

To learn how to select or change your PCP, call 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 HPSM to reassign you to a different provider in the HPSM network if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If HPSM reassigns you to a different provider, they will tell you in writing.

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, HPSM 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
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

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

Payment

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

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

You must get pre-approval (prior authorization) before you go to an Out-of-Network Provider, except for:

- Emergency care
- Urgent Care (within your Home Region, out-of-network urgent care requires pre-approval)
- Sensitive care

If you do not get pre-approval, you may have to pay for care from providers who are out of the 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 when you feel you shouldn't have to, you can also file a claim form. You will need to tell us in writing why you had to pay for the item or service. We will read your claim and decide if you can get money back. You can get a claim form online at **kp.org**. You can also call 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.

Referrals

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

Examples of specialists that require a referral include:

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

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

If you have a health problem that needs special medical care for a long time, you may need a standing referral. This means you can 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 or emergency care visits
- Family planning (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 IHCs)

Minors also do not need a referral for:

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

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.

Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed disease, illness, or injury.

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

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Network Providers
- Transplants
- Out-of-network services, including hospitalization

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**).

You never need pre-approval for emergency care or Urgent Care, even if it is out-of-network or outside your Home Region. This includes labor and delivery if you are pregnant. You do not need pre-approval for most sensitive services. For more information on sensitive services, go to the section “Sensitive care” in this chapter.

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 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 jeopardize 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 receiving the request for services.

Kaiser Permanente does **not** pay the reviewers to deny coverage or services. If The Permanente Medical Group does not approve the request, we will send you a Notice of

Action (“NOA”) letter. The NOA letter will tell you how to file an appeal if you do not agree with the decision.

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

Second opinions

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

To get a second opinion, call your PCP. Your PCP can refer you to a Network Provider who is an appropriately qualified medical professional for your medical condition for a second opinion. You may also call us 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 is no provider in the Kaiser Permanente network to give you a second opinion, we will pay for a second opinion from an out-of-Network Provider. If there isn’t a Network Provider who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with an Out-of-Network Provider for a second opinion. We will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic, 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 an appeal (or grievance). To learn more about appeals, see Chapter 6 (“Reporting and solving problems”) in this Member Handbook.

Women’s health specialists

You may go to a women’s health specialist within the 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).

4. Benefits and services

What your health plan covers

This section 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 services, emergencies or urgent care services.

Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces pain from a diagnosed disease, illness or injury. 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 services, as described in the Chapter 3 section called "Sensitive care"

Note: You may be able to receive certain services from an out-of-network Federally Qualified Health Center ("FQHC") or Rural Health Clinic ("RHC"). Call HPSM for more information on FQHC and RHC services.

The following are examples of the services we cover:

- Ambulatory (outpatient) services
- Outpatient prescription drugs, supplies, and supplements. CCS-eligible services under the Whole Child Model Program
- Emergency services
- Hospice and palliative care
- Hospitalization
- Investigational services
- Laboratory and radiology services, such as X-rays
- Managed Long-term services and supports ("MLTSS")
- Maternity and newborn care
- Mental health services for mild to moderate conditions
- Non-emergency medical transportation ("NEMT")
- Non-medical transportation ("NMT")
- Pediatric services
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative (therapy) services and devices
- Reconstructive surgery
- Substance use disorder screening services

- Telehealth services from Kaiser Permanente 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 Health Plan of San Mateo and as listed in this Member Handbook and any amendments.

Benefit policies and the processes for how to get covered services may vary among HPSM's provider networks. If you would like information on how to change provider networks, please call HPSM's Member Services at **1-800-750-4776**, (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m.

Medi-Cal benefits covered by Health Plan

Outpatient (ambulatory) services

Adult Immunizations

You can get adult immunizations (shots) from a Network Provider without pre-approval. We cover those shots recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC").

For information on immunizations for children, see the heading for "Pediatric services" 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 receive outpatient care.

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 center, 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. Chiropractic services are limited to two services per month in combination with acupuncture, audiology, occupational therapy and speech therapy services. We may authorize additional visits as 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 end of the month that includes 60-days following the end of a pregnancy;
  - Residents in a skilled nursing facility, intermediate care facility, or subacute care facility

- ***Chiropractic services from FQHCs and RHCs***

  Medi-Cal may cover chiropractic services for Members of all ages when received at an FQHC or RHC in HPSM's network. FQHCs and RHCs may require a referral to get services. To get more information about services available at an FQHC or RHC, call HPSM Member Services at **1-800-750-4776** (TTY **711 or 1-**

800-735-2929).

Dialysis/hemodialysis services

We cover medically necessary dialysis treatments. We also cover hemodialysis (chronic dialysis) and peritoneal dialysis services. You must meet all medical criteria developed by The 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.

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 governing 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 accord 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” later in this Chapter 4.

Telehealth services

Kaiser Permanente may be able to provide some of your services through telehealth. 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. Telehealth may also include sharing information with your provider without a live conversation. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. Telehealth visits are not available for all medical conditions or for all covered services. You can ask your doctor if telehealth is available for your medical condition. You are not required to use telehealth services.

Mental health services

Outpatient mental health services

We cover mental health services provided by a Network Provider. You do not need a referral to see a mental health provider within the Kaiser Permanente network. You may get an initial mental health assessment without pre-approval or a referral. 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 can provide mental health services to you.

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 cover the following services for mild to moderate mental health conditions:

- 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”)

Medi-Cal covers services to diagnose and treat mental health conditions that are identified as a “mental disorder” in the most recent Diagnostic and Statistical Manual of Mental Disorders (“DSM”). Medi-Cal does not cover services for conditions that the DSM does not identify as a “mental disorder.” For example, the DSM identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

For help finding more information on mental health services provided by Kaiser Permanente you can call **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. 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 services include up to a 72-hour emergency supply of prescription drugs if a pharmacist or hospital emergency department gives you the medication as part of your emergency visit.

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.

Emergency room services

We cover emergency room services that are needed to treat a medical emergency. Remember, a medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, it could result in serious harm to your health or body. No services are covered outside the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico.

Health education

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

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma).

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

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 and can continue for an additional year for those Members who qualify. The program uses approved lifestyle changes including, but not limited to, the following:

- 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 for additional program and eligibility information.

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. If you choose hospice care:

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

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

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

- A network doctor has diagnosed you with a terminal illness and determines that your life expectancy is 6 months or less
- The services are provided in 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

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

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

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

Palliative care

We cover palliative care for Members who meet the Medi-Cal eligibility criteria for these services. Palliative care reduces physical, emotional, social and spiritual discomforts for a Member with a serious illness.

Adults who are age 21 or older cannot receive both palliative care and hospice care at the same time. If you are getting palliative care and meet the eligibility for hospice care, you can ask to change to hospice care at any time.

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.

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.

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, when medically appropriate.

Certified Nurse Midwife (“CNM”) services

We cover medically necessary services provided by certified nurse midwives.

Licensed Midwife (“LM”)

We cover medically necessary services provided by licensed nurse midwives.

Testing and counseling for genetic disorders

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

The Provisional Postpartum Care Extension Program

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 Chapter 4 of your Member Handbook.

Outpatient prescription drugs, supplies, and supplements

Covered drugs

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

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

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

- Dentists, if the drug is for dental care
- Out of network doctors, if The 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 emergency services or out-of-area urgent care

- An out of network pharmacist or hospital emergency room may give you up to a 72-hour emergency supply

- Out of network doctors, if the drug is related to Short-Doyle mental health services

- Out of network doctors, if the drug is related to specialty mental health services

To find out if a drug is on the formulary or to get a copy of the formulary, call **1-800-464-4000** (TTY **711**). You may also visit our website at **kp.org/formulary**.
Note: The fact that a drug is on the list does not necessarily mean that your doctor will prescribe it for a particular medical condition.

Day supply limit

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

- ***Hormonal contraceptives***

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

- ***All other items***

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

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

Pharmacies

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

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

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

Schedule II drugs

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

Medicare Part D

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

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

Rehabilitative and habilitative ("therapy") services and devices

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

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

We cover the rehabilitative and habilitative services described in this section.

Acupuncture

We cover acupuncture services medically necessary to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of the needles) are limited to two services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services. We may pre-approve additional services as medically necessary.

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 audiology services. Outpatient audiology is limited to two services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services. We may pre-approve additional services as medically necessary.
For information on hearing aids, see the heading "Hearing aids" later in this Chapter 4.

Behavioral health treatments

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

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

BHT services teach skills 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 inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment

Durable medical equipment requires pre-approval. We cover medically necessary items that a doctor prescribes for you. The item must be necessary to help you with activities

of daily living or to prevent major physical disability. See Chapter 7 of this Member Handbook for the definition of “Medically Necessary.”

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
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- 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

Note: The services that are subject to prior authorization (pre-approval) may vary among HPSM’s provider networks. If you would like information on how to change provider networks, please call HPSM Member Services at **1-800-750-4776** (TTY **711 or 1-800-735-2929**), Friday 9:30 a.m. to 6 p.m.

Hearing aids

We cover hearing aids if you are tested for hearing loss, the hearing aids are medically necessary, and you receive a prescription from your doctor. Coverage is limited to the lowest cost aid that meets your medical needs. We will choose who will supply the 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.

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

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

- A network doctor finds that the services can be provided in a safe and effective way in your home
- You get the services from Network Providers

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

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

Medical supplies, equipment and appliances

We cover medically necessary medical equipment, appliances, and supplies that are approved by a doctor, including implanted hearing devices.

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. Occupational therapy services are limited to two services per month in combination with acupuncture, audiology, chiropractic and speech therapy services. We may pre-approve additional services as medically necessary.

Note: The services that are subject to prior authorization (pre-approval) may vary among HPSM's provider networks. If you would like information on how to change provider networks, please call HPSM Member Services at **1-800-750-4776** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 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 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

We cover medically necessary orthotic and prosthetic devices and services that are medically necessary and prescribed for you. 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 HPSM's provider networks. If you would like information on how to change provider networks, please call HPSM Member Services at **1-800-750-4776** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 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 HPSM's provider networks. If you would like information on how to change provider networks, please call HPSM Member Services at **1-800-750-4776** (TTY **711** or **1-800-735-2929**), Monday through Friday, 8 a.m. to 6 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.

Speech therapy

We cover speech therapy that is medically necessary. Speech therapy services are limited to two services per month, in combination with acupuncture, audiology, chiropractic and occupational therapy. We may pre-approve additional services as medically necessary.

Cancer Clinical Trials

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

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

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

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

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

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

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

We cover the following preventive services:

- Advisory Committee for Immunization Practices recommended vaccines

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

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

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

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

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, contact your county mental health plan. To locate your county's mental health plan's toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx**.

Pediatric services

We cover the following services:

- Early and periodic screening, diagnostic and treatment (EPSDT) services that are recommended by pediatricians' Bright Futures guidelines to help you or your child stay healthy. These services are at no cost to you.
- If you or your child are under 21 years old, Kaiser Permanente covers well-child visits. Well-child visits are a comprehensive set of preventive, screening, diagnostic, and treatment services
- Kaiser Permanente will make appointments and provide transportation to help children get the care they need
- Preventive care can be regular health check-ups and screenings to help your doctor find problems early. Regular check-ups help you or your child's doctor look for any problems with you or your child's medical, dental, vision, hearing, mental health, and any substance use disorders. Kaiser Permanente covers screening services (including lead blood level assessment) any time there is a need for them, even if it is not during your or your child's regular check-up. Also, preventive care can be shots you or your child need. Kaiser Permanente must make sure that all enrolled children get needed shots at the time of any health care visit. Preventive care services and screenings are available at no cost and without pre-approval (prior authorization)
- When a problem 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 Kaiser Permanente will cover the care at no cost to you. These services include:
    - ♦ Doctor, nurse practitioner, and hospital care
    - ♦ Shots to keep you healthy
    - ♦ Physical, speech/language, and occupational therapies
    - ♦ Home health services, which could be medical equipment, supplies, and appliances
    - ♦ Treatment for vision and hearing, which could be eyeglasses and hearing aids
    - ♦ Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities

- Case management 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

- Care coordination to help you or your child get the right care, even if we are not responsible for paying for that care. These services include:
  - Treatment and rehabilitative services for mental health and substance use disorders
  - Treatment for dental issues, which could be orthodontics

Reconstructive surgery

We cover:

- Surgery when there is a problem with a part of your body. This problem could be caused by a birth defect, 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.

Transgender services

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

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:

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

- ***Eyeglass lenses***

  New or replacement eyeglass lenses are provided by DHCS's eyeglass lens vendor. If DHCS's vendor cannot provide you with the lenses you need, we will arrange for your lenses to be made at another optical lab. You will not have to pay extra if we have to make arrangements because DHCS's vendor cannot make your eyeglass lenses.

  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***

  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.

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, keracotonus.

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 HPSM's provider networks. If you would like information on how to change provider networks, please call HPSM Member Services at **1-800-750-4776** (TTY **711 or 1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m.

Non-emergency medical transportation ("NEMT")

You are entitled to use non-emergency medical transportation ("NEMT") to get to your appointments when it's a Medi-Cal covered service. If you cannot get to your medical, dental, mental health, substance use, and pharmacy appointment by car, bus, train or taxi, you can ask your doctor for NEMT. Your doctor will decide the correct type of transportation to meet your needs.

NEMT is an ambulance, litter van, wheelchair van or air transport. NEMT is not a car, bus or taxi. Kaiser Permanente allows the lowest cost NEMT for your medical needs when you need a ride to your appointment. That means, for example, if you are physically or medically able to be transported by a wheelchair van, we will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation not possible.

NEMT must be used when:

- It is physically or medically needed as determined with a written authorization by a doctor or other provider; or 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 network doctor determines that you need NEMT, he or she will prescribe the NEMT that best meets your needs. We will call you to schedule your transportation.

Limits of NEMT

There are no limits for receiving NEMT to or from medical, dental, mental health and substance use disorder appointments covered by Kaiser Permanente when a provider has prescribed it for you. Some pharmacy services are covered under NEMT such as pharmacy trips for medication. For more information or to ask for NEMT services related to pharmacy, please call your doctor or provider. If the appointment type is covered by Medi-Cal but not through Kaiser Permanente, we will help you to schedule your transportation.

What does not apply?

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

Cost to Member

There is no cost when transportation is authorized by us.

Non-medical transportation (“NMT”)

You can use non-medical transportation (“NMT”) when you are:

- Traveling to and from an appointment for a Medi-Cal covered service
- 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.

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

To ask NMT for services that have been authorized, please call Kaiser Permanente's transportation provider at **1-844-299-6230** at least three business days (Monday through Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have all of the following when you call:

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

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

Limits of NMT

There are no limits for getting NMT to or from medical, dental, mental health and substance use disorder appointments when a provider has requested it for you. If the appointment type is covered by Medi-Cal but not through the health plan, your health plan will provide for or help you schedule your transportation. Members cannot drive themselves or be reimbursed directly.

What does not apply?

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service
- You need assistance from the driver to and from the residence, vehicle or place of treatment due to a physical or medical condition
- 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

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

Care coordination

We offer services to help you coordinate your health care needs at no cost to you. If you have questions or concerns about your health or the health of your child, call **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.

Managed long-term services and supports ("MLTSS")

We cover the following MLTSS benefits for Members who qualify:

- Skilled Long-term care in a skilled nursing facility, intermediate care facility, or subacute care facility (91+ days)
- Community-Based Adult Services ("CBAS")
- Multipurpose Senior Services Program ("MSSP")
- Personal care services/In-home supports and services ("IHSS")
    - ♦ If you qualify for IHSS, you will get these services from the county.

For information about these programs and who is eligible, talk to your PCP or call our Medicaid Improvement Unit at **1-866-842-2574** (TTY **711**)

Whole Child Model ("WCM") Program

The WCM program incorporates CCS program covered services for Medi-Cal eligible CCS children and youth into Medi-Cal Managed Care. CCS is a state program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems and who meet the CCS program rules. If Health Plan of San Mateo or your PCP believes your child has a CCS condition, he or she will be referred to the CCS county program to be assessed for eligibility. If your child is determined eligible for WCM, he or she will get their CCS care through Health Plan of San Mateo and Kaiser Permanente.

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

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 your child for the CCS condition.

Coordinated Care Initiative ("CCI")

The California Coordinated Care Initiative ("CCI") works to improve care coordination for dual eligibles (people who qualify for both Medicaid and Medicare). It has two main parts: Cal MediConnect and Managed Long-term services and supports

Cal MediConnect

The Cal MediConnect program aims to improve care coordination for beneficiaries dually eligible for Medicare and Medi-Cal. It lets them enroll in a single plan to manage all of their benefits, instead of having separate Medi-Cal and Medicare plans. It also aims for high-quality care that helps people stay healthy and in their homes for as long as possible.

Cal MediConnect plans cover the following:

- A network of providers working together for you

- A personal care coordinator who will make sure you get the care and support you need
- A customized review of your health needs and care plan

Managed Medi-Cal long-term supports and services ("MLTSS"):

Individuals dually eligible for Medicare and Medi-Calmust join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MLTSS and Medicare wrap-around benefits.

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

Services you can get through Fee-For-Service ("FFS") Medi-Cal or other programs

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

Dental services

Medi-Cal covers some dental services, including:

- Diagnostic and preventive dental hygiene (such as examinations, X-rays and teeth cleanings)
- Topical fluoride
- 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

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

SMHS may include these outpatient, residential and inpatient services:

Outpatient services:

- Mental health services (assessments, plan development, therapy, rehabilitation and collateral)
- Medication support services
- Day treatment intensive services
- Day rehabilitation services
- Crisis intervention services
- Crisis stabilization services
- Targeted case management services
- Therapeutic behavioral services
- Intensive care coordination ("ICC")
- Intensive home-based services ("IHBS")
- Therapeutic foster care ("TFC")

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

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

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.**

Substance use disorder treatment services

Substance use disorder treatment services are covered through county mental health plans. To locate your county's mental health plan's toll-free telephone numbers online, visit **http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx**.

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

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

- Certain exams and services
- Comfort or convenience items
- Cosmetic services
- Disposable supplies
- Experimental services
- Fertility services (including infertility services, artificial insemination, and assisted reproductive technology services)
- Hair loss or growth treatment

- Items and services that are not health care items and services
- Massage therapy
- Personal care services
- Reversal of sterilization
- Routine foot care items and services
- Services not approved by the federal Food and Drug Administration
- Services performed by unlicensed people
- Services related to a noncovered service

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.

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

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

Fertility services

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

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. 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

- 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 under as part of the following benefits in Chapter 4 (“Benefits and services”) of this Member Handbook:

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

Personal care services

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
- Managed long-term services and supports (“MLTSS”)
- Skilled nursing/intermediate/subacute facility care

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.

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.

Coordination of benefits

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

Evaluation of new and existing technologies

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

5. Rights and responsibilities

As a Member of Kaiser Permanente, you have certain rights and responsibilities. This chapter 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

Kaiser Permanente Members have these rights:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information
- To be provided with information about the plan and its services, including covered services and member rights and responsibilities
- 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 oral interpretation services for their 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 access Minor Consent services
- To get written Member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W&I Code Section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To 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 Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services, pursuant to 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 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

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. If you are injured, and someone else 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**.

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 have Medicare coverage, 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 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. Or go through your health plan. Or call 1-800-541-5555 (TTY/TDD 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.

Notice about estate recovery

The Medi-Cal program must seek repayment from 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 the estate recovery, go to **http://dhcs.ca.gov/er**. Or call **1-916-650-0490** or 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 a 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 HPSM, 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 Health Plan of San Mateo.

Notice that Health Plan of San Mateo is not our agent

Health Plan of San Mateo 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 Health Plan of San Mateo know your new address.

6. Reporting and solving problems

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

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

You can use the Kaiser Permanente grievance and appeal process to let us know about your problem. You may also contact Health Plan of San Mateo instead of Kaiser Permanente. Using either Kaiser Permanente's or Health Plan of San Mateo's grievance process will not take away any of your legal rights and remedies. Neither Kaiser Permanente nor Health Plan of San Mateo 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, 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 **1-800-464-4000** (TTY **711**).

Complaints

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

You can file a complaint through Kaiser Permanente or Health Plan of San Mateo any time 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 reason for your complaint
  - Call Health Plan of San Mateo Member Services at **1-800-750-4776** (TTY **711** or **1-800-735-2929**), Monday through Friday, 8 a.m. to 6 p.m. Give them your health plan 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 Health Plan of San Mateo Member Services at **1-800-750-4776** (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:

    Health Plan of San Mateo

801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

- **In person:**
  - Fill out a Complaint or Benefit Claim/Request form at a Member Services office located at a network facility
  - Fill out a form at Health Plan of San Mateo's office at
    801 Gateway Blvd., Suite 100
    South San Francisco, CA 94080
- **Online**:
  - Use the online form on our website at **kp.org**
  - Visit the online form on the Health Plan of San Mateo website at www.**hpsm**.org

If you need help filing your complaint, we can help you. We can give you no-cost language services. Call **1-800-464-4000** (TTY **711**). You can also get help from Health Plan of San Mateo. They can also give you no-cost language services.

If you filed your complaint with Health Plan of San Mateo, they will work with you and Kaiser Permanente to solve the problem. To learn more about the Health Plan of San Mateo grievance process, call them at **1-800-750-4776** (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 Health Plan of San Mateo, 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 Health Plan of San Mateo to make a fast decision because the time it takes to resolve your complaint would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call us at **1-800-464-4000** (TTY **711**) or call Health Plan of San Mateo at **1-800-750-4776** (TTY **711** or **1-800-735-2929**). We or Health Plan of San Mateo will make a decision within 72 hours of receiving your complaint.

Appeals

An appeal is different from a complaint. An appeal is a request for Kaiser Permanente or Heath Plan of San Mateo 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 you are currently getting treatment and you want to continue getting treatment, then you must ask for an appeal within 10 calendar days from the date the NOA was delivered to you, or before the date Kaiser Permanente says services will stop. When you ask for an appeal under these circumstances, treatment will continue upon your request. We may require you to pay for the cost of services if the final decision denies or changes a service.

You can file an appeal through Kaiser Permanente or Health Plan of San Mateo any time 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 Health Plan of San Mateo Member Services at **1-800-750-4776**, Monday through Friday, 8 a.m. to 6 p.m. (TTY **711** or **1-800-735-2929**). Give them your health plan ID number, your name, and service you are appealing
- **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 network facility (see **kp.org/facilities** for locations)
    - Call Health Plan of San Mateo Member Services at **1-800-750-4776** (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 service you are appealing. Mail the form to:

Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

- **In person:**
  - Fill out an appeal form at a Member Services office located at a network facility
  - Fill out a form at Health Plan of San Mateo's office at
    801 Gateway Blvd., Suite 100
    South San Francisco, CA 94080
- **Online**:
  - Use the online form on our website at **kp.org**
  - Visit the Health Plan of San Mateo website at www.**hpsm.org**

If you need help filing your appeal, we can help you. We can give you no-cost language services. Call **1-800-464-4000** (TTY **711**). You can also get help from Health Plan of San Mateo. They can also give you no-cost language services.

If you file your appeal with Health Plan of San Mateo, they will work with you and Kaiser Permanente to solve the problem. To learn more about the Health Plan of San Mateo grievance process, call them at **1-800-750-4776** (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. If you filed your appeal with Health Plan of San Mateo, they will respond within the same timeframes. If we do not tell you its 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 Health Plan of San Mateo 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 HPSM at **1-800-750-4776** (TTY **711** or **1-800-735-2929**). We or HPSM will make a decision within 72 hours of receiving your appeal.

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

If you filed an appeal and got a letter from us 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 will review your case. DMHC's toll-free telephone number (**1-888-466-2219**) and a TTY line (**1-877-688-9891**) for the hearing and speech impaired. You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: **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.

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

HPSM. 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 its 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 **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 Kaiser Permanente 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.

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 Health Plan of San Mateo.

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 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:

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

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

If you notice potential signs of misconduct, contact 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. 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**)
- Health Plan of San Mateo **1-800-750-4776** (TTY **711** or **1-800-735-2929**)

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.

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 (IHS, 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 or social workers 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.

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.

County Organized Health System ("COHS"): A local agency created by a county board of supervisors to contract with the Medi-Cal program. You are automatically enrolled in a COHS plan if you meet enrollment rules. Enrolled recipients choose their health care provider from among all COHS providers.

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 EOC and any amendments.

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

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.

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

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

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

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

Family planning services: Services to prevent or delay pregnancy.

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

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

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

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

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

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

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

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

Types of health care providers, include, but are not limited to:

- Audiologist is a provider who tests hearing

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

- Respiratory therapist is a provider who helps you with your breathing
- Speech pathologist is a provider who helps you with your speech

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

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

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

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.

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.

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

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

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

Member: Any eligible Medi-Cal beneficiary assigned to Kaiser Permanente through Health Plan of San Mateo 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 care.

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

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

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

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

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

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

Other health coverage ("OHC"): A 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 his or her Home Region. For more information, 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.

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, or any other health care 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.

Premium: An amount paid for coverage; cost for coverage. Premiums do not apply for Medi-Cal coverage. You may have premiums for other health coverage.

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

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

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 services
- You need family planning care

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner

- OB/GYN
- IHC
- FQHC or 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 services: Medically necessary services for family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions.

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

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

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

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

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

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.

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