Kern Family Health Care®

Medicare (D-SNP)

2026 Member Handbook

H4057_EOC2701_C

Kern Family Health Care Medicare (HMO D-SNP) *Member Handbook*

January 1, 2026 – December 31, 2026

Your Health and Drug Coverage under Kern Family Health Care Medicare (HMO D-SNP)

Member Handbook Introduction

This *Member Handbook,* otherwise known as the *Evidence of Coverage,* tells you about your coverage under our plan through December 31, 2026. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Member Handbook*.

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

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means Kern Family Health Care Medicare (HMO D-SNP).

This document is available for free in Spanish.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at 1-866-661-3767 (TTY users call 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. The call is free.

You can ask that we always send you information in the language or format you need. This is called a standing request. We will keep track of your standing request, so you do not need to make separate requests each time we send you information. To get this document in a language other than English and/or in an alternate format, please contact Member Services at 1-866-661-3767, (TTY users call 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. A representative can help you make or change a standing request.

H4057_EOC2601_C OMB Approval 0938-1444 (Expires: June 30, 2026)

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

ENGLISH

ATTENTION: If you need help in your language, call **1-866-661-3767** (TTY: **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-866-661-3767** (TTY: **711**). These services are free of charge.

Arabic العربية

يُرجى الانتباه :إذا احتجت إلى المساعدة بلغتك، فاتصل ب **1-866-661-3767** (TTY **711**)
تتوفر أيُضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريُقة بريُل والخط الكبيُر .اتصل ب **1-866-661-3767** (TTY **711**).
هذه الخدمات مجانيُة.

Հայուհի (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ձեզ օգնություն է անհրաժեշտ ձեր լեզվով, զանգահարեք **1-866-661-3767** (TTY **711**): Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, ինչպիսիք են Բրայլի գրերով և խոշոր տառերով փաստաթղթերը: Զանգահարեք **1-866-661-3767** (TTY **711**): Այս ծառայությունները անվճար են:

ខ្មែរ (Cambodian-Mon-Khmer)

យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅលេខ **1-866-661-3767** (TTY **711**)។ ជំនួយ និងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងការបោះពុម្ពធំក៏មានផងដែរ។ ទូរស័ព្ទទៅ **1-866-661-3767** (TTY **711**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ។

简体中文 (Simplified Chinese)

注意：如果您需要母语帮助，请致电 **1-866-661-3767**（TTY **711**）。我们还提供残障人士辅助服务，例如盲文和大字印刷文件。请致电 **1-866-661-3767**（TTY **711**）。这些服务均免费

繁體中文 (Traditional Chinese)

注意：如果您需要母語協助，請致電 **1-866-661-3767** (TTY **711**)。我們也提供殘障人士輔助服務，例如點字和大字印刷文件。請致電 **1-866-661-3767** (TTY **711**)。這些服務均免。

فارسی (Farsi)

توجه: اگر می خواهید به زبان خود کمک دریافت کنید، با
تماس بگیرید. کمک ها و **1-866-661-3767** (TTY: **711**)
خدمات مخصوص افراد دارای معلولیت، مانند نسخه های خط بریل و
چاپ با حروف بزرگ، نیز موجود است. با **1-866-661-3767**
تماس بگیرید. این خدمات رایگان ارائه می شوند (**711**. :TTY)

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में मदद चाहिए, तो 1**-866-661-3767** (TTY **711**) पर कॉल करें। विकलांग लोगों के लिए सहायता और सेवाएँ, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। **1-866-661-3767** (TTY **711**) पर कॉल करें। ये सेवाएँ निःशुल्क हैं।

Hmoob (Hmong)

*CEEB TOOM: Yog tias koj xav tau kev pab ua yog lus Hmong, hu rau 1-**866-661-3767** (TTY **711**). Cov kev pab thiab kev pabcuam rau cov neeg tsis taus, zoo li cov ntaub ntawv nyob rau hauv daim ntawv Braille thiab luam ntawv loj, kuj muaj. Hu rau 1-**866-661-3767** (TTY **711**). Cov kev pab cuam no pub dawb.*

日本語 (Japanese)

ご注意：ご希望の言語でサポートが必要な場合は、**1-866-661-3767**（TTY **711**）までお電話ください。点字や拡大文字による資料など、障がいのある方向けの支援サービスもご利用いただけます。**1-866-661-3767**（TTY **711**）までお電話ください。これらのサービスは無料です。

한국어 (Korean)

주의: 한국어로 도움이 필요하시면 **1-866-661-3767** (TTY **711**) 번으로 전화하십시오. 점자 및 큰 활자체 문서와 같은 장애인을 위한 지원 및 서비스도 이용하실 수 있습니다. **1-866-661-3767** (TTY **711**) 번으로 전화하십시오. 이러한 서비스는 무료입니다.

ພາສາລາວ (Laotian)

ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ **1-866-661-3767** (TTY **711**). ການຊ່ວຍເຫຼືອ ແລະການບໍລິການສໍາລັບຄົນພິການ, ເຊັ່ນ: ເອກະສານທີ່ເປັນຕົວອັກສອນນູນ ແລະ ການພິມຂະໜາດໃຫຍ່, ຍັງມີຢູ່. ໂທ **1-866-661-3767** (TTY **711**). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າ.

Mien

CAU FIM JANGX LONGX: Se gorngv meih qiemx longc mienh tengx faan benx meih nyei waac, douc waac lorz taux1- ***866-661-3767*** *(TTY* ***711****). Ninh mbuo mbenc duqv maaih jaa-dorngx aengx caux gong-bou jau-louc tengx ziux goux waaic fangx mienh, dorh sou zoux benx braille, nqaapv bieqc domh zei-linh.Douc waac lorz taux 1-****866-661-3767*** *(TTY* ***711****). Naaiv deix gong-bou jau-louc benx wangv-henh tengx hnangv oc.*

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ **1-866-661-3767** (TTY **711**) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। **1-866-661-3767** (TTY **711**) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

Румынский (Russian)

ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните по телефону **1-866-661-3767** (TTY **711**). Также доступны пособия и услуги для людей с ограниченными возможностями, такие как документы на шрифте Брайля и крупным шрифтом. Позвоните по телефону **1-866-661-3767** (TTY **711**). Эти услуги бесплатны.

Español (Spanish)

ATENCIÓN: Si necesita ayuda en su idioma, llame al **1-866-661-3767** (TTY **711**). También disponemos de ayuda y servicios para personas con discapacidad, como documentos en braille y letra grande. Llame al **1-866-661-3767** (TTY **711**). Estos servicios son gratuitos.

Tagalog (Filipino)

PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-866-661-3767** (TTY **711**). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento nasa braille at malaking print. Tumawag sa **1-866-661-3767** (TTY **711**). Ang mga serbisyong ito ay walang bayad.

ภาษาไทย (Thai)

หมายเหตุ: หากคุณต้องการความช่วยเหลือในภาษาของคุณ โปรดโทร **1-866-661-3767** (TTY **711**)
นอกจากนี้ยังมีบริการช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารอักษรเบรลล์และเอกสารตัวพิมพ์ใหญ่ โปรดโทร 1**-866-661-3767** (TTY **711**) บริการเหล่านี้ไม่มีค่าใช้จ่าย

Українська (Ukrainian)

УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте за номером **1-866-661-3767** (TTY **711**). Також доступні допоміжні засоби та послуги для людей з інвалідністю, такі як документи шрифтом Брайля та великим шрифтом. Зателефонуйте за номером **1-866-661-3767** (TTY **711**). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)

LƯU Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi số **1-866-661-3767** (TTY **711**). Các dịch vụ hỗ trợ và dịch vụ dành cho người khuyết tật, như tài liệu chữ nổi và chữ in lớn, cũng có sẵn. Gọi số **1-866-661-3767** (TTY **711**). Các dịch vụ này miễn phí.

Other languages

You can get this *Member Handbook* and other plan materials in other languages at no cost to you. Kern Family Health Care Medicare (HMO D-SNP) provides written translations from qualified translators. Call 1-866-661-3767 (TTY 711),

8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. The call is 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 a timely manner, in other formats such as braille, 20-point font large print, audio format, and accessible electronic formats (data CD) at no cost to you. Call 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. The call is free.

Interpreter services

Kern Family Health Care Medicare (HMO D-SNP) provides oral interpretation services, as well as sign language, from a qualified interpreter, on a 24-hour basis, at no cost to you. You don't have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters unless it's an emergency. Interpreter, linguistic, and cultural services are available for free. Help is available 24 hours a day, 7 days a week. For language help, or to get this handbook in a different language, call 1-866-661-3767 (TTY 711). The call is free.

Table of Contents

Chapter 1: Getting started as a member 10

Chapter 2: Important phone numbers and resources 21

Chapter 3: Using our plan's coverage for your health care and other covered services 46

Chapter 4: Benefits chart 67

Chapter 5: Getting your outpatient drugs 150

Chapter 6: What you pay for your Medicare and Medi-Cal drugs 172

Chapter 7: Asking us to pay our share of a bill you received for covered services or drugs 188

Chapter 8: Your rights and responsibilities 195

Chapter 9. What to do if you have a problem or complaint 214

Chapter 10: Ending your membership in our plan 263

Chapter 11: Legal notices 274

Chapter 12: Definitions of important words 279

Disclaimers

- Kern Family Health Care Medicare (HMO D-SNP) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. Enrollment in Kern Family Health Care Medicare (HMO D-SNP) depends on contract renewal.
- Benefits and/or copayments may change on January 1, 2027.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.
- Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Kern Family Health Care Medicare (HMO D-SNP), a health plan that covers all of your Medicare services and coordinates all of your Medicare and Medi-Cal services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Welcome to our plan 12

B. Information about Medicare and Medi-Cal 12

B1. Medicare 12

B2. Medi-Cal 12

C. Advantages of our plan 13

D. Our plan's service area 14

E. What makes you eligible to be a plan member 14

F. What to expect when you first join our health plan 14

G. Your care team and care plan 15

G1. Care team 15

G2. Care plan 16

H. Summary of Important Costs 16

H1. Medicare Prescription Payment Amount 16

I. This *Member Handbook* 17

J. Other important information you get from us 17

J1. Your Member ID Card 17

J2. *Provider and Pharmacy Directory* 18

J3. *List of Covered Drugs* 19

J4. The *Explanation of Benefits* 19

K. Keeping your membership record up to date 20

K1. Privacy of personal health information (PHI) 20

A. Welcome to our plan

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

Kern Family Health Care Medicare (HMO D-SNP) will help manage your health care by:

- Paying for your health care services,
- Giving you access to a large provider network with primary care physicians (PCPs), specialists, clinics, pharmacies, and hospitals,
- Helping you find other health care services you may qualify for and need like behavioral health and long-term services and supports,
- Providing care coordination to help you manage your providers and services making sure they all work together to help meet your health goals.

B. Information about Medicare and Medi-Cal

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medi-Cal

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

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

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

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

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

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

C. Advantages of our plan

You'll now get all your covered Medicare and Medi-Cal services from our plan, including drugs. **You don't pay extra to join this health plan.**

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

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

New members to Kern Family Health Care Medicare (HMO D-SNP): In most instances, you'll be enrolled in Kern Family Health Care Medicare (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Kern Family Health Care Medicare (HMO D-SNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you'll receive your Medi-Cal services through Kern Family Health Care

Medicare (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at 1-866-661-3767 (TTY users call 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30 if you have any questions.

D. Our plan's service area

Our service area includes these counties in California: Kern.

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

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- are age 21 and older at the time of enrollment, **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for Medi-Cal**.**

If you lose Medi-Cal eligibility but can be expected to regain it within three (3) months, then you're still eligible for our plan.

Call Member Services for more information.

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

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

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

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

We'll send you more information about this HRA.

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

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.
    - We determine an existing relationship by reviewing your available health information or information you give us.
    - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. You can make this request by calling 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. If you're at risk of harm, we must respond within 3 days.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

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

After the continuity of care period ends, you'll need to use doctors and other providers in the Kern Family Health Care Medicare (HMO D-SNP) network unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Refer to **Chapter 3** of this *Member Handbook* for more information on getting care.

G. Your care team and care plan

G1. Care team

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

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

G2. Care plan

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

Your care plan includes:

- your health care goals,
- steps to help you achieve your goals,
- a timeline for getting the services you need, **and**
- an evaluation to see if you met your goals.

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

H. Summary of Important Costs

Our plan has no premium.

Your costs may include the following:

- Medicare Prescription Payment Plan Amount (**Section H1**)

H1. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, **Section M3,** tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. This *Member Handbook*

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

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

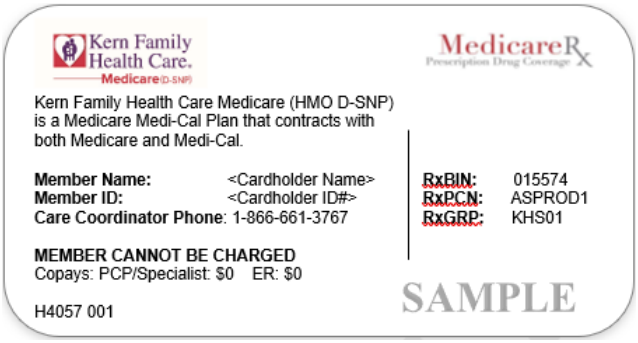
The contract is in effect for the months you're enrolled in our plan between January 1, 2026 and December 31, 2026.

J. Other important information you get from us

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

J1. Your Member ID Card

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


Kern Family Health Care. Medicare (D-SNP)

MedicareRx Prescription Drug Coverage

Kern Family Health Care Medicare (HMO D-SNP) is a Medicare Medi-Cal Plan that contracts with both Medicare and Medi-Cal.

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
Care Coordinator Phone: 1-866-661-3767

RxBIN: 015574
RxPCN: ASPROD1
RxGRP: KHS01

MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: $0 ER: $0

H4057 001

SAMPLE

In case of emergency, please call **911** or seek appropriate emergency care.

Member Services: 1-866-661-3767 / 661-716-5342, TTY 711
Behavioral Health Crisis: 988
Pharmacy Help Desk: 1-833-546-0101
24-hour Nurse Advice Line: 1-866-661-3767 / 661-716-5342, TTY 711

Website: kernfamilyhealthcare.com

Send Claims To: Kern Family Health Care Medicare (D-SNP)
PO Box 9187, Bakersfield, CA 93389-9187
Claim Inquiry: 1-866-661-3767 / 661-716-5342, TTY 711

SAMPLE

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

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your Medi-Cal card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card

if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out what to do if you get a bill from a provider.

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

- Medi-Cal dental services: Additional dental services are available through the Medi-Cal Dental Program. For more information you can visit the website at dental.dhcs.ca.gov/.
- County behavioral health services: Medi-Cal specialty mental health services are provided by the Kern Behavioral Health Recovery Services 24-hour Crisis Hotline at 1-800-991-5272, 24 hours a day, 7 days a week.
- In Home Supportive Services (IHSS): For more information about In-Home Supportive Services (IHSS), call Kern County Aging and Adult Services at 1-661-868-1003.
- Medi-Cal Rx: For more information about Medi-Cal Rx, call 1-800-977-2273.

J2. *Provider and Pharmacy Directory*

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

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

You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

The *Provider and Pharmacy Directory* provides a list of all doctors, hospitals, clinics, and pharmacies that are part of Kern Family Health Care Medicare (HMO D-SNP)'s network.

Definition of network providers

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

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

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

Definition of network pharmacies

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

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

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they have been removed and replaced as described in **Chapter 5, Section E.** Medicare approved the Kern Family Health Care Medicare (HMO D-SNP) *Drug List.*

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

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

J4. The *Explanation of Benefits*

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

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

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

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

K. Keeping your membership record up to date

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

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and,**
- if you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

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

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this *Member Handbook*.

Chapter 2: Important phone numbers and resources

Introduction

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

Table of Contents

A. Member Services 23

B. Your Care Coordinator 26

C. Health Insurance Counseling and Advocacy Program (HICAP) 28

D. Nurse Advice Call Line 29

E. Behavioral Health Crisis Line 30

F. Quality Improvement Organization (QIO) 31

G. Medicare 32

H. Medi-Cal 33

I. Medi-Cal Managed Care and Mental Health Office of the Ombudsman 34

J. County Social Services 35

K. County Behavioral Health Services Agency 36

L. California Department of Managed Health Care 37

M. Programs to Help People Pay for Drugs 38

M1. Extra Help from Medicare 38

M2. AIDS Drug Assistance Program (ADAP) 39

M3. The Medicare Prescription Payment Plan 39

N. Social Security 40

O. Railroad Retirement Board (RRB) 41

P. Group insurance or other insurance from an employer 42

Q. Other resources 43

R. Medi-Cal Dental 44

A. Member Services

CALL	1-866-661-3767. This call is free. 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.
FAX	Coverage Decision (Medical Care) Fax: 1-661-605-0315 Coverage Decision (Part D Drugs) Fax: 1-858-790-7100 Appeals and Grievances Fax: 1-661-605-0200 Part D Drug Appeals: 1-858-790-6060
WRITE	Kern Family Health Care Medicare (HMO D-SNP) PO Box 9187 Bakersfield, CA 93389-9187
WEBSITE	https://www.kernfamilyhealthcare.com

Contact Member Services to get help with:

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

  - To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.

- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Member Services.

- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
  - You can call us and explain your complaint at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can make a complaint about our plan to the Medicare Medi-Cal Ombudsman Program by calling 1-855-501-3077.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.

- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx

website (www.medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Member Handbook*.

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

- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this *Member Handbook*.

- payment for health care or drugs you already paid for
  - We are not allowed to reimburse you for Medi-Cal covered benefits.
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Member Handbook*.

B. Your Care Coordinator

Your Care Coordinator is your primary point of contact at Kern Family Health Care Medicare (HMO D-SNP). Your Care Coordinator manages all of your providers and services to make sure you get the care you need. We will assign you a Care Coordinator. You can also request or contact a Care Coordinator at the number listed below. You can change your Care Coordinator at any time by calling us.

CALL	1-866-661-3767. This call is free. 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30
WRITE	Kern Family Health Care Medicare (HMO D-SNP) PO Box 9187 Bakersfield, CA 93389-9187
WEBSITE	https://www.kernfamilyhealthcare.com

Contact your care coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about dental benefits
- questions about transportation to medical appointments
- questions about Long-term Services and Supports (LTSS), including Community-Based Adult Services (CBAS) and Nursing Facilities (NF)
- questions about community supports
- help with scheduling your appointments

You might be able to get these services:

- Community-Based Adult Services (CBAS)
- skilled nursing care
- physical therapy
- occupational therapy
- speech therapy
- medical social services
- home health care
- In-Home Supportive Services (IHSS) through your county social service agency
- sometimes you can get help with your daily health care and living needs

C. Health Insurance Counseling and Advocacy Program (HICAP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	1-800-434-0222 Monday - Friday 8:00 am to 5:00 pm
WRITE	Kern County Aging and Adult Services ATTN: Health Insurance Counseling and Advocacy Program 5357 Truxtun Ave. Bakersfield, CA 93309
WEBSITE	http://www.co.kern.ca.us/aas/

Contact HICAP for help with:

- questions about Medicare
- HICAP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - assist with billing or claims issues.

D. Nurse Advice Call Line

You can contact the Nurse Advice Call Line with questions about your health or health care. You can call the Nurse Advice Line 24 hours a day, 7 days a week for any health related question. Our nurses are trained professionals who can provide appropriate health information, education and advice, including helping you to get urgent or emergency level care. If you have specific questions about ongoing treatment, you should call your physician's office. Nurse Advice Line does not replace your physician's office.

CALL	1-866-661-3767. This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who don't speak English.
TTY	711. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

E. Behavioral Health Crisis Line

If you are experiencing a behavioral health or substance abuse crisis, services are available to offer emotional support and resources to you.

CALL	Call or text 988. This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who don't speak English.
TTY	711. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Contact the Behavioral Health Crisis Line for help with:

- questions about behavioral health and substance abuse services
- questions about substance use disorder services

For questions about your county specialty mental health services, refer to **Section K**.

F. Quality Improvement Organization (QIO)

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

CALL	1-877-588-1123
WRITE	Commence Health PO Box 2687 Virginia Beach, VA 23450
WEBSITE	https://www.livantaqio.cms.gov

Contact Commence Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	www.medicare.gov ● Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. ● Find Medicare-participating doctors or other health care providers and suppliers. ● Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly “wellness” visits). ● Get Medicare appeals information and forms. ● Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. ● Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

H. Medi-Cal

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

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

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

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

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

The Office of the Ombudsman helps solve problems from a neutral standpoint to ensure that our members receive all medically necessary covered services. They will listen, answer your questions, analyze your situation, explain policies and procedures, provide information, advice, and options, and suggest appropriate referrals. It's their job to help develop fair solutions to health care access problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-888-452-8609 Monday through Friday, 8 a.m. to 5 p.m.
TTY	1-800-430-7077 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
EMAIL	MMCDOmbudsmanOffice@dhcs.ca.gov
WEBSITE	www.dhcs.ca.gov/services/MH/Pages/mh-ombudsman.aspx

J. County Social Services

If you need help with your IHSS benefits or Medi-Cal eligibility, contact your local County Social Services agency.

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

CALL	1-661-868-1003. This call is free. Monday - Friday 8:00 AM – 5:00 PM
TTY	1-661-868-0910 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Kern County Aging and Adult Services 5357 Truxtun Ave. (just east of Mohawk) Bakersfield, CA 93309
WEBSITE	https://www.kerncounty.com/government/aging-adult-services

Contact your County Social Services agency for any questions about your Medi-Cal eligibility.

CALL	1-661-631-6000 This call is free. Monday - Friday 7:30 AM - 4:00 PM
TTY	1-661-631-6200 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Kern County Department of Human Services 100 E California Ave Bakersfield, CA 93307
WEBSITE	https://www.kcdhs.org/

K. County Behavioral Health Services Agency

Medi-Cal specialty mental health services and substance use disorder services are available to you through the county if you meet access criteria.

CALL	Crisis Hotline: 988 Mental Health Access Line: 1-800-991-5272 Substance Use Access Line: 1-866-266-4898 These calls are free. 24 hours a day, 7 days a week We have free interpreter services for people who don't speak English.
TTY	711 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Contact the county Behavioral Health agency for help with:

- questions about specialty mental health services provided by the county
- questions about substance use disorder services provided by the county

L. California Department of Managed Health Care

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

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

M. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

M1. Extra Help from Medicare

Because you're eligible for Medi-Cal, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Below are examples of paperwork that you can provide as evidence to support your proof of eligibility:
  - A copy of your Medi-Cal card if it includes your eligibility date during the period of time in question
  - A copy of a letter from the state or the Social Security Administration showing Medicare Low-Income Subsidy status
  - A copy of a state document that confirms active Medi-Cal status during the period of time in question
  - A screen print from the state's Medi-Cal systems showing Medi-Cal status during the period of time in question
- If you have been a resident of a long-term care (LTC) facility (like a nursing home), you may be able to provide the following as proof of eligibility:
  - A remittance from the facility showing Medi-Cal payment for a full calendar month for you during the period of time in question

  - A copy of a state document that confirms Medi-Cal payment to the facility on your behalf
  - A screen print from the state's Medi-Cal systems showing your institutional status, for Medi-Cal payment purposes, during the period of time in question

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them debt, we may make the payment directly to the pharmacy. If the state paid on your behalf, we may make payment directly to the state. Call Member Services at the number at the bottom of the page if you have questions.

M2. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the California Department of Public Health, Office of AIDS. Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050.

M3. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Services at the phone number at the bottom of the page or visit www.medicare.gov.

N. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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

O. Railroad Retirement Board (RRB)

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

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

P. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at the phone number at the bottom of the page with any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can also call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse's or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

Q. Other resources

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

If you have problems with:

- Medi-Cal
- Medicare
- your health plan
- accessing medical services
- appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- medical billing
- IHSS (In-Home Supportive Services)

The Medicare Medi-Cal Ombudsman Program assists with complaints, appeals, and hearings. The phone number for the Ombudsman Program is 1-855-501-3077.

R. Medi-Cal Dental

Starting July 1, 2026:

Certain dental services are available through Medi-Cal Dental for:

- Members who are eligible for federal full-scope Medi-Cal
- Members who are not eligible for federal full-scope Medi-Cal and meet at least one of the three exceptions below:
  - Under age 19;
  - Designated by the county as pregnant (and up to one year after pregnancy ends); and/or
  - Designated by the county as foster youth or former foster youth under age 26 who were in foster care on their 18th birthday.

Dental services include, but are not limited to, services such as:

- initial examinations, X-rays, cleanings, and fluoride treatments
- restorations and crowns
- root canal therapy
- partial and complete dentures, adjustments, repairs, and relines

Dental benefits are available through Medi-Cal Fee-for-Service (FFS) and Dental Managed Care (DMC).

CALL	1-800-322-6384 The call is free. Medi-Cal Dental FFS representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday.
TTY	1-800-735-2922 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.dental.dhcs.ca.gov smilecalifornia.org

Instead of Medi-Cal Dental Fee-For-Service, you may get dental benefits through a dental managed care plan.

Starting July 1, 2026:

Dental managed care plans are available in Sacramento and Los Angeles Counties, but there are some exceptions. If you fit under one or more of these exceptions, you may be disenrolled from your dental managed care plan:

- Members who are not eligible for federal full-scope Medi-Cal aged 19 and older and are not pregnant or within one year postpartum (after pregnancy) or foster youth or former foster youth can see any Medi-Cal Dental FFS provider for dental emergencies only.
- Members who are not eligible for federal full-scope Medi-Cal aged 19 and older and are designated by the county as pregnant or within one year postpartum (after pregnancy) can see any Medi-Cal Dental FFS provider for full-scope Medi-Cal.
- Members who are not eligible for federal full-scope Medi-Cal aged 19 and older who are designated by the county as foster youth or former foster youth under age 26 who were in foster care on their 18th birthday can see any Medi-Cal Dental FFS provider for full-scope Medi-Cal.

If you want more information about dental plans, or want to change dental plans, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free. Dental managed care plan contacts are also available here: www.dhcs.ca.gov/services/Pages/ManagedCarePlanDirectory.aspx.

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

Introduction

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

Table of Contents

A. Information about services and providers 48

B. Rules for getting services our plan covers 48

C. Your care coordinator 50

C1. What a care coordinator is 50

C2. How you can contact your care coordinator 50

C3. How you can change your care coordinator 50

D. Care from providers 50

D1. Care from a primary care provider (PCP) 50

D2. Care from specialists and other network providers 52

D3. When a provider leaves our plan 52

D4. Out-of-network providers 53

E. Long-term services and supports (LTSS) 54

F. Behavioral health (mental health and substance use disorder) services 54

F1. Medi-Cal behavioral health services provided outside our plan 54

G. Transportation services 56

G1. Non-Emergency Medical Transportation....56

G2. Non-medical transportation....57

H. Covered services in a medical emergency, when urgent needed, or Long-term services and supports (LTSS)....59

H1. Care in a medical emergency....59

H2. Urgently needed care....60

H3. Care during a disaster....61

I. What if you're billed directly for covered services....61

I1. What to do if our plan doesn't cover services....61

J. Coverage of health care services in clinical research study....62

J1. Definition of a clinical research study....62

J2. Payment for services when you participate in a clinical research study....62

J3. More about clinical research studies....63

K. How your health care services are covered in a religious non-medical health care institution....63

K1. Definition of a religious non-medical health care institution....63

K2. Care from a religious non-medical health care institution....63

L. Durable medical equipment (DME)....64

L1. DME as a member of our plan....64

L2. DME ownership if you switch to Original Medicare....64

L3. Oxygen equipment benefits as a member of our plan....65

L4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan....65

A. Information about services and providers

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

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

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

B. Rules for getting services our plan covers

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

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

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean services that are reasonable and necessary to diagnose and treat your medical condition. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
    - In most cases, our plan must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.

- You don't need referrals from your PCP for emergency care or urgently needed care, to use a woman's health provider, or for any of the other services listed in **Section D1** of this chapter.

- **You must get your care from network providers** (for more information, go to **Section D** in this chapter)**.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section H** in this chapter).
  - If you need care that our plan covers and our network providers can't provide it, you can get care from an out-of-network provider. In this situation, we cover the care as if you got it from a network provider. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible.
  - When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of this *Member Handbook*. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network. After 12 months, we'll no longer cover your care if you continue to use providers that aren't in our network.

Other Health Coverage: Medi-Cal members must utilize all other health coverage (OHC) prior to Medi-Cal when the same service is available under your health coverage since Medi-Cal is the payer of last resort. This means that in most cases, Medi-Cal will be the secondary payer to the Medicare OHC, covering allowable costs not paid by our plan or other OHC up to the Medi-Cal rate.

New members to Kern Family Health Care Medicare (HMO D-SNP): In most instances, you'll be enrolled in Kern Family Health Care Medicare (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Kern Family Health Care Medicare (HMO D-SNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you'll receive your Medi-Cal services through Kern Family Health Care. There will be no gap in your Medi-Cal coverage. Please call us at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm, 7 days a week from October 1 – March 31 and Monday through Friday from April 1 – September 30, if you have any questions.

C. Your care coordinator

C1. What a care coordinator is

A care coordinator is a trained person who works for our plan to provide care coordination services for you. This person helps to manage all your health care services with your health care providers to make sure you get what you need.

C2. How you can contact your care coordinator

You can contact your care coordinator at 1-866-661-3767 (TTY 711) from 8:00 am to 8:00 pm, 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

C3. How you can change your care coordinator

You can change your care coordinator by calling us at 1-866-661-3767 (TTY 711) from 8:00 am to 8:00 pm, 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

Definition of a PCP and what a PCP does for you

A PCP is a primary care provider that is medically trained to give you medical care and treatment. Your PCP will be the health care provider you will see first for your health care services.

The Kern Family Health Care Medicare (HMO D-SNP) *Provider and Pharmacy Directory* lists all providers who may serve as a PCP. Certain specialists, including Obstetrician-gynecologists are eligible as primary care physicians if they agree to act as one.

You will get your routine or basic health care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of Kern Family Health Care Medicare (HMO D-SNP). In most cases, you must see your PCP to get a referral before you see any other health care provider.

Members may choose a Federally Qualified Health Center (FQHC) as a PCP if the FQHC is listed as a PCP in the *Provider and Pharmacy Directory*.

Your choice of PCP

Find the name of the PCP that you want to choose in the *Provider and Pharmacy Directory*. Once you choose a PCP, call Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm, 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30, to let us know your choice. You can also call Member Services if you need help choosing a PCP.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

You can change your PCP at any time by calling Member Services. In most cases, the change will be effective the first of the month following the date your change request is received.

Services you can get without approval from your PCP

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

- Emergency services from network providers or out-of-network providers
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. If you call Member Services before you leave the service area, we can help you receive dialysis while you're away.
- Flu shots and COVID-19 vaccine as well as hepatitis B vaccines and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.

Additionally, if you're an American Indian Member, you may get Covered Services from an Indian Health Care Provider of your choice, without requiring a referral from a Network PCP or Prior Authorization.

D2. Care from specialists and other network providers

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

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

When your PCP thinks you need specialized treatment, he or she will give you a referral to see a plan specialist. For some services, you or your PCP must call us and request prior authorization, Prior authorization is a request to approve a service before you receive it. Please refer to the Benefits Chart in **Chapter 4** for information about which services require prior authorization and/or a referral.

D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We'll help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization is required to see an out-of-network provider.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9, Section K3**, for more information.)

D4. Out-of-network providers

You must go to contracted providers in the Kern Family Health Care Medicare (HMO D-SNP) network in order to receive benefits. Kern Family Health Care Medicare (HMO D-SNP) will cover out-of-network providers in the following situations:

- Emergency care and out-of-area urgent services within the United States and its territories.
- If you need covered medical services and the providers in Kern Family Health Care Medicare (HMO D-SNP)'s network cannot provide the services. Prior authorization is required in this situation.
- Kidney dialysis services that you receive at a Medicare-certified dialysis facility when you are temporarily out of the service area.
- Family planning
- Native American Indian Health Care Services
- Women's obstetrical and gynecological services
- Services during a declared disaster or public health emergency

If you use an out-of-network provider, the provider must accept Medicare and/or Medi-Cal.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Medi-Cal.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.

- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

LTSS can help you stay at home and avoid a hospital or skilled nursing facility stay. You have access to certain LTSS through our plan, including skilled nursing facility care, Community Based Adult Services (CBAS), and Community Supports. Another type of LTSS, the In Home Supportive Services program, is available through your county social service agency. Please call Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm, 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30 for more information about LTSS.

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

You have a right to access medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan doesn't provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through Kern Behavioral Health Recovery Services 24-hour Crisis Hotline at 988, 24 hours a day, 7 days a week.

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

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by Kern Behavioral Health Recovery Services include:

- mental health services
- medication support services
- day treatment intensive services
- day rehabilitation
- crisis intervention services
- crisis stabilization services
- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services

- targeted case management
- justice-Involved Reentry
- assertive community treatment (ACT)
- forensic assertive community treatment (FACT)
- coordinated specialty care (CSC) for first episode psychosis (FEP)
- clubhouse services
- enhanced community health worker (CHW) Service
- supported employment
- community-based mobile crisis intervention services
- therapeutic behavioral services
- therapeutic foster care
- intensive care coordination
- intensive home-based services

Drug Medi-Cal services provided by Kern Behavioral Health Recovery Services include:

- intensive outpatient treatment services
- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program
- medications for addiction treatment (also called Medication Assisted Treatment)
- community-based mobile crisis intervention services

Drug Medi-Cal Organized Delivery System (DMC-ODS) services are available to you through Kern Behavioral Health Recovery Services if you meet criteria to receive these services. DMC-ODS Services include:

- outpatient treatment services
- intensive outpatient treatment services

- partial hospitalization services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- community-based mobile crisis intervention services early intervention services (for members under age 21)
- early periodic screening, diagnosis, and treatment (for members under age 21)
- inpatient treatment services

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

For information about the availability of behavioral health services, processes to determine medical necessity, referral procedures between Kern Family Health Care Medicare (HMO D-SNP) and Kern Behavioral Health Recovery Services, and problem resolution processes, call Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm, 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

G. Transportation services

G1. Non-Emergency Medical Transportation

You're entitled to non-emergency medical transportation if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. Non-emergency medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. If you need non-emergency medical transportation, you can talk to your PCP and ask for it. Your PCP will decide the best type of transportation to meet your needs. If you need non-emergency medical transportation, they'll prescribe it by completing a form and submitting it to Kern Family Health Care Medicare (HMO D-SNP) for approval. Depending on your medical need, the approval is good for one year. Your PCP will reassess your need for non-emergency medical transportation for re-approval every 12 months.

Non-emergency medical transportation is an ambulance, litter van, wheelchair van, or air transportation. Kern Family Health Care Medicare (HMO D-SNP) allows for the lowest cost covered transportation mode and most appropriate non-emergency medical transportation for your medical needs when you need a ride to your appointment. For example, if you can physically or medically be transported by a wheelchair van, Kern Family Health Care Medicare (HMO D-SNP) won't pay for an ambulance. You're only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Non-emergency medical transportation must be used when:

- You physically or medically need it as determined by written authorization from your PCP because you aren't able to 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.

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call Kern Family Health Care Medicare (HMO D-SNP) at 1-866-661-3767 (TTY 711) at least 2 business days (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Medical transportation limits

Kern Family Health Care Medicare covers the lowest cost medical transportation that meets your medical needs from your home to the closest provider where an appointment is available. Medical transportation won't be provided if Medicare or Medi-Cal doesn't cover the service. If the appointment type is covered by Medi-Cal, but not through the health plan, Kern Family Health Care Medicare (HMO D-SNP) will help you schedule your transportation. A list of covered services is in **Chapter 4** of this handbook. Transportation isn't covered outside Kern Family Health Care Medicare (HMO D-SNP)'s network or service area unless pre-authorized.

G2. Non-medical transportation

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

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

Kern Family Health Care (HMO D-SNP) allows you to use a car, taxi, bus, or other public/private way of getting to your appointment for services authorized by your provider. Kern Family Health Care (HMO D-SNP) uses their Transportation Department to arrange for non-medical transportation. We cover the lowest cost, non-medical transportation type that meets your needs.

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Kern Family Health Care (HMO D-SNP) must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. You can tell us by calling or emailing, or in person. **You can't be reimbursed for driving yourself**.

Mileage reimbursement requires all of the following:

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

To ask for a ride for services that have been authorized, call Kern Family Health Care Medicare (HMO D-SNP) at 1-866-661-3767 (TTY 711) at least 2 business days (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Note: American Indian Members may contact their local Indian Health Clinic to ask for non-medical transportation.

Non-medical transportation limits

Kern Family Health Care Medicare (HMO D-SNP) provides the lowest cost non-medical transportation that meets your needs from your home to the closest provider where an appointment is available. **You can't drive yourself or be reimbursed directly.**

Non-medical transportation **doesn't** apply if:

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

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

H1. Care in a medical emergency

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

- serious risk to your life or to that of your unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant woman in active labor, when:
  - There isn't enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories, from any provider with an appropriate state license, even if they're not part of our network.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. Call Member Services at the phone number on the back of your Member ID Card.

Covered services in a medical emergency

Our plan covers ambulance services in situations when getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Medicare doesn't provide coverage for emergency medical care outside the United States and its territories.

Getting emergency care if it wasn't an emergency

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

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

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

H2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

We cover urgently needed care only if:

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

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances, we cover urgently needed care you get from an out-of-network provider.

You can receive urgently needed care from an urgent care center listed in the *Provider and Pharmacy Directory*. You can also contact Member Services at the phone number on the back of your Member ID Card for assistance in accessing urgent care services.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed, even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan doesn't cover urgently needed care or any other care that you get outside the United States and its territories.

H3. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: www.kernfamilyhealthcare.com.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Member Handbook* for more information.

I. What if you're billed directly for covered services

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this *Member Handbook* to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

I1. What to do if our plan doesn't cover services

Our plan covers all services:

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

If you get services that our plan doesn't cover, **you pay the full cost yourself,** unless it's covered by another Medi-Cal program outside our plan.

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

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

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

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

J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

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

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

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

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

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study

- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

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

J3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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

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

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

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

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

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

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

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

- You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

Medicare inpatient hospital coverage limits apply. Please refer to the Benefits Chart in **Chapter 4** for more information.

L. Durable medical equipment (DME)

L1. DME as a member of our plan

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

You own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you usually **won't** own the rented DME items, no matter how long you rent it.

In some limited situations, we transfer ownership of the DME item to you. Call Member Services at the phone number at the bottom of the page for more information.

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

L2. DME ownership if you switch to Original Medicare

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

When you have Medicare and Medi-Cal, Medi-Cal usually pays the Medicare cost sharing (like deductibles, coinsurance, and copayments) for Medicare-covered services, including DME, so you may pay nothing out of pocket.

If you no longer have Medi-Cal, you'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

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

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

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

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

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

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

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above. Medicare and Medi-Cal cover these payments if you're still enrolled in Medicare and Medi-Cal.

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

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

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

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.

- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

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

Chapter 4: Benefits chart

Introduction

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

New members to Kern Family Health Care Medicare (HMO D-SNP): In most instances you'll be enrolled in Kern Family Health Care Medicare (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Kern Family Health Care Medicare (HMO D-SNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you'll receive your Medi-Cal services through Kern Family Health Care. There will be no gap in your Medi-Cal coverage. Please call us at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30, if you have any questions.

Table of Contents

A. Your covered services 69

B. Rules against providers charging you for services 69

C. About our plan's Benefits Chart 69

D. Our plan's Benefits Chart 72

E. Community Supports 125

F. Benefits covered outside of our plan 139

F1. California Community Transitions (CCT) 139

F2. Medi-Cal Dental 140

F3. In-Home Supportive Services (IHSS) 142

F4. 1915(c) Home and Community Based Services (HCBS) Waiver Programs 142

F5. County Behavioral Health Services Provided Outside Our Plan (Mental Health and Substance Use Disorder Services) 145

G. Benefits not covered by our plan, Medicare, or Medi-Cal 148

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. This chapter also explains limits on some services.

Because you get help from Medi-Cal, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Member Handbook* for details about our plan's rules.

If you need help understanding what services are covered, call Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

B. Rules against providers charging you for services

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

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

C. About our plan's Benefits Chart

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

We pay for the services listed in the Benefits Chart when the following rules are met. You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and Medi-Cal covered services according to the rules set by Medicare and Medi-Cal.
- The services including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a

hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care or unless your plan or a network provider gave you a referral. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this *Member Handbook* has more information about getting a referral and when you **don't** need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need a PA with an asterisk (*).
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- If you lose your Medi-Cal benefits, within the 3 month period of deemed continued eligibility, your Medicare benefits in this plan will continue. However, your Medi-Cal service may not be covered. Contact your county eligibility office or Health Care Options for information about your Medi-Cal eligibility. You can keep your Medicare benefits, but not your Medi-Cal benefits.

Important Benefit Information for Members with Certain Chronic Conditions.

- If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits:
  - Cardiovascular disorders
  - Chronic heart failure

  - Diabetes mellitus
  - Overweight, obesity and metabolic syndrome
  - Severe hematologic disorders
  - Chronic lung disorders
  - Neurologic disorders
  - Stroke
  - Dementia
- Your care coordinator has access to your health information and will determine if you qualify when you have the chronic conditions mentioned above.
- Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.
- Contact us for additional information.

All preventive services are free. This apple shows the preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

	Covered Service	What you pay
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Acupuncture We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary. We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: ● lasting 12 weeks or longer; ● not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); ● not associated with surgery; **and** ● not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Acupuncture (continued) Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0

Covered Service		What you pay
	Ambulance services * Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter). The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 Prior authorization may be required for non-emergency transport.
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0
	Asthma Preventive Services You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.	$0

Covered Service		What you pay
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
	Breast cancer screening (mammograms) We pay for the following services: ● one baseline mammogram between the ages of 35 and 39 ● one screening mammogram every 12 months for women aged 40 and over ● clinical breast exams once every 24 months	$0
	Cardiac (heart) rehabilitation services * We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 Services may require prior authorization.
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: ● discuss aspirin use, ● check your blood pressure, **and/or** ● give you tips to make sure you're eating well.	$0

Covered Service		What you pay
	Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0
	Cervical and vaginal cancer screening We pay for the following services: ● for all women: Pap tests and pelvic exams once every 24 months ● for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months ● for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months ● for women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years	$0
	Chiropractic services * We pay for the following services: ● adjustments of the spine to correct alignment We cover two (2) manual manipulation services of the spine every month without a prior authorization. Other services may require medical necessity review and prior authorization.	$0 May require prior authorization.
	Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. $0

Covered Service		What you pay
	Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Colorectal cancer screening (continued) ● Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. ● Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
	Dental services * We pay for certain dental services, including but not limited to, cleanings, fillings, and dentures. What we don't cover may be available through Medi-Cal Dental, described in **Section F2** below. We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. **This benefit is continued on the next page**	$0 Services may require prior authorization.

Covered Service		What you pay
	Dental services (continued) We partner with Delta Dental to compliment the services offered through the Medi-Cal Dental Program. We cover preventive dental services and procedures including: • Oral Exams – 1 per year • Cleanings – 1 per year • Fluoride Treatment – 1 per year • X-Rays – 1 every year • 1 nutritional counseling visit per year for control of dental disease We also cover comprehensive dental services and procedures including: • Restorative services * • Periodontic services * • Prosthodontic services (fixed and removable) * Additional dental services are available through the Medi-Cal Dental Program. For more information you can visit the website at dental.dhcs.ca.gov/.	
	Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0

Covered Service		What you pay
	Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: ● high blood pressure (hypertension) ● history of abnormal cholesterol and triglyceride levels (dyslipidemia) ● obesity ● history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0

Covered Service		What you pay
	Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): ● Supplies to monitor your blood glucose, including the following: ○ a blood glucose monitor ○ blood glucose test strips ○ lancet devices and lancets ○ glucose-control solutions for checking the accuracy of test strips and monitors ● For people with diabetes who have severe diabetic foot disease, we pay for the following: ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) ● In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.	$0
	Doula Services For individuals who are pregnant, we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery. Up to nine additional postpartum visits may be provided as well.	$0

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies * Refer to **Chapter 12** of this *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: ● wheelchairs, including electric wheelchairs ● crutches ● powered mattress systems ● dry pressure pad for mattress ● diabetic supplies ● hospital beds ordered by a provider for use in the home ● intravenous (IV) infusion pumps and pole ● speech generating devices ● oxygen equipment and supplies ● nebulizers ● walkers ● standard curved handle or quad cane and replacement supplies ● cervical traction (over the door) ● bone stimulator ● dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you.	$0 Services may require prior authorization.

Covered Service		What you pay

	Emergency care
	
	Emergency care means services that are:
	● given by a provider trained to give emergency services, **and**
	● needed to evaluate or treat a medical emergency.
	
	A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	● serious risk to your health or to that of your unborn child; **or**
	● serious harm to bodily functions; **or**
	● serious dysfunction of any bodily organ **or**
	● loss of a limb, or loss of function of a limb.
	● In the case of a pregnant woman in active labor, when:
	  ○ There isn't enough time to safely transfer you to another hospital before delivery.
	  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	
	We only cover emergency care that you receive within the U.S. or its territories.
		$0
		
		If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you may be transferred to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.

Covered Service		What you pay
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: ● family planning exam and medical treatment ● family planning lab and diagnostic tests ● family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) ● family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) ● limited fertility services such as counseling and education about fertility awareness techniques, and/or preconception health counseling, testing, and treatment for sexually transmitted infections (STIs) ● counseling and testing for HIV and AIDS, and other HIV-related conditions ● permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) ● genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: ● treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) ● treatment for AIDS and other HIV-related conditions ● genetic testing	$0

Covered Service		What you pay
	Health and wellness education programs We offer many programs that focus on certain health conditions. These include: ● health education classes; ● nutrition education classes; ● smoking and tobacco use cessation; **and** ● nursing hotline	$0
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We also pay for hearing aids when prescribed by a physician or other qualified provider, including: ● molds, supplies, and inserts ● repairs ● an initial set of batteries ● six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid ● trial period rental of hearing aids ● assistive listening devices, surface-worn bone conduction hearing devices ● hearing aid-related audiology and post-evaluation services **This benefit is continued on the next page**	$0 for hearing exams You pay $0 up to the benefit limit of $1,500 total for two (2) approved hearing aids. Cost beyond that amount is your responsibility.

Covered Service		What you pay
	Hearing services (continued) We also offer the following additional benefits through NationsBenefits: ● One routine hearing exam every year. ● Up to $1,500 total toward the cost of up to two (2) approved hearing aids from NationsBenefits every calendar year. ● One hearing aid fitting/evaluation every year. ● 3 follow-up visits with the original provider within the first year of the hearing aid fitting ● 60-day, 100% money back trial period from the date of the hearing aid fitting ● 3-year supply of batteries, up to 60 cells per ear, per year, for non-rechargeable hearing aids. Batteries must be obtained through NationsBenefits ● 3-year comprehensive manufacturer's warranty. You must use a provider in the NationsBenefits network and obtain your hearing aids through NationsBenefits. To schedule an appointment with a local hearing provider, call 1-877-647- 0759 (TTY: 711), 8 a.m. – 8 p.m. local time.	

Covered Service		What you pay
	Help with certain chronic conditions We cover some food products through our Healthy Foods program at no cost to you. You will receive an allowance or spending limit per quarter (every 3 months), to purchase food items at retail stores, or through our vendor's website. NationsBenefits is the vendor for this program. In order to be eligible for this benefit, you must have certain chronic conditions. Only those members that have a specific chronic condition would be eligible for the Healthy Foods program – see Chronic conditions list below: • Cardiovascular disorders • Chronic heart failure • Diabetes mellitus • Overweight, obesity and metabolic syndrome • Severe hematologic disorders • Chronic lung disorders • Neurologic disorders • Stroke • Dementia You can use this benefit to get items such as fruits, vegetables, meats and canned foods, and other eligible products included on the NationsBenefits website, and/or retail stores (based on approved list). • This benefit becomes available on the first day of each quarter; January 1, April 1, July 1, and October 1 • $93 quarterly allowance (every three months) • The remaining balance will not roll over to the next benefit period (quarter)	$0

Covered Service		What you pay
	Help with certain chronic conditions (continued) You can order: • Retail – Use your NationsBenefits Supplemental Benefits Mastercard® Prepaid Card at participating grocery and retail locations. Your card must be activated before you use your benefit. You can activate your card at KFHCMedicare.NationsBenefits.com/activate. • Online – visit KFHCMedicare.NationsBenefits.com • By Phone – call 1-877-647-0759 (TTY: 711), 8 a.m.-8 p.m. local time. • By Mail – Complete and mail an order form. You can call 1-877-647-0759 (TTY: 711) to obtain an order form. You will receive a Mastercard® Prepaid Card, issued by The Bancorp Bank N.A., under license by Mastercard International Incorporated. This card can be used for eligible expenses wherever Mastercard is accepted. Mastercard and the circles design is a trademark of Mastercard International Incorporated. The card is valid only in the United States. The card does not allow any cash access. To learn more about this benefit or obtain an order form, you can also call or write: Kern Family Health Care Medicare (HMO D-SNP) PO Box 9187 Bakersfield, CA 93389-9187 1-866-661-3767 (TTY 711)	

Covered Service		What you pay
	HIV screening We pay for one HIV screening exam every 12 months for people who: ● ask for an HIV screening test, **or** ● are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy. We also pay for additional HIV screening(s) when recommended by your provider.	$0
	Home health agency care * Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: ● part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) ● physical therapy, occupational therapy, and speech therapy ● medical and social services ● medical equipment and supplies	$0 Services may require prior authorization and/or a referral.

Covered Service		What you pay
	Home infusion therapy * Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: ● the drug or biological substance, such as an antiviral or immune globulin; ● equipment, such as a pump; **and** ● supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: ● professional services, including nursing services, provided in accordance with your care plan; ● member training and education not already included in the DME benefit; ● remote monitoring; **and** ● monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0 Services may require prior authorization and/or a referral.

	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: ● drugs to treat symptoms and pain ● short-term respite care ● home care **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:** ● Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** ● Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** ● Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this *Member Handbook*. **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Hospice care (continued) **Note:** If you have a serious illness, you may be eligible for palliative care, which provides team-based patient and family-centered care to improve your quality of life. You may receive palliative care at the same time as curative/regular care. Please see Palliative Care section below for more information. **Note:** If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen the hospice benefit.	

Covered Service		What you pay
	Immunizations We pay for the following services: ● pneumonia vaccines ● flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary ● hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B ● COVID-19 vaccines ● human papillomavirus (HPV) vaccine ● other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Member Handbook* to learn more.	$0
	Inpatient hospital care * We pay for the following services and other medically necessary services not listed here: ● semi-private room (or a private room if medically necessary) ● meals, including special diets ● regular nursing services ● costs of special care units, such as intensive care or coronary care units **This benefit is continued on the next page**	$0 Services may require prior authorization. You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Covered Service		What you pay
	Inpatient hospital care (continued) ● drugs and medications ● lab tests ● X-rays and other radiology services ● needed surgical and medical supplies ● appliances, such as wheelchairs ● operating and recovery room services ● physical, occupational, and speech therapy ● inpatient substance abuse services ● in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. ● blood, including storage and administration ● physician services **This benefit is continued on the next page**	

Covered Service		What you pay
	Inpatient hospital care (continued) **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not **sure** if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
	Inpatient services in a psychiatric hospital * We pay for mental health care services that require a hospital stay. ● If you need inpatient services in a freestanding psychiatric hospital, we pay for the first 190 days. After that, the local county mental health agency pays for medically necessary inpatient psychiatric services. Authorization for care beyond the 190 days is coordinated with the local county mental health agency. ○ The 190-day limit **doesn't** apply to inpatient mental health services provided in a psychiatric unit of a general hospital ● If you're 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD).	$0 Services may require prior authorization.

Covered Service		What you pay
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay* We don't pay for your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: ● doctor services ● diagnostic tests, like lab tests ● X-ray, radium, and isotope therapy, including technician materials and services ● surgical dressings ● splints, casts, and other devices used for fractures and dislocations ● prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: ○ an internal body organ (including contiguous tissue), **or** ○ the function of an inoperative or malfunctioning internal body organ. **This benefit is continued on the next page**	$0 Services may require prior authorization.

Covered Service		What you pay
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued) ● leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition ● physical therapy, speech therapy, and occupational therapy	
	Kidney disease services and supplies * We pay for the following services: ● Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. ● Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. ● Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care **This benefit is continued on the next page**	$0 Services may require prior authorization.

Covered Service		What you pay
	Kidney disease services and supplies (continued) ● Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments ● Home dialysis equipment and supplies ● Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to “Medicare Part B drugs” in this chart.	
	Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: ● are aged 50-77, **and** ● have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** ● have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer, or you smoke now, or you have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0

Covered Service		What you pay
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0
	Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: ● long-term dietary change, **and** ● increased physical activity, **and** ● ways to maintain weight loss and a healthy lifestyle.	$0

Covered Service		What you pay
	Medicare Part B drugs * These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: ● drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services ● insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) ● other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized ● the Alzheimer's drug Leqembi® (generic lecanemab) which is given intravenously (IV) ● clotting factors you give yourself by injection if you have hemophilia ● transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them ● osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself. **This benefit is continued on the next page**	$0 Services may require prior authorization.

Covered Service		What you pay
	Medicare Part B drugs (continued) ● some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision ● certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does ● oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug ● certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B ● calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar ● certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics **This benefit is continued on the next page**	

Covered Service		What you pay
	Medicare Part B drugs (continued) ● erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Retacrit) ● IV immune globulin for the home treatment of primary immune deficiency diseases ● parenteral and enteral nutrition (IV and tube feeding) The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: www.kernfamilyhealthcare.com. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan.	
	Nursing facility care * A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. **This benefit is continued on the next page**	$0 Services may require prior authorization.

Covered Service		What you pay
	Nursing facility care (continued) Services that we pay for include, but aren't limited to, the following: ● semiprivate room (or a private room if medically necessary) ● meals, including special diets ● nursing services ● physical therapy, occupational therapy, and speech therapy ● respiratory therapy ● drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) ● blood, including storage and administration ● medical and surgical supplies usually given by nursing facilities ● lab tests usually given by nursing facilities ● X-rays and other radiology services usually given by nursing facilities ● use of appliances, such as wheelchairs usually given by nursing facilities ● physician/practitioner services **This benefit is continued on the next page**	

Covered Service		What you pay
	Nursing facility care (continued) ● durable medical equipment ● dental services, including dentures ● vision benefits ● hearing exams ● chiropractic care ● podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: ● a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). ● a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0

Covered Service		What you pay
	Opioid treatment program (OTP) services * Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: ● intake activities ● periodic assessments ● medications approved by the FDA and, if applicable, managing and giving you these medications ● substance use counseling ● individual and group therapy ● testing for drugs or chemicals in your body (toxicology testing)	$0 Services may require prior authorization.

Covered Service		What you pay
	Outpatient diagnostic tests and therapeutic services and supplies * We pay for the following services and other medically necessary services not listed here: ● X-rays ● radiation (radium and isotope) therapy, including technician materials and supplies ● surgical supplies, such as dressings ● splints, casts, and other devices used for fractures and dislocations ● lab tests ● blood, including storage and administration ● diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition ● other outpatient diagnostic tests	$0 Services may require prior authorization and/or a referral.

Covered Service		What you pay
	Outpatient hospital observation * We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits.* This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf	$0 Services may require prior authorization.

Covered Service		What you pay
	Outpatient hospital services * We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: ● Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ○ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient." ○ Sometimes you can be in the hospital overnight and still be "outpatient." ○ You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. ● Labs and diagnostic tests billed by the hospital ● Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it ● X-rays and other radiology services billed by the hospital ● Medical supplies, such as splints and casts ● Preventive screenings and services listed throughout the Benefits Chart ● Some drugs that you can't give yourself	$0 Services may require prior authorization and/or a referral.

Covered Service		What you pay
	Outpatient mental health care * We pay for mental health services provided by: ● a state-licensed psychiatrist or doctor ● a clinical psychologist ● a clinical social worker ● a clinical nurse specialist ● a licensed professional counselor (LPC) ● a licensed marriage and family therapist (LMFT) ● a nurse practitioner (NP) ● a physician assistant (PA) ● any other Medicare-qualified mental health care professional as allowed under applicable state laws We pay for the following services, and maybe other services not listed here: ● clinic services as medically necessary ● day treatment as medically necessary ● psychosocial rehab services as medically necessary ● partial hospitalization or intensive outpatient programs ● individual and group mental health evaluation and treatment **This benefit is continued on the next page**	$0 Some services may require prior authorization and/or a referral.

Covered Service		What you pay
	Outpatient mental health care (continued) ● psychological testing when clinically indicated to evaluate a mental health outcome ● outpatient services for the purposes of monitoring drug therapy ● outpatient laboratory, drugs, supplies and supplements ● psychiatric consultation Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by the Kern Behavioral Health Recovery Services 24-hour Crisis Hotline at 1-800- 991-5272, 24 hours a day, 7 days a week. You can also call or text the Behavioral Health Crisis Line at 988, 24 hours a day, 7 days a week.	
	Outpatient rehabilitation services * We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 Services may require prior authorization and/or a referral.

Covered Service		What you pay
	Outpatient substance use disorder services * We pay for the following services, and maybe other services not listed here: ● alcohol misuse screening and counseling ● treatment of drug abuse ● group or individual counseling by a qualified clinician ● subacute detoxification in a residential addiction program ● alcohol and/or drug services in an intensive outpatient treatment center ● extended-release Naltrexone (vivitrol) treatment Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by the Kern Behavioral Health Recovery Services 24-hour Crisis Hotline at 1-800- 991-5272, 24 hours a day, 7 days a week. You can also call or text the Behavioral Health Crisis Line at 988, 24 hours a day, 7 days a week.	$0 Services may require prior authorization and/or a referral.
	Outpatient surgery * We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$0 Services may require prior authorization and/or a referral.

Covered Service		What you pay
	Palliative Care Palliative care is covered by our plan. Palliative care is for people with serious illness. It provides patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative Care **isn't** hospice, therefore you don't have to have a life expectancy of six months or less to qualify for palliative care. Palliative care is provided at the same time as curative/regular care. Palliative care includes the following: ● advance care planning ● palliative care assessment and consultation ● a plan of care including all authorized palliative and curative care, including mental health and medical social services ● services from your designated care team ● care coordination ● pain and symptom management You may not get hospice care and palliative care at the same time if you're over the age of 21. If you're getting palliative care and meet the eligibility for hospice care, you can ask to change to hospice care at any time.	$0

Covered Service		What you pay
	Partial hospitalization services and intensive outpatient services * Partial hospitalization is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that' s more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.	$0 Services may require prior authorization and/or a referral.
	Physician/provider services, including doctor's office visits * We pay for the following services: ● medically necessary health care or surgery services given in places such as: ○ physician's office ○ certified ambulatory surgical center ○ hospital outpatient department ○ consultation, diagnosis, and treatment by a specialist **This benefit is continued on the next page**	$0 Some services may require prior authorization and/or a referral.

Covered Service		What you pay
	Physician/provider services, including doctor's office visits (continued) ○ basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment ○ telehealth services to diagnose, evaluate, or treat symptoms of a stroke ○ telehealth services for members with a substance use disorder or co-occurring mental health disorder ○ telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ you have an in-person visit within 6 months prior to your first telehealth visit ○ you have an in-person visit every 12 months while receiving these telehealth services ○ exceptions can be made to the above for certain circumstances ○ telehealth services for mental health visits provided by rural health clinics and federally qualified health centers. ● virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if** ○ you're not a new patient **and** ○ the check-in isn't related to an office visit in the past 7 days **and** ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Physician/provider services, including doctor's office visits (continued) ● Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: ○ you're not a new patient and ○ the evaluation isn't related to an office visit in the past 7 days and ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment ● Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient ● Second opinion by another network provider before surgery	
	Podiatry services * We pay for the following services: ● diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) ● routine foot care for members with conditions affecting the legs, such as diabetes	$0 Services may require prior authorization and/or a referral.

Covered Service		What you pay
	Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: ● FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. ● Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. ● Up to 8 HIV screenings every 12 months. ● A one-time hepatitis B virus screening.	$0
	Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months: ● a digital rectal exam ● a prostate specific antigen (PSA) test	$0

Covered Service		What you pay
	Prosthetic and orthotic devices and related supplies * Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: ● testing, fitting, or training in the use of prosthetic and orthotic devices ● colostomy bags and supplies related to colostomy care ● enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections ● pacemakers ● braces ● prosthetic shoes ● artificial arms and legs ● breast prostheses (including a surgical brassiere after a mastectomy) ● prostheses to replace all of part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect ● incontinence cream and diapers We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	$0 Services may require prior authorization.
	Pulmonary rehabilitation services * We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 Services may require prior authorization.

Covered Service		What you pay
	Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: ● You're at high risk because you use or have used illicit injection drugs. ● You had a blood transfusion before 1992. ● You were born between 1945-1965. ● If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

	Skilled nursing facility (SNF) care * For a definition of skilled nursing facility care, go to **Chapter 12.** We pay for the following services, and maybe other services not listed here: ● a semi-private room, or a private room if it's medically necessary ● meals, including special diets ● skilled nursing services ● physical therapy, occupational therapy, and speech therapy ● drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ● blood, including storage and administration ● medical and surgical supplies given by SNFs ● lab tests given by SNFs ● X-rays and other radiology services given by nursing facilities ● appliances, such as wheelchairs, usually given by nursing facilities ● physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: ● a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ● a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 Services may require prior authorization.

Covered Service		What you pay
	Smoking and tobacco use cessation Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).	$0

Covered Service		What you pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: ● up to 36 sessions during a 12-week period if all SET requirements are met ● an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: ● 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) ● in a hospital outpatient setting or in a physician's office ● delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD ● under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0

Covered Service		What you pay
	Transportation: Non-emergency medical transportation * This benefit allows for medical transportation for a service covered by your plan and Medicare. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with paratransit. The forms of transportation are authorized when: ● Your medical provider determines your medical and/or physical condition doesn't allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, **and** prior authorization is required and you'll need to call your plan to arrange a ride Schedule your transportation at least two days in advance by calling Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.	$0 Some services may require prior authorization
	Transportation: Non-medical transportation This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation. Transportation is required for the purpose of obtaining needed medical care covered by Medi-Cal, including travel to dental appointments and to pick up drugs. Transportation for services dually covered by Medi-Cal and Medicare are covered. Schedule your transportation at least two days in advance by calling Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.	$0

Covered Service		What you pay
	Urgently needed care Urgently needed care is care given to treat: ● a non-emergency that requires immediate medical care, **or** ● an unforeseen illness, **or** ● an injury, **or** ● a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances, it's not possible, or it's unreasonable, to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). Urgently needed services are covered within the U.S. and its territories.	$0

Covered Service		What you pay
	Vision care We partner with VSP to provide the following services: ● one routine eye exam, including refraction, every year **and** ● eyeglass lenses (including single, lined bifocal, lined trifocal, and lenticular lenses) every year ● up to $300 for eyeglass frames every year **or** ● up to $300 for contact lenses every year, in lieu of eyeglasses. We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: ● people with a family history of glaucoma ● people with diabetes ● African-Americans who are 50 and over ● Hispanic Americans who are 65 and over For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.	You pay $0 for either eyeglasses or contacts, up to the $300 benefit limit. You will have to pay any costs for eyeglasses or contacts over the $300 limit.

Covered Service		What you pay
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: ● a review of your health, ● education and counseling about preventive services you need (including screenings and shots), **and** ● referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

E. Community Supports

You may get supports under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members. If you qualify, these services may help you live more independently. They don't replace benefits that you already receive under Medi-Cal. Examples of Community Supports that we offer include:

Housing Transition/Navigation: Members experiencing homelessness or at risk of experiencing homelessness receive help to find, apply for, and secure housing.

- Eligibility requirements:
  1. Members who meet the following social *and* clinical risk factor requirements:
     a) **Social Risk Factor Requirement**: Experiencing or at risk of homelessness.
     b) **Clinical Risk Factor Requirement**: Must have one or more of the following qualifying clinical risk factors:
        i. Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);

ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);

iii. One or more serious chronic physical health conditions;

iv. One or more physical, intellectual, or developmental disabilities; or

v. Individuals who are pregnant up through 12-months postpartum.

OR

2. Members who are determined eligible for Transitional Rent.

OR

3. Members who are prioritized for a permanent supportive housing.

- Limitations include:
  - Restrictions and limitations for housing transition/navigation services must be identified as reasonable and necessary in the member's Individualized Housing Support Plan.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Housing deposits: Members receive assistance with housing security deposits, utilities set-up fees and first month of utilities. Members can also receive funding for medically necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.

- Eligibility requirements:

1. Members who meet the following social and clinical risk factor requirements:

a) **Social Risk Factor Requirement**: Experiencing or at risk of homelessness.

b) **Clinical Risk Factor Requirement**: Must have one or more of the following qualifying clinical risk factors:

i. Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);

ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);

iii. One or more serious chronic physical health conditions;

iv. One or more physical, intellectual, or developmental disabilities; or

v. Individuals who are pregnant up through 12-months postpartum.

OR

2. Members who are determined eligible for Transitional Rent.

OR

3. Members who are prioritized for a permanent supportive housing.

- Limitations include:
  - Members who have already received housing deposits.
  - Members must also receive housing transition navigation services (at a minimum, the associated tenant screening, housing assessment and Individualized Housing Support Plan) in conjunction with this service.
  - Services do not include room and board or payment of rental assistance.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Housing Tenancy & Sustaining Services: Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.

- Eligibility requirements:
  1. Members who meet the following social and clinical risk factor requirements:
     a) **Social Risk Factor Requirement**: Experiencing or at risk of homelessness.
     b) **Clinical Risk Factor Requirement**: Must have one or more of the following qualifying clinical risk factors:
        i. Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);

ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);

iii. One or more serious chronic physical health conditions;

iv. One or more physical, intellectual, or developmental disabilities; or

v. Individuals who are pregnant up through 12-months postpartum.

OR

2. Members who are determined eligible for Transitional Rent.

OR

3. Members who are prioritized for a permanent supportive housing.

- Limitations include:
  - Services do not include room and board or payment of rental assistance.
  - The services must be identified as reasonable and necessary in the member's housing support plan.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Transitional Rent: Transitional Rent provides up to six months of rental assistance in interim and permanent settings to Members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria, as described further below.

- Eligibility requirements:

1. Members who meet the following social and clinical risk factor requirements:

a) Clinical Risk Factor Requirement: Must have one of more of the following qualifying clinical risk factors:

i. Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);

ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);

iii. One or more serious chronic physical health conditions;

iv. One or more physical, intellectual, or developmental disabilities; or

Individuals who are pregnant up through 12-months postpartum.

b) **Social Risk Factor Requirement**: Experiencing or at risk of homelessness.

AND

2. Member must be included within one of the following transitioning populations:

a) Transitioning out of an institutional or congregate residential setting:

i. Individuals transitioning out of an institutional or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use disorder treatment facility, an inpatient or residential mental health facility, or nursing facility.

ii. Transitioning out of a carceral setting: Individuals transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities.

iii. Transitioning out of interim housing: Individuals transitioning out of transitional housing, rapid rehousing, a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing, whether funded or administered by HUD, or at the State or local level.

iv. Transitioning out of recuperative care or short-term post hospitalization housing: Individuals transitioning out of short-term post-hospitalization housing or recuperative care, whether the stay was covered by Medi-Cal managed care, or another source.

v. Transitioning out of foster care: Individuals having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.

OR

b) Members with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

OR

c) Eligible for Full-Service Partnership (FSP): FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.

- Limitations include:
  - Member may not receive more than a combined six months of Short-Term Post-Hospitalization Housing. Recuperative Care, and Transitional Rent during any rolling 12-month period.
  - Transitional Rent can provide up to six months of rental assistance and rent and housing fees per demonstration, subject to the six-month global cap on Room and Board services within a rolling 12-month period. The six months of Transitional Rent are not required to be continuous.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Short-Term Post Hospitalization Housing: Members who do not have a residence, and who have high medical or mental health and substance use disorder needs, receive short-term housing for up to six months to continue their recovery. To receive this support, members must also have been discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.

- Eligibility requirements: Members are eligible for Short-Term Post-Hospitalization Housing if they meet all of the following criteria:
  1. Individuals who are exiting an institution, which includes recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential

substance use disorder or mental health treatment facility, correctional facility, or nursing facility.

AND

2. Member must be experiencing or at risk of homelessness

AND

3. Meet one of the following criteria:

   i. Are receiving California Integrated Care Management (CICM);

   ii. Have one or more serious chronic conditions;

   iii. Have serious mental illness; or

   iv. Are at risk of institutionalization or requiring residential services as a result of a substance use disorder.

AND

4. Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing.

- Limitations include:
  - Member cannot exceed a duration of six (6) months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Recuperative Care (Medical Respite): Members who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness receive recuperative care. A stay in recuperative care setting allows the member to recover from an injury or illness while also obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing. Recuperative care is for members who have medical needs significant enough to result in emergency department visits, hospital admissions, or other institutional care.

- Eligibility requirements:

  1. Member must be recently discharged from a hospital or institution

AND

2. Member requires recovery in order to heal from an injury or illness

AND

3. Member must be homeless or at risk of homelessness

- Limitations include:
  - Member cannot exceed a duration of six (6) months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Environmental Accessibility Adaptations: Members receive physical modifications to their home to ensure their health and safety and allow them to function with greater independence. Home modifications can include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.

- Eligibility requirements:

  1. Members at risk for institutionalization in a nursing facility

  AND

  2. Member must receive consent from owner of the home

  AND

  3. Member must obtain request from their physician

- Limitations include:
  - If another State Plan service, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of independence and avoiding institutional placement, the State Plan service must be used first.
  - Services must be conducted in accordance with applicable State and local building codes.
  - Services are payable up to a total lifetime maximum of $7,500.
  - Services do not include aesthetic embellishments.

  - Changes to the home are only allowed if they help the member with a medical need or health problem. Fixes that help the whole household but not the member's health are not allowed.
  - Services do not allow for additions to the home to add square footage.
  - Kern Family Health Care Medicare (D-SNP) must provide the owner and Member with written documentation that the modifications are permanent, and the State is not responsible for maintenance or repair of a modification nor for removal of any modification if the Member ceases to reside at the residence.

- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Caregiver Respite Services: This provides short-term relief for member caregivers. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.

- Eligibility requirements:

  1. Members must be dependent on a qualified caregiver who provides most of the member's support, and the caregiver requires relief to avoid placement in a facility.

  OR

  2. Children that were previously covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program, members enrolled in California Children's Services or Genetically Handicapped Persons Program, and members with Complex Care needs.

- Limitations include:

  - In the home, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.
  - Service limit is up to 336 hours per calendar year (limited exceptions may apply)
  - This service is only to avoid placements for which Kern Family Health Care would be responsible.
  - Respite services cannot be provided virtually, or via telehealth.

- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Asthma Remediation: Members receive physical changes to their homes to avoid acute asthma episodes caused by environmental triggers like mold. Modifications can include filtered vacuums, dehumidifiers, air filters, and ventilation improvements.

- Eligibility requirements:
  1. Members with an in-home environmental trigger assessment within the last 12 months that identifies medically appropriate Asthma Remediations and states how the changes meet the needs of the Member.
- Limitations include:
  - If another service, such as Durable Medical Equipment (DME), is available and would prevent asthma emergencies or hospitalizations, that service will be used first.
  - Asthma remediations must comply with State and local building codes.
  - Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the member's condition has changed so significantly that additional changes are needed to ensure the health, welfare, and safety of the member, or are needed to enable the member to be more independent in the home and avoid institutionalization or hospitalization.
  - Does not include adaptations or improvements that are of general utility to the household.
  - Benefits do not include aesthetic updates.
  - Kern Family Health Care Medicare (D-SNP) must provide the owner and Member with written documentation that the modifications are permanent, and the State is not responsible for maintenance or repair of a modification nor for removal of any modification if the Member ceases to reside at the residence.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Medically Tailored Meals: Members receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.

- Eligibility requirements:
  1. Member has a qualifying nutrition-sensitive medical condition, such as (but not limited to): cancer, cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
- Limitations include:
  - Service covers up to two (2) meals and/or meal packages per day.
  - May be approved for up to 12 weeks and may be reauthorized if medically necessary.
  - Meals, food, payments, and nutrition services from other programs cannot be funded through these benefits.
  - These benefits are not covered solely for food insecurities.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Sobering Centers: Members who are found to be publicly intoxicated are provided with a short-term, safe, supportive environment in which to become sober. Sobering centers provide services such as medical triage, a temporary bed, meals, substance use education and counseling, and linkage to other health care services.

- Eligibility requirements:
  1. Members ages 18 and older who are intoxicated, cooperative, able to walk, nonviolent, and free from any medical distress

  AND

  2. Member would otherwise be taken to the emergency department or a jail, or who are in an emergency department and can be moved to a Sobering Center.
- Limitations include:
  - This service is covered for less than 24 hours.

- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Assisted Living Facility Transition: Helps members transfer from a skilled nursing facility to a home-like setting and prevents members from going back to a skilled nursing facility.

- Eligibility requirements:

  1. Members residing in a nursing facility who:

     a. Have resided 60+ days in a nursing facility and

     b. Are willing to live in an assisted living setting as an alternative to a nursing facility; and

     c. Are able to reside safely in an assisted living facility.

  OR

  2. Members residing in the Community who:

     a. Are interested in remaining in the community.

     AND

     b. Are willing and able to reside safely in an assisted living facility

     AND

     c. Meet the minimum criteria to receive nursing facility level of care services and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility level of care services at an assisted living facility.

  OR

  3. Members who are getting facility level health care services on an acute or post-acute care basis (such as hospitalization or a short-term skilled nursing facility stay) may be eligible for this Community Support, as long as they otherwise meet the eligibility criteria.

- Limitations include:

  - Room and board expenses are not included in this service.

  - Members may receive assistance with room and board from other sources at the same time as receiving this service.

- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Community or Home Transition Services: Members may get help to pay for costs related to the transfer from a skilled nursing facility.

- Eligibility requirements:

  1. Currently receiving medically necessary nursing facility level of care services and instead of remaining in the nursing facility or Recuperative Care setting are choosing to transition home and continue to receive medically necessary nursing facility level of care services.

  AND

  2. Has lived 60+ days in a nursing home and/or Recuperative Care setting

  AND

  3. Interested in moving back to the community

  AND

  4. Able to reside safely in the community with appropriate and cost-effective supports and services.

- Limitations include:

  - Community Transition Services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

  - Non-recurring set-up expenses are payable up to a total lifetime maximum amount of $7,500.00.

  - Community Transition Services must be necessary to ensure the health, welfare, and safety of the member, without which the member would be unable to move to the private residence or public subsidized housing and would then require continued or re-institutionalization.

  - Member cannot get the same services from this program and other waiver programs at the same time.

- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Personal Care and Homemaker Services: Members can get services to help with activities of daily living.

- Eligibility requirements:

  1. Members at risk for hospitalization, or institutionalization in a nursing facility.

  OR

  2. Members with functional deficits and no other adequate support system.

  OR

  3. Members approved for In-Home Supportive Services.

- Limitations include:

  - This service cannot be used instead of referring to the In-Home Supportive Services program.
  - Member must be referred to the In-Home Supportive Services program when they meet referral criteria.
  - If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours.
  - Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

Day Habilitation Services: Members get services from a trained caregiver on the self-help, social, and adaptive skills needed to live successfully in the community. These skills include the use of public transportation, cooking, cleaning, managing personal finances, dealing with and responding appropriately to governmental agencies and personnel, and developing and maintaining interpersonal relationships. This support can be provided in a member's home or in an out-of-home, non-facility setting.

- Eligibility requirements:
  1. Member is homeless.

  OR

  2. Member left homelessness and entered housing in the past 24 months.

  OR

  3. Member is at risk of homelessness or institutionalization.
- Limitations include:
  - Members who are rated proficient in all categories will be ineligible for this service.
  - Services can be given continuous, or through periodic meetings in an indvidual or group setting.
- Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider.

If you need help or would like to find out which Community Supports may be available for you, call Member Services at 1-866-661-3767 (TTY 711) 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30 or call your health care provider.

F. Benefits covered outside of our plan

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

F1. California Community Transitions (CCT)

The California Community Transitions (CCT) program uses local Lead Organizations to help eligible Medi-Cal beneficiaries, who've lived in an inpatient facility for at least 60 consecutive days, transition back to, and remaining safely in, a community setting. The CCT program funds transition coordination services during the pre-transition period and for 365 days post transition to assist beneficiaries with moving back to a community setting.

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

For CCT transition coordination services

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

For services not related to your CCT transition

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

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

No change in drug coverage benefit

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

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

F2. Medi-Cal Dental

Starting July 1, 2026:

Certain dental services are available through Medi-Cal Dental for:

- Members who are eligible for federal full-scope Medi-Cal
- Members who are not eligible for federal full-scope Medi-Cal and meet at least one of the three exceptions below:
  - Under age 19;
  - Designated by the county as pregnant (and up to one year after pregnancy ends); and/or
  - Designated by the county as foster youth or former foster youth under age 26 who were in foster care on their 18th birthday.

Dental services include:

- Complete and partial dentures
- Crowns (prefabricated/laboratory)
- Diagnostic and preventive dental services such as examinations, X-rays, and teeth cleanings

- Emergency care for pain control
- Fillings
- Orthodontics for children who qualify
- Root canal treatments (anterior/posterior)
- Scaling and root planing
- Tooth extractions
- Topical fluoride
- initial examinations, X-rays, cleanings, and fluoride treatments
- restorations and crowns
- root canal therapy
- partial and complete dentures, adjustments, repairs, and relines

For adults aged 19 and older who do not qualify for federal full-scope Medi-Cal, emergency dental services will continue to be covered. Covered emergency dental services are those treatments needed right away to stop severe pain or to diagnose and treat sudden serious medical problems. This includes care for:

- Bleeding that does not stop
- Painful swelling in or around your mouth
- A toothache or jaw pain
- Injuries to your face or jawbone
- Infection in your gums or teeth with pain or swelling
- After surgery care (such as bandage changes or stitch removal)
- A broken or knocked-out tooth
- Cutting or fixing wires in braces that hurt your cheeks or gums

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

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

F3. In-Home Supportive Services (IHSS)

- The IHSS Program will help pay enrolled care providers for services provided to you so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.
- To receive services, an assessment is conducted to determine which types of services may be authorized for each participant based on their needs. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.
- Your care coordinator can help you apply for IHSS with your county social service agency. For information about IHSS, call Kern County Aging and Adult Services at 1-661-868-1003.

F4. 1915(c) Home and Community Based Services (HCBS) Waiver Programs

Assisted Living Waiver (ALW)

- The Assisted Living Waiver (ALW) offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.
- Members who are enrolled in ALW can remain enrolled in ALW while also receiving benefits provided by our plan. Our plan works with your ALW Care Coordination Agency to coordinate the services you receive.
- The ALW is currently only available in the following counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma.
- Your care coordinator can help you apply for the ALW.

Please see the list below of ALW care coordination agencies for Kern County:

A-Biz Health Systems (818) 654-6874	AARP Care Coordination Agency (805) 695-3200
All Hours Adult Care (844) 657-4748	Beta Hospice Care (747) 293-5777
Calstro Hospice (909) 929-7312	Central Coast Healthcare Services (818) 852-7260
I Care Hospice (818) 238-9188	Libertana Home Health Care (818) 902-5000
Star Nursing (916) 542-1445	True Care Home Health (888) 944-6248
Vigilans Home Health Services (909) 748-7980	Virtue Home Care (888) 802-2227

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

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

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

Home and Community-Based Alternative (HCBA) Waiver

- The HCBA Waiver provides care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary care management team comprised of a nurse and social worker. The team coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services, etc.), and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.

- Members who are enrolled in the HCBA Waiver can remain enrolled in the HCBA Waiver while also receiving benefits provided by our plan. Our plan works with your HCBA waiver agency to coordinate the services you receive.
- Your care coordinator can help you apply for the HCBA. The HCBA for Kern County is Libertana Home Health. You can also contact Libertana Home Health at 1-800-750-1444.

Medi-Cal Waiver Program (MCWP)

- The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV as an alternative to nursing facility care or hospitalization. Case management is a participant centered, team approach consisting of a registered nurse and social work case manager. Case managers work with the participant and primary care provider(s), family, caregiver(s), and other service providers, to assess care needs to keep the participant in their home and community.
- The goals of the MCWP are to: (1) provide home and community-based services for persons with HIV who may otherwise require institutional services; (2) assist participants with HIV health management; (3) improve access to social and behavioral health support and (4) coordinate service providers and eliminate duplication of services.
- Members who are enrolled in the MCWP Waiver can remain enrolled in the MCWP Waiver while also receiving benefits provided by our plan. Our plan works with your MCWP waiver agency to coordinate the services you receive.
- Your care coordinator can help you apply for the MCWP. You can contact MCWP at 1-916-449-5900 or CDPHMCWP@cdph.ca.gov.

Multipurpose Senior Services Program (MSSP)

- The Multipurpose Senior Services Program (MSSP) provides both social and health care management services to assist individuals with remaining in their own homes and communities.
- While most of the program participants also receive In-Home Supportive Services, MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases some needed services that aren't otherwise available to prevent or delay institutionalization. The total annual combined cost of care

management and other services must be lower than the cost of receiving care in a skilled nursing facility.

- A team of health and social service professionals provides each MSSP participant with a complete health and psychosocial assessment to determine needed services. The team then works with the MSSP participant, their physician, family, and others to develop an individualized care plan. Services include:
  - care management
  - adult day care
  - minor home repair/maintenance
  - supplemental in-home chores, personal care, and protective supervision services
  - respite services
  - transportation services
  - counseling and therapeutic services
  - meal services
  - communication services.
- Members who are enrolled in the MSSP Waiver can remain enrolled in the MSSP Waiver while also receiving benefits provided by our plan. Our plan works with your MSSP provider to coordinate the services you receive.
- Your care coordinator can help you apply for MSSP. You can contact the MSSP for Kern County at 1-800-510-2020 or visit their website at https://www.kerncounty.com/government/aging-adult-services.

F5. County Behavioral Health Services Provided Outside Our Plan (Mental Health and Substance Use Disorder Services)

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan doesn't provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through county behavioral health agencies.

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

- mental health services
- medication support services
- day treatment intensive services
- day rehabilitation
- crisis intervention services
- crisis stabilization services
- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services
- targeted case management
- community based mobile crisis intervention services
- therapeutic behavioral services
- therapeutic foster care
- intensive care coordination
- intensive home-based services
- justice-involved reentry
- assertive community treatment (ACT)
- forensic assertive community treatment (FACT)
- coordinated specialty care (CSC) for first episode psychosis (FEP)
- clubhouse services
- enhanced community health worker (CHW) services

Drug Medi-Cal Organized Delivery System services are available to you through your county behavioral health agency if you meet criteria to receive these services.

- intensive outpatient treatment services
- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program
- medications for addiction treatment (also called Medication Assisted Treatment)
- community based mobile crisis intervention services
- early intervention services (for members under age 21)
- early periodic screening, diagnosis, and treatment (for members under age 21)

Drug Medi-Cal Organized Delivery System Services include:

- outpatient treatment services
- intensive outpatient treatment services
- partial hospitalization services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- community based mobile crisis intervention services
- early intervention services (for members under age 21)
- early periodic screening, diagnosis, and treatment (for members under age 21)
- inpatient treatment services

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

For more information about the availability of behavioral health services, processes to determine medical necessity, referral procedures between Kern Family Health Care Medicare (HMO D-SNP) and Kern County, and problem resolution processes, call Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

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

This section tells you about benefits excluded by our plan. “Excluded” means that we don’t pay for these benefits. Medicare and Medi-Cal don’t pay for them either.

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

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

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

- services considered not “reasonable and medically necessary,” according to Medicare and Medi-Cal, unless listed as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses

- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- meals delivered to your home
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.

Chapter 5: Getting your outpatient drugs

Introduction

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

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

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5, Section D** "If you're in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

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

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medi-Cal lists.

You generally must use a network pharmacy to fill your prescription. (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "*Drug List*" for short. (Refer to **Section B** of this chapter.)

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9**, Section G4, to learn about asking for an exception.
- Please also note that the request to cover your prescribed drug will be evaluated under both Medicare and Medi-Cal standards.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug. Medi-Cal defines medically accepted indication as any use of a covered outpatient drug that is recognized by the FDA or is supported by peer-reviewed medical literature and accepted by recognized medical references.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter).

Table of Contents

A. Getting your prescription filled....154

A1. Filling your prescription at a network pharmacy....154

A2. Using your Member ID Card when you fill a prescription....154

A3. What to do if you change your network pharmacy....154

A4. What to do if your pharmacy leaves the network....155

A5. Using a specialized pharmacy....155

A6. Using mail-order services to get your drugs....155

A7. Getting a long-term supply of drugs....157

A8. Using a pharmacy not in our plan's network....157

A9. Paying you back for a prescription....158

B. Our plan's *Drug List*....158

B1. Drugs on our *Drug List*....158

B2. How to find a drug on our *Drug List*....159

B3. Drugs not on our *Drug List*....159

B4. *Drug List* cost-sharing tiers....161

C. Limits on some drugs....161

D. Reasons your drug might not be covered....163

D1. Getting a temporary supply....163

D2. Asking for a temporary supply....165

D3. Asking for an exception....165

E. Coverage changes for your drugs....166

F. Drug coverage in special cases....168

F1. In a hospital or a skilled nursing facility for a stay that our plan covers....168

F2. In a long-term care facility 168

F3. In a Medicare-certified hospice program 168

G. Programs on drug safety and managing drugs 169

G1. Programs to help you use drugs safely 169

G2. Programs to help you manage your drugs 169

G3. Drug management program (DMP) to help members safely use opioid medications ... 170

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website or contact Member Services or your care coordinator.

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

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

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

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

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

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

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

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

A4. What to do if your pharmacy leaves the network

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

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Indian Health Care Provider (IHCP) Pharmacies. American Indian and Alaska Native Members have access to pharmacies at an Indian Health Care Provider (IHCP) to the extent they have an enrolled retail pharmacy. If you're not American Indian or Alaska Native, you may still receive services from a retail pharmacy at an IHCP if you are assigned to the clinic or for an emergency.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)
- To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs **not** available through our plan's mail-order service are marked with NM in our *Drug List*.

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

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, go to our website at https://www.kernfamilyhealthcare.com. You can also call Member Services at 1-866-661-3767 (TTY users call 711) for help.

Usually, a mail-order prescription arrives within 5 - 7 days. If mail-order is delayed, you can pick up the prescription locally by requesting that the mail-order pharmacy transfer the prescription to your local pharmacy.

Mail-order processes

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

1. **New prescriptions the pharmacy gets from you**

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets from your provider's office**

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

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

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

   For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

   - The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

- If you choose not to use our auto refill program, contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling 1-855-243-3479, Monday through Friday 8:00 am – 8:00 pm EST or Saturday 9:00 am – 5:00 pm EST.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Call 1-855-243-3479, Monday through Friday 8:00 am – 8:00 pm EST or Saturday 9:00 am – 5:00 pm EST to let us know the best way to contact you.

A7. Getting a long-term supply of drugs

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

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

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

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with your care coordinator or Member Services first to find out if there's a network pharmacy nearby.

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

- When trying to fill a specialized drug that is otherwise not available in an in-network pharmacy (although this is rare).
- When trying to fill a drug that has a limited distribution source required by law (although this is rare).
- When filling a drug in an emergency situation when in-network pharmacies are not readily accessible, available or not operational.

- During any Federal disaster or other public health emergency in which you are evacuated or otherwise displaced from your place of residence.

You may get up to a 30-day supply up to two times for drugs filled at an out-of-network pharmacy.

A9. Paying you back for a prescription

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

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

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

B. Our plan's *Drug List*

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

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

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

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D.

Most of the drugs you get from a pharmacy are covered by your plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting your prescriptions through Medi-Cal Rx.

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name drugs or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List.*

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

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

- Visit our plan's website at https://www.kernfamilyhealthcare.com. The *Drug List* on our website is always the most current one.
- Call your care coordinator or Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.
- Drugs that are not covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information.
- Use our "Real Time Benefit Tool" at https://www.kernfamilyhealthcare.com to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call your care coordinator or Member Services.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs are not on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List.* For more information refer to **Chapter 9.**

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

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Medi-Cal can't cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms*
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride* preparations
- Drugs used for the treatment of sexual or erectile dysfunction, except as described in Chapter 4.
- Drugs used for the treatment of anorexia, weight loss or weight gain*
- Outpatient drugs made by a company that says you must have tests or services done only by them

*Select products may be covered by Medi-Cal. Please visit the Medi-Cal Rx website (www.medi-calrx.dhcs.ca.gov) for more information.

B4. *Drug List* cost-sharing tiers

Every drug on our *Drug List* is in one of six (6) tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug. Tiers 1 and 6 are the lowest cost with tiers 3, 4 and 5 being the highest cost if the drug is a brand.

- Tier 1 (Preferred Generic): This is the lowest tier and includes preferred generic drugs.
- Tier 2 (Generic): This tier includes generic drugs.
- Tier 3 (Preferred Brand): This tier includes preferred brand drugs.
- Tier 4 (Non-Preferred Drugs): This tier includes non-preferred brand and generic drugs. This tier also includes certain drugs not normally covered by the Part D program.
- Tier 5 (Specialty Tier): This tier includes specialty drugs. It includes very high-cost brand and generic drugs.
- Tier 6 (Select Care Drugs): This tier includes select care drugs for treating conditions such as diabetes, high blood pressure, and high cholesterol.

To find out which cost-sharing tier your drug is in, look for the drug on our *Drug List*.

Chapter 6 of this *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

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

Note that sometimes a drug may appear more than once in our *Drug List.* This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't

apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

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

1. **Limiting use of a brand name drug- or original biological product when a generic or interchangeable biosimilar version is available.**

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you the generic or interchangeable biosimilar version.

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

2. **Getting plan approval in advance**

   For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at www.kernfamilyhealthcare.com for more information about prior authorization.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

   If Drug A **doesn't** work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website at www.kernfamilyhealthcare.com for more information about step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

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

D. Reasons your drug might not be covered

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

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

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

D1. Getting a temporary supply

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

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

1. The drug you've been taking:
   - is no longer on our *Drug List* **or**
   - was never on our *Drug List* **or**

- is now limited in some way.

You must be in one of these situations:

- You're new to our plan.
  - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
  - This temporary supply is for up to 30-days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30-days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 34-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply. If you are a current member moving from one treatment setting to another, this is called a Level of Care Change. We will provide a transition supply of your drugs when you experience a change in level of care.
  - We will cover a temporary 30-day supply when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs.
  - Examples of Level of Care Changes may include the following:
    - Members who enter long-term care facilities from the hospital.
    - Members who are discharged from a hospital to a home.
    - Members who end their skilled nursing facility Medicare Part A stay and who need to revert to their Part D plan formulary.
    - Members who give up hospice status to revert to standard Medicare Part A and B benefits.
    - Members who end a long-term care facility stay and return to the community.
    - Members who are discharged from a psychiatric hospital with drug regimens that are highly individualized.

D2. Asking for a temporary supply

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

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

- Change to another drug.

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

  OR

- Ask for an exception.

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

D3. Asking for an exception

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

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

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

If you need help asking for an exception, contact Member Services or your care coordinator.

E. Coverage changes for your drugs

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

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's *Drug List.* For more information on these drug rules, refer to **Section C**.

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

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

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

- Check our current *Drug List* online at www.kernfamilyhealthcare.com **or**
- Call Member Services at the number at the bottom of the page to check our current *Drug List*.

Changes we may make to the *Drug List* that affect you during the current plan year

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

- **A new generic drug becomes available.** Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the Drug List now. When that happens, we may

remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower. When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

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

Removing unsafe drugs and other drugs that are off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our Drug List. If you're taking the drug, we'll send you a notice after we make the change. You can contact your doctor to find a different drug that we cover for your condition. You can also call Member Services at 1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST) 7 days a week from October 1- March 31, and Monday through Friday from April 1- September 30.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

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

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

- If there's a similar drug on our *Drug Lis*t you can take instead, **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

Changes to the *Drug List* that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug or what you pay for the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current year. You'll need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

F. Drug coverage in special cases

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

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

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

F2. In a long-term care facility

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

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

F3. In a Medicare-certified hospice program

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

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that

case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.

- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

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

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

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

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

- may not be needed because you take another similar drug that does the same thing.
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

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

pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

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

Then, they'll give you:

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

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

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

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

If you have questions about these programs, contact Member Services or your care coordinator.

G3. Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide

your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may include:

- Requiring you to get all prescriptions for those medications from a certain pharmacy(ies).
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s).
- Limiting the amount of opioid or benzodiazepine medications we cover for you.

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

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

The DMP may not apply to you if you:

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

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

Introduction

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

- Medicare Part D drugs, **and**
- Drugs and items covered under Medi-Cal Rx, **and**
- Drugs and items covered by our plan as additional benefits.

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

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

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

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

- Our *List of Covered Drugs*.
  - We call this the “*Drug List*.” It tells you:
    - Which drugs we pay for
    - Which of the six tiers each drug is in
    - If there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Member Services. You can also find the most current copy of our *Drug List* on our website at www.kernfamilyhealthcare.com.

  - Most of the drugs you get from a pharmacy are covered by Kern Family Health Care Medicare (HMO D-SNP). Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.

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

Table of Contents

A. The *Explanation of Benefits* (EOB) 175

B. How to keep track of your drug costs 176

C. Drug Payment Stages for Medicare Part D drugs 177

C1. Our plan has six cost sharing tiers 178

C2. Your pharmacy choices 178

C3. Getting a long-term supply of a drug 179

C4. What you pay 179

D. Stage 1: The Initial Coverage Stage 182

D1. Your pharmacy choices 182

D2. Getting a long-term supply of a drug 183

D3. What you pay 183

D4. End of the Initial Coverage Stage 186

E. Stage 2: The Catastrophic Coverage Stage 186

F. Your drug costs if your doctor prescribes less than a full month's supply 186

G. What you pay for Part D vaccines 187

G1. What you need to know before you get a vaccine 187

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits (EOB)*. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives**. When applicable, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count toward your total out-of-pocket costs.
- Most of the drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (www.medi-

calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal customer service center at 1-800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.

- To find out which drugs our plan covers, refer to our *Drug List*.

B. How to keep track of your drug costs

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

1. **Use your Member ID Card.**

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

2. **Make sure we have the information we need.**

   You can ask us to pay you back for our share of the cost of the drug. You can submit your receipt to Kern Family Health Care Medicare (HMO D-SNP), PO Box 9187, Bakersfield, CA 93389-9187. Here are examples of when you should give us copies of your receipts:

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

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

3. **Send us information about payments others make for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic

Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

4. Check the EOBs we send you.

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

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Kern Family Health Care Medicare (HMO D-SNP) Member Services. You can also find answers to many questions on our website: www.kernfamilyhealthcare.com.

What about possible fraud?

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

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

If you think something is wrong, or missing, or if you have any questions, call Member Services. Keep these EOBs. They're an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

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

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2026. You begin this stage when you've paid a certain amount of out-of-pocket costs.

C1. Our plan has six cost sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our *Drug List* is in one of six (6) cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our *Drug List*.

- Tier 1 drugs have the lowest copay. There is no copay for drugs in this tier.
- Tier 2 drugs have a medium copay. The copay is $0 or $1.60, depending on your income.
- Tier 3 drugs have the highest copay. The copay is $0 or $1.60 or $4.90, depending on your income.
- Tier 4 drugs have a medium to high copay. The copay is $0 or $1.60 for generic drugs, and $0 or $1.60 or $0 or $1.60 or $4.90 for brand name drugs, depending on your income.
- Tier 5 drugs have a medium to high copay. The copay is $0 or $1.60 for generic drugs, and $0 or $1.60 or $4.90 for brand name drugs, depending on your income.
- Tier 6 drugs have the lowest copay. There is no copay for drugs in this tier.

C2. Your pharmacy choices

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

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

- Our plan's mail-order pharmacy.

Refer to **Chapter 9** of this *Member Handbook* to learn about how to file an appeal if you're told a drug won't be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of this *Member Handbook* and our *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

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

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

C4. What you pay

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

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

Most of the drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal customer service center at 1-800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.

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

	A network pharmacy A one-month or up to a 90-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 34-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 (Preferred Generic)	$0	$0	$0	$0
Cost-sharing Tier 2 (Generic)	$0 or $1.60 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 The copays can vary based on the level of Extra Help you get.
Cost-sharing Tier 3 (Preferred Brand)	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.

	A network pharmacy A one-month or up to a 90-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 34-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 4 (Non-Preferred Drug)	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.
Cost-sharing Tier 5 (Specialty Tier)	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.
Cost-sharing Tier 6 (Select Care Drugs)	$0	$0	$0	$0

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

D. Stage 1: The Initial Coverage Stage

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

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

- Tier 1 drugs have the lowest copay. There is no copay for drugs in this tier.
- Tier 2 drugs have a medium copay. The copay is $0 or $1.60, depending on your income.
- Tier 3 drugs have the highest copay. The copay is $0 or $1.60 or $4.90, depending on your income.
- Tier 4 drugs have a medium to high copay. The copay $0 or $1.60 for generic drugs, and $0 or $1.60 or $4.90 for brand name drugs, depending on your income.
- Tier 5 drugs have a medium to high copay. The copay is $0 or $1.60 for generic drugs, and $0 or $1.60 or $4.90 for brand name drugs, depending on your income.
- Tier 6 drugs have the lowest copay. There is no copay for drugs in this tier.

D1. Your pharmacy choices

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

- A network retail pharmacy **or**
- An out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.
- Our plan's mail-order pharmacy.

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

D2. Getting a long-term supply of a drug

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

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

D3. What you pay

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

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

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

	A network pharmacy A one-month or up to a 90-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 34-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 (Preferred Generic)	$0	$0	$0	$0
Cost-sharing Tier 2 (Generic)	$0 or $1.60 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 The copays can vary based on the level of Extra Help you get.
Cost-sharing Tier 3 (Preferred Brand)	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.	$0 or $1.60 or $4.90 The copays can vary based on the level of Extra Help you get.

	A network pharmacy A one-month or up to a 90-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 34-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 4 (Non-Preferred Drug)	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.
Cost-sharing Tier 5 (Specialty Tier)	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	Not Available	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.	$0 or $1.60 (generic drugs) $0 or $1.60 or $4.90 (brand name drugs) The copays can vary based on the level of Extra Help you get.
Cost-sharing Tier 6 (Select Care Drugs)	$0	$0	$0	$0

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

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $2,100. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

We offer additional drugs that aren't normally covered in a Medicare Drug Plan. Payments made for these drugs don't count toward your out-of-pocket costs.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the $2,100 limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $2,100 for your Part D drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs. For Medicaid drugs and excluded drugs under our enhanced benefit you pay $0 or 1.60 for generic drugs and $0 or $1.60 or $4.90 for brand name drugs, depending on your income.

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

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

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

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

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.60. This means that the amount you pay for your drug is less than $0.06 per day. If you get a 7 day supply of the drug, your payment is less than $.06 per day multiplied by 7 days, for a total payment less than $0.42.

- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,
  - Coordinate refills with other drugs you take, **and**
  - Take fewer trips to the pharmacy.

G. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List.* Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *Drug List* or contact Member Services for coverage and cost sharing details about specific vaccines.

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

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

G1. What you need to know before you get a vaccine

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

- We can tell you about how our plan covers your vaccine and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

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

Introduction

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

Table of Contents

A. Asking us to pay for your services or drugs 189

B. Sending us a request for payment 193

C. Coverage decisions 193

D. Appeals 194

A. Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow Kern Family Health Care Medicare (HMO D-SNP) providers to bill you for these services. We pay our providers directly, and we protect you from any charges.

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

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost, it's your right to be paid back.
  - If you paid for services covered by Medicare, we'll pay you back.
- If you paid for Medi-Cal services you already received, you may qualify to be reimbursed (paid back) if you meet all of the following conditions:
  - The service you received is a Medi-Cal covered service that we're responsible for paying. We won't reimburse you for a service that isn't covered by Kern Family Health Care Medicare (HMO D-SNP).
  - You received the covered service after you became an eligible Kern Family Health Care Medicare (HMO D-SNP) member.
  - You ask to be paid back within one year from the date you received the covered service.
  - You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
  - You received the covered service from a Medi-Cal enrolled provider in Kern Family Health Care Medicare's (HMO D-SNP) network. You don't need to meet this condition if you received emergency care, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval (prior authorization).
- If the covered service normally requires pre-approval (prior authorization), you need to provide proof from the provider that shows a medical need for the covered service.

- Kern Family Health Care Medicare (HMO D-SNP) will tell you if they will reimburse you in a letter called a Notice of Action. If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, Kern Family Health Care Medicare (HMO D-SNP) will pay you back for the full amount you paid. We'll reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal but isn't in our network and refuses to pay you back, Kern Family Health Care Medicare (HMO D-SNP) will pay you back, but only up to the amount that FFS Medi-Cal would pay. Kern Family Health Care Medicare (HMO D-SNP) will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you don't meet one of the above conditions, we won't pay you back.
- We won't pay you back if:
  - You asked for and received services that aren't covered by Medi-Cal, such as cosmetic services.
  - The service isn't a covered service for Kern Family Health Care Medicare (HMO D-SNP).
  - You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- If we don't cover the services or drugs, we'll tell you.

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

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

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

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.

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

2. When a network provider sends you a bill

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

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

3. If you're retroactively enrolled in our plan

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

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

4. When you use an out-of-network pharmacy to fill a prescription

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

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Refer to **Chapter 5** of this *Member Handbook* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full prescription cost because you don't have your Member ID Card with you

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

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

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

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

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

cost you paid if the price you paid is higher than our negotiated price for the prescription.

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

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

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help.

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

Kern Family Health Care Medicare (HMO D-SNP)
PO Box 9187
Bakersfield, CA 93389-9187

C. Coverage decisions

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

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

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

- If we decide not to pay for our share of the cost of the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9.

D. Appeals

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

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

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

Chapter 8: Your rights and responsibilities

Introduction

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

Table of Contents

A. Your right to get services and information in a way that meets your needs 197

A. Su derecho de obtener servicios e información de una manera que satisfaga sus necesidades 198

B. Our responsibility for your timely access to covered services and drugs 199

C. Our responsibility to protect your personal health information (PHI) 200

C1. How we protect your PHI 200

C2. Your right to look at your medical records 201

D. Our responsibility to give you information 207

E. Inability of network providers to bill you directly 208

F. Your right to leave our plan 208

G. Your right to make decisions about your health care 209

G1. Your right to know your treatment choices and make decisions 209

G2. Your right to say what you want to happen if you can't make health care decisions for yourself 209

G3. What to do if your instructions aren't followed 211

H. Your right to make complaints and ask us to reconsider our decisions 211

H1. What to do about unfair treatment or to get more information about your rights 211

I. Your responsibilities as a plan member 212

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

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call your care coordinator or Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English including Spanish and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Services or write to PO Box 9187, Bakersfield, CA 93389-9187.
    - To request materials in the available languages and formats, call Member Services at 1-866-661-3767 (TTY 711) 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.
    - You can make a standing request so that all future mailings are in your requested language or format.
    - To cancel or change your standing request, call Member Services at 1-866-661-3767 (TTY 711) 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

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

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

A. Su derecho de obtener servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que todos los servicios, tanto clínicos como no clínicos, se le brinden de una manera culturalmente competente y accesible, incluyendo aquellos con dominio limitado del inglés, habilidades limitadas de lectura, discapacidad auditiva, o aquellos con diversos orígenes culturales y étnicos. También debemos informarle sobre los beneficios de nuestro plan y sus derechos de una manera que pueda comprenderlos. Debemos informarle sobre sus derechos cada año que sea miembro de nuestro plan.

- Para obtener información de una manera que pueda comprender, llame a Servicios para Miembros o su coordinador de atención médica. Nuestro plan cuenta con servicios gratuitos de interpretación para responder a las preguntas en diferentes idiomas.
- Nuestro plan también puede brindarle materiales en otros idiomas además del inglés, incluyendo el español, y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, por favor llame a Servicios para Miembros o escriba a PO Box 9187, Bakersfield, CA 93389-9187.
    - Para solicitar materiales en los idiomas y formatos disponibles, llame a Servicios para Miembros al 1-866-661-3767 (TTY 711) de las 8:00 a. m. a las 8:00 p. m. (hora del Pacífico, PST), los 7 días de la semana del 1º de octubre al 31 de marzo, y de lunes a viernes del 1º de abril al 30 de septiembre.
    - Puede solicitar que siempre le enviemos la información en el idioma o formato que necesite. Esto se denomina «solicitud permanente». Para cancelar o modificar su solicitud permanente, llame a Servicios para Miembros al 1-866-661-3767 (TTY 711) los 7 días de la semana del 1º de octubre al 31 de marzo, y de lunes a viernes del 1º de abril al 30 de septiembre.

Si tiene problemas para obtener información de nuestro plan debido a problemas con el idioma o una discapacidad y desea presentar una queja, llame a:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.
- Oficina de Derechos Civiles de Medi-Cal al 916-440-7370. Los usuarios de la línea TTY deben llamar al 711.
- Departamento de Salud y Servicios Humanos de los EE. UU., Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de la línea TTY deben llamar al 1-800-537-7697.

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

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Member Handbook*.
  - Call your care coordinator or Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Member Handbook*.
- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to **Chapter 1** of this *Member Handbook*.
- You have the right to make your own healthcare decisions with help from your care team and care coordinator.

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

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

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

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We provide you with a written notice that advises you about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

Members who may consent to receive sensitive services aren't required to get any other member's authorization to receive sensitive services or to submit a claim for sensitive services. Kern Family Health Care Medicare (HMO D-SNP) will direct communications regarding sensitive services to a member's alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. Kern Family Health Care Medicare (HMO D-SNP) won't disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Kern Family Health Care Medicare (HMO D-SNP) will accommodate requests for confidential communication in the form and format requested, if it's readily producible in the requested form and format, or at alternative locations. A member's request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

You can ask us to contact you by your preferred method of contact (for example, home or work phone number) or to send mail to a different address. We will consider all fair requests. We must approve your request if you tell us you would be in danger if we do not. We protect your personal health information (PHI) as required by Federal and State laws.
Members may request confidential communication by calling Member Services at the number below.

C1. How we protect your PHI

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

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

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

- We must release PHI to government agencies checking on our plan's quality of care.
- We may release PHI if ordered by a court, but only if it's allowed by California law.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws. To better serve you and improve your health care, we may give Medi-Cal your health information. If Medi-Cal releases or uses your information, it will be done according to federal laws. Where required by law, when our business partners work with us, they must also protect the privacy of any PHI we share with them and are not allowed to give PHI to others except as allowable by law, and this notice.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Member Services.

You can learn more about your privacy rights by reviewing our Notice of Privacy Practices (NOPP) on the next page.

Kern Family Health Care Medicare (HMO D-SNP)
Notice of Privacy Practices
Effective: January 1, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We will follow the terms of this Notice of Privacy Practices. We have the right to change this notice, and to apply the new notice to health information we hold. If we need to make changes, we will tell you. We will also tell you where to get the new notice on our website. If you ask us, we will send a copy to you.

If you are of the age and capacity to consent to sensitive services, you do not have to get any other member's authorization to get these services or for your doctor to ask us for payment. Please see the definition of "Sensitive Services" in **Chapter 12** of the *Member Handbook*.

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

What is the reason for this notice?

Kern Family Health Care Medicare (HMO D-SNP) must make your health information private. We must also tell you how we protect your private health information (PHI).

How does Kern Family Health Care Medicare (HMO D-SNP) protect my privacy and data?

Kern Family Health Care Medicare (HMO D-SNP) has policies and processes to protect oral, written, and electronic information about you across our company. These policies also apply to information about your race / ethnicity, language, gender identity, and sexual orientation. These policies show how we protect your data. They also state how it can be used, and how it cannot be used. Some of the ways we protect your information is by:

- Having rules about who can see your information
- Having safe methods for how we store paper and electronic information
- Using identification badges and computer logins
- Having security in our building
- Training our team members

How does Kern Family Health Care Medicare (HMO D-SNP) use information on my race/ethnicity, language, gender identity and sexual orientation?

We may use this information to…

- Assess health care differences
- Create special programs
- Develop communications
- Tell providers about language needs and pronouns
- Help with clinical care

We will not use this data for…

- Decisions about coverage or benefits
- Underwriting

How does Kern Family Health Care Medicare (HMO D-SNP) use and share my health information?

We store health records about you like...

- Claims history
- Enrollment
- Care management
- Requests for approving some health care services

We use this information and share it with others for…

- **Treatment**
  We use your health information to plan your health care. For example, we share information with hospitals or doctors to help them give you services.
- **Payment**
  We use and share your health information to pay for care you get. For example, we tell providers that you are a member of Kern Family Health Care (HMO D-SNP) and tell them about your benefits.
- **Health Care Operations**
  We use and share your health information if we need it to help us run our health plan. For example, we use our claims data for quality purposes.
- **Contractors**
  We share health information with others that help us in the tasks shown above. We get agreements before we share information to keep your data safe. For

example, we may give some information to the company that helps us get you rides for your care.

- **Contacting You**
  We may call you or send you a text or letter to remind you about a visit. Or, to give you information about your care. We may also contact you about other health-related services.

Can others that help me with my care get information about me?

Yes, if we feel it is needed, we may give medical information to a friend or family member that helps with your care. Or when you have told us we can. We may tell them about your enrollment dates with us or that we paid for your care.

- When someone gives us proof they are allowed to get your health information such as power of attorney or guardianship
- If you are not able to give us permission. For example, if you are not conscious, we may share your information if we believe it is in your best interest
- Or if it will help to lessen a serious threat to your health

Can my health information ever be given without my permission?

Yes, we may share health information without your consent. Health information can be shared for the reasons already listed. We can also share information with state or federal agencies. Or, other times where we must by law. We must meet many conditions before we can share your information for these reasons. The below website gives you more information on this: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

We may be required or allowed to share health information without your consent:

- When laws tell us we must
- To help with public health and safety, like preventing disease, helping with product recalls, or if we suspect abuse, neglect, or domestic violence.
- For health research
- To respond to an organ or tissue donation request
- To work with a medical examiner or funeral director
- With agencies responsible for audits
- When we get a court order.
- When there may be fraud.

Are there any times when my PHI is not shared?

We follow laws that may limit how we use or share your information. For example, there are rules about sharing health information about:

- HIV/AIDS status
- Mental health
- Psychotherapy notes
- Developmental disabilities
- Drug and alcohol services

We will not allow the sale of PHI or other sharing or uses of your health information without you agreeing in writing.

What rights do I have as a Kern Family Health Care Medicare (HMO D-SNP) member?

As a Kern Family Health Care Medicare (HMO D-SNP) member you have rights…

- You have the right for us to tell you if we have a breach or did not follow the laws.
- You have the right to ask us to limit how we share or use your information. We do not have to agree. We may say "no" if it would affect your care.
- You have the right to ask us to use or share your information other than what is shown here. You have the right to change your mind by telling us in writing.
- You have the right to ask us to give information to your family, friends, or others that help with your care.
- You have the right to share your health information if you need help from a disaster.
- You have the right to tell us to contact you for fundraising efforts.
- You have the right to ask us to contact you only by mail, or at another address, or by phone. We must say "yes" if you tell us you would be in danger if we do not.
- You have the right to see or get a copy your records we hold. You must ask us in writing. We will answer you within 30 days. If your records are in another location, please give us 60 days to give you an answer. We may charge a fee for copying your records. We may also say "no" to your request. If we say "no," we will send you a letter with the reason. You have the right to appeal if we say "no."
- If you think the information in our records is wrong, you have the right to ask us to change it. We may deny your request. If we say "no," we will tell you why in writing within 30 days. If we say "no," you have the right to send us a statement add to the record.
- You have the right to get a report of non-routine sharing of your health information that we have made. You can ask for up to six years before the date of your request. There are some limitations. For example, we do not have records of:
    - Information shared with your consent

- Information shared for the treatment, payment, or the health plan operations
- Information shared with you
- Certain other disclosures.

We do not have full copies of all of your medical records. If you want to look at, get a copy of, or change anything in your medical records, please contact your provider first.

How do I access these rights?

You can access any of your rights by sending a letter to our Privacy Official at the address shown below. For help, call us at the phone number shown.

How do I file a complaint (grievance) if my privacy rights are violated?

You have the right to file a complaint with our Privacy Officer. You may also file a complaint with the Secretary of Health and Human Services.

We will not hold anything against you in any way for filing a complaint. Filing a grievance will not affect the health care services you receive or your benefits.

Contact us at:

Privacy Officer
Kern Family Health Care Medicare (HMO D-SNP)
2900 Buck Owens Blvd
Bakersfield, CA 93308
1-866-661-3767 (TTY 711), 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

Contact the California Department of Health Care Services at:

DHCS Privacy Officer
1501 Capitol Avenue - MS0010
P.O. Box 997413
Sacramento, CA 95899-7413

1-916-445-4656
1-866-866-0602
privacyofficer@dhcs.ca.gov

Contact the Secretary of Health and Human Services at:

Secretary of Health and Human Services, Office for Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-877-696-6775
https://www.hhs.gov/hipaa/filing-a-complaint/index.html

The Department of Health Care Services (DHCS) also publishes a notice of privacy practices. You can review this notice on the DHCS web site: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf.

You may also request a copy of this Notice of Privacy Practices (NOPP) by calling Member Services. The NOPP is available on our website or by calling Member Services.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. Our plan can also give you materials in languages other than English, including Spanish. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers

  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Member Handbook:*
  - For more information about when you can join a new MA or drug benefit plan.

- For information about how you'll get your Medi-Cal benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we'll not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people can't make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're being hospitalized and you have a signed advance directive**, take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Kern Family Health Care Medicare (HMO D-SNP) will tell you about changes to the state law no later than 90 days after the change.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint by calling the Office of the Ombudsman 1-888-452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* – or you want more information about your rights, you can call:

- Member Services.
- The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. For more details about HICAP, refer to **Chapter 2, Section C**.
- The Medi-Cal Ombudsman at 1-888-452-8609. For more details about this program, refer to **Chapter 2** of this *Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read this *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this *Member Handbook*.
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plan assessment and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment**.**
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:

- Medicare Part A and Medicare Part B premiums. For most Kern Family Health Care Medicare (HMO D-SNP) members, Medi-Cal pays for your Medicare Part A premium and for your Medicare Part B premium.
- For some of your drugs covered by our plan, you must pay your share of the cost when you get the drug. This will be a copayment/copay (a fixed amount). **Chapter 6, Section C4,** tells what you must pay for your drugs.
- **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call your care coordinator or Member Services.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* advises you about our service area.
  - We can help you find out if you're moving outside our service area.
  - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Medi-Cal.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Tell us if you have a new phone number** or a better way to contact you.
- **Call your care coordinator or Member Services for help if you have questions or concerns.**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

- This chapter has information about your rights. Read this chapter to find out what to do if: You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.
- You have a problem or complaint with your long-term services and supports, which include Community-Based Adult Services (CBAS) and Nursing Facility (NF) services.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you have a problem with your care, you can call the Medicare Medi-Cal Ombudsman Program at 1-855-501-3077 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombudsman Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** of your *Member Handbook*.

Table of Contents

A. What to do if you have a problem or concern 217

A1. About the legal terms 217

B. Where to get help 217

B1. For more information and help 217

C. Understanding Medicare and Medi-Cal complaints and appeals in our plan 219

D. Problems with your benefits 219

E. Coverage decisions and appeals 220

E1. Coverage decisions 220

E2. Appeals 220

E3. Help with coverage decisions and appeals 221

E4. Which section of this chapter can help you 222

F. Medical care 223

F1. Using this section 223

F2. Asking for a coverage decision 224

F3. Making a Level 1 Appeal 226

F4. Making a Level 2 Appeal 229

F5. Payment problems 235

G. Medicare Part D drugs 236

G1. Medicare Part D coverage decisions and appeals 237

G2. Medicare Part D exceptions 238

G3. Important things to know about asking for an exception 240

G4. Asking for a coverage decision, including an exception 240

G5. Making a Level 1 Appeal 243

G6. Making a Level 2 Appeal 245

H. Asking us to cover a longer hospital stay 247

H1. Learning about your Medicare rights 248

H2. Making a Level 1 Appeal 249

H3. Making a Level 2 Appeal 251

I. Asking us to continue covering certain medical services 252

I1. Advance notice before your coverage ends 252

I2. Making a Level 1 Appeal 252

I3. Making a Level 2 Appeal 254

J. Taking your appeal beyond Level 2 255

J1. Next steps for Medicare services and items 255

J2. Additional Medi-Cal appeals 257

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests 257

K. How to make a complaint 258

K1. What kinds of problems should be complaints 258

K2. Internal complaints 260

K3. External complaints 261

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP isn't connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is 1-800-434-0222.

Help from the Medicare Medi-Cal Ombudsman Program

You can call the Medicare Medi-Cal Ombudsman Program and speak with an advocate about your health coverage questions. They may be able to offer free legal help. The Ombudsman Program isn't connected with us or with any insurance company or health plan. Their phone number is 1-855-501-3077, and their website is www.healthconsumer.org.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help from the California Department of Health Care Services

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can help. They can help if you have problems joining, changing, or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609.

Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care (DMHC) for free help. The DMHC is responsible for overseeing health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891. You can also visit DMHC's website at www.dmhc.ca.gov.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-866-661-3767 (TTY 711),** 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30, and use your health plan's grievance process before contacting the department. Utilizing this grievance

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

C. Understanding Medicare and Medi-Cal complaints and appeals in our plan

You have Medicare and Medi-Cal. Information in this chapter applies to all your Medicare and Medi-Cal managed care benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes can’t be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** "Coverage decisions and appeals."	**No.** My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Part B drugs as medical care**.**

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision when we review a request for service or a claim. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or Medi-Cal. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

In most cases, you must start your appeal at Level 1. If your health problem is urgent or involves an immediate and serious threat to your health, or if you're in severe pain and need a faster decision, you may ask for an IMR Medical Review from the Department of Managed Health Care at www.dmhc.ca.gov.. Refer to **Section F4** for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **Medicare Medi-Cal Ombudsman Program at 1-855-501-3077.**
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **The Help Center at the Department of Managed Health Care (DMHC)** for free help. The DMHC helps people with appeals regarding Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891. You can also visit DMHC's website at www.dmhc.ca.gov. While the DMHC can help people in Managed Medi-Cal plans, it can't help people in Medicare plans only and in the following County Organized Health Systems (COHS): Partnership Health Plan, Gold Coast Health Plan, CenCal Health, Central California Alliance for Health, and CalOptima. The federal government regulates Medicare, plans, and the Department of Health Care Services regulates COHS plans.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.

- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
  - Ask for a legal aid attorney from the Medicare Medi-Cal Ombudsman Program at 1-855-501-3077.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://www.kernfamilyhealthcare.com. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care. For information about requesting a longer hospital stay, please refer to **Section H**.

This section is about your benefits for medical care that's described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the following situations:

1. You think we cover medical care you need but aren't getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** "Asking us to cover a longer hospital stay" or **Section I** "Asking us to continue covering certain medical services" to find out more.

- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

6. You're experiencing delays in care or you can't find a doctor.

What you can do: You can file a complaint. Refer to **Section K2**.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- calling: 1-866-661-3767, TTY: 711.
- faxing: 1-661-605-0315.
- writing: PO Box 9187, Bakersfield, CA 93389-9187 .

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within**:**

- **5 business days** after we get your request **for a medical service or item that's subject to our prior authorization rules**.
- **5 business days,** and no later than **14 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request for a **Medicare Part B drug**.

Fast coverage decision

> The legal term for fast coverage decision is **expedited determination**.

When you ask us to make a coverage decision about your medical care that requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer about a:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so, and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K How to Make a Complaint**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3 Making a Level 1 Appeal**).

In limited circumstances, we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your authorized representative must contact us. Call us at 1-866-661-3767 (TTY 711) 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-866-661-3767 (TTY 711) 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://www.kernfamilyhealthcare.com.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care, you and/or your doctor can request a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K How to Make a Complaint**.

If we tell you we're stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal, or sooner if your health requires a quicker response**. We'll give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter , we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. In California, a State Hearing is called a State Fair Hearing. To file a State Hearing, refer to Section F4, **Making a Level 2 Appeal**, as applicable.
- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal, or sooner if your health requires it.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
  - If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. In

California, a State Hearing is called a State Fair Hearing. To file a State Hearing, refer to Section F4, as applicable.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days of the date we got your appeal request, or as fast as your health condition requires and within 72 hours of the date we change our decision, or within 7 calendar days of the date we got your appeal if your request is for a Medicare Part B drug.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we'll send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the IRO. In addition to the automatic Level 2 Appeal, you can also ask for a State Hearing and an Independent Medical Review with the state. However, an Independent Medical Review isn't available if you have already presented evidence in a State Hearing.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3 Making a Level 1 Appeal** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.

- If your problem is about a service usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **IRE**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

If the IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must promptly implement the decision:
    - Authorize the medical care coverage **within 72 hours, or**

  - Provide the service within **5 working days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.

- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **Within 72 hours** after we get the IRO's decision for **standard requests**, or
  - **Within 24 hours** from the date we get the IRO's decision for **expedited requests**.

- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J Next steps for Medicare services and items** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medi-Cal usually covers

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

(1) Department of Managed Health Care (DMHC)

You can file a complaint with or apply for an Independent Medical Review (IMR) from the Help Center at the DMHC. By filing a complaint, the DMHC will review our decision. The DMHC will do their own investigation of your complaint or decide whether the case qualifies for IMR. An IMR may be available for any Medi-Cal covered service or item that's medical in nature. An IMR is a review of your case by experts who aren't part of our plan or a part of the DMHC. If the IMR

is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it's not medically necessary.
- Won't cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Disputes whether a surgical service or procedure was cosmetic or reconstructive in nature.
- Won't pay for emergency or urgent Medi-Cal services that you already received.
- Hasn't resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours, or sooner, if your health requires it, for a fast appeal.

In most cases, you must file an appeal with us before requesting an IMR. Refer to **Section F3 Making a Level 1 Appeal** for information, about our Level 1 appeal process. If you disagree with our decision, you can file a complaint with the DMHC or ask the DMHC Help Center for an IMR.

NOTE: If your provider filed an appeal for you, but we don't get your Appointment of Representative form, you'll need to refile your appeal with us before you can file for a Level 2 IMR with the Department of Managed Health Care unless your appeal involves an imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

You may request for an IMR and a State Hearing, but you aren't allowed to go to IMR if you have already presented evidence in a State Hearing or had a State Hearing on the same issue.

If your treatment was denied because it was experimental or investigational, you don't have to take part in our appeal process before you apply for an IMR.

If your problem is urgent or involves an immediate and serious threat to your health or if you're in severe pain, you may bring it immediately to the DMHC's attention without first going through our appeal process.

You must **apply for an IMR within 6 months** after we send you a written decision about your appeal. The DMHC may accept your application after 6 months for good reason, such as you

had a medical condition that prevented you from asking for the IMR within 6 months, or you didn't get adequate notice from us of the IMR process.

To file a complaint or ask for an IMR:

- Fill out the IMR/Complaint Form available at: www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the DMHC Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center can't return any documents.
- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the Department's Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- Submit the IMR/Complaint Form and any attachments to the DMHC:

  Submit online: www.dmhc.ca.gov/FileaComplaint.aspx

  Submit by mail or fax:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, CA 95814-2725
  FAX: 916-255-5241

Within 7 days, DMHC will review your application and send you an acknowledgement of receipt letter. If DMHC determines the case qualifies for IMR, then an IMR decision will be made within 30 days after the receipt of all required documentation.

If your case is urgent and you qualify for IMR, an IMR decision will usually be made within 7 days after the receipt of all required documentation.

If you're not satisfied with the result of the IMR, you can still ask for a State Hearing.

An IMR can take longer if the DMHC doesn't receive all of the medical records needed from you or your treating doctor. If you're using a doctor who isn't in your health plan's network, it's important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

If the DMHC decides that your case isn't eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

(2) State Hearing

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we won't approve, or we won't continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the "Appeal Decision Letter" notice is mailed to you.

NOTE: If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read "Will my benefits continue during Level 2 appeals" on page **229** for more information.

There are two ways to ask for a State Hearing:

1. You may complete the "Request for State Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:
   - To the county welfare department at the address shown on the notice.
   - To the California Department of Social Services:

     State Hearings Division
     P.O. Box 944243, Mail Station 9-17-433
     Sacramento, California 94244-2430

   - To the State Hearings Division at fax number 916-309-3487 or toll-free at 1-833-281-0903.
2. You can call the California Department of Social Services at 1-800-743-8525. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

The State Hearings Division gives you their decision in writing and explain the reasons.

- If the State Hearings Division says **Yes** to part or all of a request for a medical item or service**,** we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Hearings Division says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or State Hearing decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the State Hearings Division describes the next appeal option.

Refer to **Section J Taking Your Appeal Beyond Level 2** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for drugs in Tiers 2, 3, 4, and 5, depending on the level of Extra Help you get. You may also have to pay a copayment for Medicare-covered services during the deeming period if you lose your Medi-Cal coverage.

If you get a bill that's more than your copay for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you or your provider the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request. If payment is made to your provider, your provider will then send the payment to you.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3 Making a Level 1 Appeal**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is Yes at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Medi-Cal usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in

the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medi-Cal follow the process in **Section E**.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that isn't on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination.**"

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**.	Refer to **Section G4 Asking for a coverage decision, including an exception**.	Refer to **Section G4 Asking for a coverage decision, including an exception**.	Refer to **Section G5 Making a Level 1 Appeal.**

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a "formulary exception."
>
> Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a tiering exception.

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a drug that isn't on our *Drug List*

- If we agree to make an exception and cover a drug that's not on our Drug List, you pay the copay that applies to drugs in Tier 4 for brand name or generic drugs.
- You can't get an exception to the required copay amount for the drug.

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our *Drug List* is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

- Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.

  - If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.

- You can't ask us to change the cost-sharing tier for any drug in Tier 5 Specialty Tier.

- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5 Making a Level 1 Appeal** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-833-546-0101 (TTY: 711), 24 hours a day, 7 days a week, including holidays, writing, or faxing us.

You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.

- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3 Help with coverage decisions and appeals** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll review your request under the fast coverage decision timeline. We'll send you a letter with this information.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we'll decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we'll use the standard deadlines instead.
  - We send you a letter that tells you we'll use the standard deadline. The letter also tells you how to make an appeal about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K How to Make a Complaint**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6 Making a Level 2 Appeal** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.

- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling **1-833-546-0101** (TTY: **711**), 24 hours a day, 7 days a week, including holidays, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness, or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4 Asking for a coverage decision, including an exception** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6 Making a Level 2 Appeal** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.

- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6 Making a Level 2 Appeal** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6 Making a Level 2 Appeal** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**. If you need help requesting a free copy of your case file, call 1-833-546-0101 (TTY: 711).
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4 Making a Level 2 Appeal** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.

- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J Taking your appeal beyond Level 2** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Member Handbook.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Notwithstanding the appeals discussed in this **Section H**, you may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im..

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In California, the QIO is Commence Health. Call them at 1-877-588-1123. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization won't hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you're in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.

- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section E4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J Taking your appeal beyond Level 2** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K How to Make a Complaint** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:

  - Call Member Services at the numbers at the bottom of the page.
  - Call the HICAP at 1-800-434-0222.

- **Contact the QIO.**
  - Refer to **Section H2 Making a Level 1 Appeal** or refer to **Chapter 2** of this *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.

- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.
- If the Quality Improvement Organization won't hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you're in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

> The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.

- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers provide their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to **Section F4** to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J Taking your appeal beyond Level 2** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the State Hearings Division will tell you what to do if you want to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.

- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	● You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	● You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	● A health care provider or staff was rude or disrespectful to you. ● Our staff treated you poorly. ● You think you're being pushed out of our plan.

Complaint	Example
Accessibility and language assistance	● You can't physically access the health care services and facilities in a doctor or provider's office. ● Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). ● Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	● You have trouble getting an appointment or wait too long to get it. ● Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	● You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	● You think we failed to give you a notice or letter that you should have received. ● You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	● You think we don't meet our deadlines for making a coverage decision or answering your appeal. ● You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. ● You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need

help making an internal and/or external complaint, you can call Member Services at 1-866-661-3767 (TTY 711) .

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Services at 1-866-661-3767 (TTY 711). You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there's anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.
- We will send you a letter within 5 calendar days of receipt of your complaint letting you know that we received it and a resolution letter within 30 days of receiving your complaint.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal", we will automatically give you a "fast complaint" and respond within 24 hours.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with Kern Family Health Care Medicare (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

Medi-Cal

You can file a complaint with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. For non-urgent matters, you may file a complaint with the DMHC if you disagree with the decision in your Level 1 appeal or if the plan hasn't resolved your complaint after 30 calendar days. However, you may contact the DMHC without filing a Level 1 appeal if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you're in severe pain, if you disagree with our plan's decision about your complaint, or if our plan hasn't resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TTY number, 1-877-688-9891. The call is free.

- Visit the Department of Managed Health Care's website (www.dmhc.ca.gov).

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

OIA/OCR Central Region – Bakersfield
5100 Young Street, Bldg B Ste, 160A
Bakersfield, CA 93311
(661) 664-2054
Fax (661) 664-2036

You may also have rights under the Americans with Disability Act (ADA) and under applicable state law. You can contact the Department for Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697 or your local Office for Civil Rights.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2 Making a Level 1 Appeal** or refer to **Chapter 2** of this *Member Handbook*.

In California, the QIO is called Commence Health. The phone number for Commence Health is 1-877-588-1123.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and Medi-Cal programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. When you can end your membership in our plan 264

B. How to end membership in our plan 265

C. How to get Medicare and Medi-Cal services separately 266

C1. Your Medicare services 266

C2. Your Medi-Cal services 270

D. Your medical items, services and drugs until your membership in our plan ends 271

E. Other situations when your membership in our plan ends 271

F. Rules against asking you to leave our plan for any health-related reason 272

G. Your right to make a complaint if we end your membership in our plan 273

H. How to get more information about ending your plan membership 273

A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal,

- you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Medi-Cal or Extra Help changed, or
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1 Your Medicare services**.
- Medi-Cal options and services in **Section C2 Your Medi-Cal services**.

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP. Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8:00 a.m. to 5:00 p.m. or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Member Handbook* for information about drug management programs.

B. How to end membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 267-269.

- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Medi-Cal services separately

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It's for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify. **Note**: The term Medi-Medi Plan is the name for integrated dual eligible special needs plans (D-SNPs) in California.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: ● Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medi-Medi Plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal plan will change to match your Medi-Medi Plan.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare drug plan, and a Medi-Cal Plan.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: ● Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll remain enrolled in your Medi-Cal Plan unless you choose a different plan.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare drug plan **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: ● Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll remain enrolled in your Medi-Cal Plan unless you choose a different plan.

4. You can change to:	Here is what to do:
Any Medicare health plan during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: ● Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal Plan may change.

C2. Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Or visit www.healthcareoptions.dhcs.ca.gov/en. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in Kern Family Health Care Medicare (HMO D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is for people who qualify for both Medicare and Medi-Cal. Note: if you no longer qualify for Medi-Cal you can temporarily continue in our plan with Medicare benefits, please see information below on deeming period.

  If you lose Medi-Cal eligibility as determined by the state of California, Kern Family Health Care Medicare (HMO D-SNP) will continue to cover your Medicare and prescription drug benefits for 3 months from the date you lose your eligibility. If you do not regain your eligibility after 3 months, we are required to disenroll you.
- If you move out of our service area.
- If you're away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.

- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or aren't lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

If you're within our plan's three-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage and Part D plan-covered Medicare benefits. However, during this period, we won't continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *Member Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Notice about laws 275

B. Federal notice about nondiscrimination 275

C. Notice about nondiscrimination for Medi-Cal 275

D. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort 276

E. Notice about Medi-Cal estate recovery 277

F. Community Advisory Committee 277

G. Combined Evidence of Coverage and Disclosure Form 278

A. Notice about laws

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

B. Federal notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

C. Notice about nondiscrimination for Medi-Cal

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. In addition, we don't unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health Care Services, Office for Civil Rights at 1-916-440-7370. TTY users can call 711 (Telecommunications Relay Service). If you believe that you've been discriminated against and want to file a discrimination grievance, contact the Kern Family Health Care Medicare (HMO D-SNP)

Grievance Coordinator at 1-866-661-3767 (TTY 711), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.

- You can also write to Kern Family Health Care Medicare (HMO D-SNP), PO Box 9187, Bakersfield, CA 93389-9187.
- You can file a complaint in person at Kern Family Health Care Medicare (HMO D-SNP), 2900 Buck Owens Blvd, Bakersfield, CA 93380.
- You can also visit our website at https://www.kernfamilyhealthcare.com.

If your grievance is about discrimination in the Medi-Cal program, you can also file a complaint with the Department of Health Care Services, Office of Civil Rights, by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you can't speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

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

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

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

D. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.

Medi-Cal members must utilize all other health coverage (OHC) prior to Medi-Cal when the same service is available under your health coverage since Medi-Cal is the payer of last resort. This means that in most cases, Medi-Cal will be the secondary payer to the Medicare OHC, covering allowable costs not paid by our plan or other OHC up to the Medi-Cal rate.

E. Notice about Medi-Cal estate recovery

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-For-Service and managed care premiums/capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment can't exceed the value of a member's probated estate.

To learn more, go to the Department of Health Care Services' estate recovery website at www.dhcs.ca.gov/er or call 1-916-650-0590.

F. Community Advisory Committee

Kern Family Health Care Medicare (HMO D-SNP) has a group called the Community Advisory Committee (CAC). This group is made up of Kern Family Health Care members, community and health care representatives of Kern County, and a member of the Kern Health Systems' Board of Directors. You can join this group if you would like. The group talks about how to improve KFHC policies and is responsible for:

- Culturally appropriate service or program design
- Priorities for health education and outreach programs
- Marketing materials and campaigns
- Community resources and information
- Advisement for educational and operational issues affecting Limited English Proficient (LEP) members
- Advisement for cultural and linguistic issues
- Advisement for diversity, equity, and inclusion issues

If you would like to be a part of this group, call 1-866-661-3767 (TTY users call 711). To see when the next meeting is scheduled, go to https://kernfamilyhealthcare.com and click on “Committees” in the “About us” menu.

G. Combined Evidence of Coverage and Disclosure Form

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: An Administrative Law Judge (ALJ) is a judge who hears and decides cases involving government agencies. A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Member Handbook* explains appeals, including how to make an appeal.

Behavioral Health: Refers to our emotional, psychological, and social well-being. In simpler terms: It's about how we think, feel, and interact with others. It's an all-inclusive term referring to mental health and substance use disorder services.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological drug that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

California Integrated Care Management (CICM): CICM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs for specific populations of vulnerable Members with the most complex medical and social needs.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your Part D drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the year. You pay nothing.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this *Member Handbook* explains how to contact CMS.

Community-Based Adult Services (CBAS): Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay $2 or $5 for a drug.

Cost-sharing: Amounts you have to pay when you get certain drugs. Cost-sharing includes copays.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Daily cost- sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

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

Department of Health Care Services (DHCS): The state department in California that administers the Medicaid Program (known as Medi-Cal).

Department of Managed Health Care (DMHC): The state department in California responsible for regulating most health plans. DMHC helps people with appeals and complaints about Medi-Cal services. DMHC also conducts Independent Medical Reviews (IMR).

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our *Drug List*. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in one of six tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that aren't covered by this health plan.

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

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health Insurance Counseling and Advocacy Program (HICAP): A program that provides free and objective information and counseling about Medicare. **Chapter 2** of this *Member Handbook* explains how to contact HICAP.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you **don't** owe any cost-sharing. Providers shouldn't bill you anything for these services.

In Home Supportive Services (IHSS): The IHSS Program will help pay enrolled care providers for services provided to you so that you can remain safely in your own home. IHSS is an alternative to out-of-home care, such as nursing homes or board and care facilities. To receive services, an assessment is conducted to determine which types of services may be authorized for each participant based on their needs. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. County social service agencies administer IHSS.

Independent Medical Review (IMR): If we deny your request for medical services or treatment, you can make an appeal. If you disagree with our decision and your problem is about a Medi-Cal service, including DME supplies and drugs, you can ask the California Department of Managed Health Care for an IMR. An IMR is a review of your case by experts who aren't part of our plan. If the IMR decision is in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity.**

Individualized Care Plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $2,100. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

***List of Covered Drugs* (*Drug List*):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS covered by our plan include Community-Based Adult Services (CBAS), also known as adult day health care, Nursing Facilities (NF), and Community Supports. IHSS and 1915(c) waiver programs are Medi-Cal LTSS provided outside our plan.

Low-income subsidy (LIS): Refer to "Extra Help"

Mail Order Program: Some plans may offer a mail-order program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

Medi-Cal: This is the name of California Medicaid program. Medi-Cal is managed by the state and is paid for by the state and the federal government.

- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medi-Cal.

Medi-Cal plans: Plans that cover only Medi-Cal benefits, such as long-term services and supports, medical equipment, and transportation. Medicare benefits are separate.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. Medi-Cal is the Medicaid program for the State of California.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medi-Cal enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this *Member Handbook* for more information.

Medi-Medi Plan: A Medi-Medi Plan is a type of Medicare Advantage plan. It's for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services.

Member (member of our plan, or plan member): A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Nursing home or facility: A facility that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information in **Chapters 2 and 9** of this *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of this *Member Handbook* explains coverage decisions.

Original Biological Product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this *Member Handbook* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to Chapter 3 of this Member Handbook for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the List of Covered Drugs and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) or our approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. Refer to **Chapter 4** of this *Member Handbook* to learn more about rehabilitation services.

Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who 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, a member will need a referral from their PCP to go to a specialist.

Specialized pharmacy: Refer to **Chapter 5** of this *Member Handbook* to learn more about specialized pharmacies.

State Hearing: If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to get services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

Kern Family Health Care Medicare (HMO D-SNP) Member Services

CALL	1-866-661-3767 Calls to this number are free. 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8:00 am to 8:00 pm (PST), 7 days a week from October 1 – March 31, and Monday through Friday from April 1 – September 30.
WRITE	Kern Family Health Care Medicare (HMO D-SNP) PO Box 9187 Bakersfield, CA 93389-9187
WEBSITE	https://www.kernfamilyhealthcare.com

Kern Family Health Care Medicare (HMO D-SNP)

2900 Buck Owens Blvd.
Bakersfield, CA 93308

Toll Free: **1 (866) 661-3767**
Local Number: **(661) 716-5342**

www.kernfamilyhealthcare.com