IMPORTANT LANGUAGE INFORMATION: You can get an interpreter at no cost to help you talk to your doctor or to Kern Family Health Care. To get an interpreter or to ask about written information in your language, please call Kern Family Health Care at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). Hearing or speech impaired members can call 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) through the TDD/TTY line at 711. If you need more help, call the HMO Help Line at 1-888-466-2219.

INFORMACIÓN IMPORTANTE DE LENGUAJE: Usted puede obtener ayuda de un intérprete sin ningún costo para hablar con su médico o con Kern Family Health Care. Para obtener ayuda de un intérprete, o para preguntar sobre información escrita en español, por favor llame a Kern Family Health Care al 661-632-1590 (Bakersfield) o 1-800-391-2000 (fuera de Bakersfield). Los miembros con problemas auditivos pueden llamar al 661-632-1590 (Bakersfield) o 1-800-391-2000 (fuera de Bakersfield) por medio de la línea TDD/TTY al 711. Si necesita ayuda adicional, llame al Centro de Ayuda del HMO al 1-888-466-2219.
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Introduction

Using This Handbook
This Member Handbook contains information about Kern Family Health Care (KFHC) benefits, how to get benefits, and rights and responsibilities of members. Please read this handbook carefully.

This Member Handbook is only a summary of the health plan. The Medi-Cal agreement between KFHC and the State of California contains the exact terms and conditions of coverage. You may review the agreement at KFHC.

Welcome! About the Health Plan
We are happy to serve your health needs. Here are three steps to get you started using KFHC services.

• **Step One** – Choose a Primary Care Provider (PCP): See “Choosing a Primary Care Provider” on page 4 for information on how to choose a PCP.

• **Step Two** – Call your PCP and make an appointment for a complete physical exam. You do not have to be sick to make an appointment for this exam. See “Initial Health Exam” on page 5 for more information. We can assist you with making your appointment. Please contact Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

• **Step Three** – Read this handbook. There are helpful tips in it about how to get health care. If you have questions, call us at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). We are happy to help.

KFHC’s office is located in Bakersfield at 5701 Truxtun Avenue, Suite 201, Bakersfield, CA 93309. Please feel free to come during regular business hours, Monday through Friday, 8:00 am to 5:00 pm to talk to one of our Member Services Representatives.

Important Phone Numbers
If you can’t reach your Primary Care Provider (PCP), call our 24-Hour Advice Nurse at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). KFHC Member Services: 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

KFHC Website, Facebook and Twitter
You can get more information about KFHC or contact us by using our website: [www.kernfamilyhealthcare.com](http://www.kernfamilyhealthcare.com). You can also “like” KFHC on Facebook at: [www.facebook.com/KernFamilyHealthCare](http://www.facebook.com/KernFamilyHealthCare) or follow us on Twitter at: [www.twitter.com/_KFHC](http://www.twitter.com/_KFHC). We post current health care news and tips to help you and your family stay healthy. You can also get important member updates and see what KFHC is doing in your community.

Interpreter Services
If you or your representative prefer to speak a language other than English, call us at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) to speak with a KFHC Member Services Representative (TDD/TTY for the hearing impaired at 711). KFHC and its participating providers have many ways to talk with you including:

- Bilingual staff (English and Spanish)
- Phone interpreters who speak more than 150 languages
- Sign language interpreters
- After hours interpreting services provided by participating providers and urgent care providers

Read your KFHC Provider Directory about the languages spoken by participating providers and their staff. Our Member Services staff can help you find a participating provider who speaks your language or who has an interpreter. You do not have to use family members or friends as interpreters. If you cannot find a health care provider who meets your language needs, you can ask to have an interpreter available for discussions of medical information at no charge. Call us before your visit if you need us to arrange an interpreter.

This handbook and other plan materials have been translated into Spanish. To request translated materials, please call KFHC Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) (TDD/TTY for the hearing impaired at 711).

If your language needs are not met by KFHC or our participating providers, you have the right to file a grievance. For information on filing a grievance, see “Grievance Process” on page 26.

Member Identification Card
All members are given a member identification (ID) card. The card contains important information about your medical benefits. You will get your member ID card in the mail within seven days of becoming a member. If you have not received or if you have lost your member ID card, please call us at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) (TDD/TTY for the hearing impaired at 711) and we will send you a new card. Please show your member ID card to your provider when you get medical care or pick up medicine at the pharmacy. You will need to show a picture ID along with your member ID card to the provider. Minors are exempt.

Be sure that the information on your member ID card is right. If it is not, call us. We will correct the error and send you a new card.

Only members are allowed to get medical services using their member ID card. If a card is used by or
for someone else, that person will be billed for the services he or she receives. If you let someone else use your member ID card, KFHC may not be able to keep you in our plan.

Using the Health Plan

To be covered under this health plan, services must be medically necessary, arranged by your KFHC participating primary care provider (PCP), and provided by KFHC participating providers, except:

- Emergency care
- Family planning services
- Sexually transmitted disease treatment
- HIV testing and counseling services
- Females may self-refer to a participating OB/GYN for obstetrical and gynecological physician services.

Certain covered services require prior authorization of coverage by KFHC in order to be covered. Participating providers have a list of services that require prior authorization of coverage. Failure to obtain prior authorization of coverage may result in denial of coverage. You may obtain a copy of the process KFHC uses to authorize services by contacting Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

There are some “carve out” services that are not covered under this health plan, but are covered by the Medi-Cal Fee-For-Service Program or other State program. This health plan will assist you in obtaining these services through the right State program. For example, if your child has a serious medical condition, he or she may be eligible for services under the California Children’s Services (CCS) Program. This health plan or your child’s PCP will refer your child to the CCS Program. Read the “Getting Services that are not Available from KFHC (carve out services)” section on page 19 for more information.

If you have a life threatening emergency, call “911” for help or go immediately to the closest emergency room.

Choosing a Primary Care Provider (PCP)

Your PCP coordinates your health care under this health plan. If you do not choose an available PCP within the first 30 days of enrollment, KFHC will choose for you. If you do not like our choice, you may change your PCP as described in “Changing your Primary Care Provider” on page 5.

The KFHC Provider Directory includes a list of participating PCPs. Included are physicians, nurse practitioners, nurse midwives, physician assistants and Federally Qualified Health Clinics (FQHCs). Decide which provider you want as your PCP. If you choose a PCP that is not a physician (for example a nurse practitioner), your care will still be under the direction of your PCP’s supervising physician. Here are some questions you may want to think about when making your choice. Is the PCP close to your home, work or school? Is he or she easy to get to by bus? Does he or she speak your language?

After you have chosen a PCP, or if you need help making a choice, call KFHC Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). A Member Services Representative will note your choice and begin the process of assigning you to that PCP.

There are some limitations on who you can choose as your PCP. You must:

- Choose a participating PCP. Refer to the KFHC Provider Directory or the KFHC website for the listing of PCPs available to you. One exception to this is that you may choose a non-participating Indian Health Service Center as your PCP if you are a Native AmericanIndian. Another exception to this is for People with Disabilities or Seniors, you may request to receive primary care services from a non-contracted PCP for up to one year (12 months from date of enrollment). Please see “Continuity of Care for New Members” on page 5.
- Choose a PCP that is accepting new patients
- Choose a PCP that serves your age and sex. For example, only females may choose an obstetrician/gynecologist as their PCP.

If we cannot assign you to the PCP of your choice, we will let you know. We will help you make another choice.
Scheduling Appointments
You may call the provider’s office directly and make an appointment with any of the following types of providers:

- Your PCP
- An Indian Health Service Center in Kern County if you are an American Indian
- A participating Obstetrician/Gynecologist
- A participating nurse midwife
- Any family planning provider for family planning services (see page 14 for a list of services you can receive from any family planning provider without a referral).

The phone number for your PCP’s office is in the KFHC Provider Directory. If you cannot keep an appointment, call the provider’s office right away to reschedule.

Follow your PCP’s or KFHC’s instructions for making appointments with other types of providers. In most cases you will need to have approval before making an appointment with participating specialists.

Getting Care if You Are a Minor (Minor Consent Services)
Members under the age of 18 may get certain services without the permission of their parent or guardian. These include services for:

- Sexual assault, including rape (members may get these services from an emergency room, participating PCPs and Obstetrician/Gynecologists, Local Health Department Clinics, or family planning clinics. You do not need KFHC prior authorization of coverage to receive these services)
- Drug or alcohol abuse for members 12 years of age or older (see “Substance Use Disorder” on page 20)
- Pregnancy (see “Maternity Care” on page 14)
- Family planning (see “Family Planning Services” on page 14)
- Sexually transmitted diseases for members 12 years of age or older (see “Sexually Transmitted Disease (STD) Treatment” on page 15)
- Outpatient mental health care for members 12 years of age or older who are in danger of serious physical or mental harm, who may cause serious physical or mental harm, or who are victims of incest or child abuse. The mental health provider will decide if the member is mature enough to participate. (see “Specialty Mental Health Services” on page 20)

Read about this type of care on the pages listed above and follow the instructions. If you need help with getting care or scheduling an appointment, call us.

Initial Health Exam
All new members should see their PCP for an initial health assessment (IHA). The first meeting with your PCP is important. It’s a time to get to know each other and review your health status. Your PCP will help you understand your medical needs and advise you about staying healthy. You should see your PCP for an IHA within 120 days of becoming a member. Children under 18 months should see their PCP within 60 days of becoming a member. Call your PCP’s office for an appointment. You may also call Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) for help making your appointment for an IHA.

Changing Your Primary Care Provider (PCP)
You may ask to change your PCP by calling KFHC Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). Requests made by the 24th of the month will be effective the first day of the following month. Requests made after the 24th of the month will be effective the first day of the second month following the request.

KFHC will change your PCP if your PCP stops participating with KFHC or if your PCP lets us know that he or she is no longer willing to be your PCP. A PCP may ask that he or she no longer serve as a member’s PCP for many reasons including:

- The member misses appointments
- The member does not follow the care plan
- The member is disruptive during an office visit

If we need to change your PCP, we will let you know. At that time, we will give you instructions on how to choose a new PCP.

Continuity of Care for New Members
A member may request coverage for continued care from a provider, including a hospital, who does not contract with KFHC if, at the time of enrollment with KFHC, the member was receiving care from the provider for one of the following conditions:

- An acute condition, for as long as the condition lasts
- A serious chronic condition, for a period of time necessary to finish a course of treatment and to arrange for a safe transfer to a participating doctor. (not to exceed 12 months from enrollment)
- A pregnancy, during the pregnancy and immediate postpartum period
- A terminal illness, for as long as the illness lasts
- The care of a newborn child between birth and
Continuity of Care for Termination of Provider

If your PCP or other health care provider stops contracting with KFHC, we will let you know by mail 60 days before the contract termination date.

KFHC will cover continuity of care for covered services rendered to you by a provider whose contract has terminated if you were receiving this care from the provider before termination and you have one of the following conditions:

- An acute condition, for as long as the condition lasts
- A serious chronic condition, for a period of time necessary to finish a course of treatment and to arrange for a safe transfer to a new participating doctor. (not to exceed 12 months)
- A pregnancy, during the pregnancy and the immediate postpartum period
- A terminal illness, for as long as the illness lasts.

The care of a newborn child between birth and age 36 months. (not to exceed 12 months)

The care of People with Disabilities or Seniors. (Maximum time 12 months from enrollment)

A surgery or other procedure that KFHC had approved as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider’s contract termination date.

Continuity of care will not apply to providers whose contracts have terminated due to medical disciplinary cause or reason, fraud or criminal activity.

The terminated provider must agree in writing to provide services to you in accordance with the terms, conditions and payment rates of his or her agreement with KFHC prior to termination. If the provider does not so agree, we do not have to cover the provider’s services beyond the contract termination date.

KFHC will not pay for services you get from a terminated provider if you do not contact us and allow us to make the necessary arrangements with the provider.

We will make a decision on the request in a timely manner appropriate for the nature of the medical condition. We will notify you of the decision in writing within five business days of the decision.

Please call us at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) to ask for continuing care coverage or to get our Continuity of Care policy.

Prior Authorization of Coverage

Your PCP will coordinate your health care needs and arrange medically necessary specialty services for you. In some cases, KFHC must approve coverage of the specialty services before you get the services. Your PCP will get the necessary referrals and approvals. Some specialty services, such as OB/GYN services, do not need prior authorization of coverage from KFHC before you get the services.

We will make a decision regarding your doctor’s request in a timely fashion appropriate for the nature of your condition, within five business days (or 72 hours if the request is urgent) of receipt of the request and all necessary information.

If you see a specialist or get specialty services before you get prior authorization of coverage from KFHC,
you will have to pay for the services. If KFHC denies a request for coverage of specialty services, KFHC will send you a letter explaining the reason for the denial of coverage. The letter will let you know how you can file a grievance if you do not agree with the denial. You can ask for the guidelines we used to make our decision by calling Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

Referrals to Specialty Physicians
Your PCP is responsible for the coordination of all your covered services. Your PCP will arrange for medically necessary lab tests, x-rays, referrals to participating specialists, hospitalization and any other covered services. To get these services, your PCP will make a referral authorizing the services when medically necessary. Your PCP will choose a participating specialist physician, participating hospital, or other participating provider from whom you may receive services. KFHC will make a coverage decision about your doctor’s referral request in a timely fashion appropriate for the nature of your condition, within five business days (or 72 hours if the request is urgent) of receipt of the request and all necessary information. The referral will indicate how many times you may see the specialist and the approved course of treatment.

For a list of participating specialists, including those who have expertise involving a complicated treatment regimen, call Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) (TDD/TTY for the hearing impaired at 711).

If there is no participating provider available to perform a medically necessary covered service, your PCP will refer you to a non-participating provider for the services, after getting prior authorization of coverage from KFHC.

In order to be covered, referrals to specialists must be made by your PCP. Services which do not require referral by your PCP are:
• Emergency care
• Sexually transmitted disease treatment
• Family planning services
• HIV testing and counseling
• Nurse midwife services
• Services from Indian Health Service Centers for Native Americans
• Obstetrical and gynecological services from an OB/GYN for female members

Standing Referrals
If you have a condition or disease that needs specialized medical care over a long period of time, you may need a standing referral to a specialist in order to get continuing specialized care. If you get a standing referral to a specialist, you will not need to get approval every time you see that specialist. If your condition or disease is life threatening, degenerative or disabling, you may need to receive a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease. To get a standing referral, call your PCP or specialist.

Obtaining a Second Opinion
You may have questions about your illness or your PCP’s recommended treatment plan. You may want to get a second opinion. You may ask for a second opinion when:
• You want to know if a surgery is wise or needed
• You question a diagnosis or plan of care for a serious illness. Serious illnesses are ones that can lead to death, disability, loss of limb, or loss of bodily function.
• Your provider cannot tell what your condition is because the signs of illness are not clear, hard to understand, or confusing
• Your provider cannot tell what your illness is because of a conflict in test results
• Your illness is not better after trying a treatment for a medically appropriate period. You may want to know if your diagnosis is right. You may want to know if you should continue the treatment.
• You have tried the plan of care and want the advice of another provider because you are concerned about your plan of care and diagnosis.

Talk to your PCP if you want a second opinion. After you or your PCP has asked us if you can get a second opinion, we will approve or deny your request quickly. If your medical condition poses an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function or if a delay would be detrimental to your ability to regain maximum function, your request for a second opinion will be processed within 72 hours after KFHC receives your request.

If you want a second opinion from a specialist, KFHC and your PCP will help you choose the specialist. The specialist must be a participating specialist, unless a qualified participating specialist is not available. If a participating specialist is not available, we will arrange for you to see a non-participating specialist.

Utilization Review
Some services need prior authorization of coverage
information, see “Grievance Process” on page 26.

Brand Name and Generic Drugs
If a drug is available in generic form, the brand name version of that drug will not be on the formulary. If a generic becomes available for a brand name drug during your treatment, you must change to the generic in order for it to be covered by KFHC. Your doctor may ask for prior authorization of coverage from KFHC for a brand name drug. You must fail a trial of the generic drug before prior authorization of coverage of the brand name will be considered. We will make an exception to this rule if your provider sends us a request, and we decide that it is medically necessary for you to have the brand name drug without trying the generic drug first.

Emergency Refills
During weekends, holidays and non-business hours, a pharmacy may give you enough drugs (72 hour supply maximum) to last until the next working day. Prior authorization of coverage is not needed.

Discontinued Drugs
If a drug you are taking is removed from the formulary, your doctor can ask that KFHC approve coverage of your continued use of the drug. KFHC will deny coverage of a drug that was previously prescribed by a participating physician and is continuing to be prescribed for a medical condition even though it is not included in the current formulary.

Formulary Development
A special KFHC committee decides which drugs are included on the KFHC formulary. The committee uses medical criteria to make the decision. The criteria include therapeutic efficacy, cost effectiveness, safety, community standard of care, prior utilization patterns and specific requests. The committee is made up of participating physicians, participating pharmacists, and KFHC employees. This committee meets once a quarter. A list of formulary drugs is printed once a year. Call Member Services if you would like for us to mail you our formulary.

Getting After Hours Care
Urgent care and emergency care is available 24 hours a day. Find out how to get urgent care by reading “Getting Urgent Care” on page 9. Find out how to get emergency care by reading “Getting Emergency Care” on page 9. If your medical need is not urgent or an emergency, you should wait until regular business hours to get care by your PCP. If you are not sure what to do, please call our 24-hour Advice Nurse at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).
Getting Urgent Care

Urgent care is services that are medically necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, prolonged pain, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent medical problems are not the same as emergencies. See “Getting Emergency Care” on page 9 for information on what qualifies as an emergency and what you should do if you need emergency care.

KFHC covers urgent care when you are outside Kern County, or when you are inside Kern County and your PCP does not have an available appointment within the next 48 hours. To be covered, the urgent care must be needed because the illness or injury will become much more serious if you wait for a regular doctor’s appointment. Talk to your PCP about what he or she wants you to do when the office is closed and you feel urgent care may be needed.

If you think you need urgent care when you are inside Kern County, we encourage you to call your PCP for advice. If you can’t reach your PCP, you can also call our 24-Hour Advice Nurse at 661-632-1590 (Bakersfield), or 1-800-391-2000 (outside of Bakersfield) for medical advice. Prior approval for an Urgent Care visit is no longer required. If your PCP does not have an available appointment within the next 48 hours, please go to the nearest participating urgent care provider unless KFHC tells you that you may go to a non-participating provider.

If you think you need urgent care when you are outside Kern County, we encourage you to call your PCP for advice. If you can’t reach your PCP, you can also call our 24-Hour Advice Nurse at 661-632-1590 (Bakersfield), or 1-800-391-2000 (outside of Bakersfield) for medical advice. When you are outside Kern County, you may receive urgent care from a non-participating urgent care provider.

KFHC does not cover urgent care provided outside of the United States.

Getting Emergency Care

An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the member’s health in serious jeopardy (or, in the case of a pregnant woman, the health of the woman or her unborn child)
- Causing serious impairment to the member’s bodily functions
- Causing serious dysfunction of any of the member’s bodily organs or parts

Examples include:

- Broken bones
- Chest pain
- Severe burns
- Fainting
- Drug overdose
- Paralysis
- Severe cuts that won’t stop bleeding
- Psychiatric emergency conditions (a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder)

If you have a medical emergency, call 911 or go to the nearest emergency room.

Outpatient emergency care is covered without prior authorization of coverage if it is provided in the United States. Emergency care requiring hospitalization is covered without prior authorization of coverage if it is provided in the United States, Canada or Mexico. Emergency care provided in any other country, or while at sea is not covered. You can get emergency care from participating or non-participating providers.

Call KFHC Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) within 48 hours after receiving emergency care. If you can’t do this, call as soon as you can.

What to Do If You Are Not Sure If You Have an Emergency

If you are not sure whether you have an emergency or require urgent care call your PCP or call KFHC’s 24-Hour Advice Nurse at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

Post-Stabilization Care

Once the emergency condition has been stabilized or it has been decided that an emergency condition does not exist, prior authorization of coverage from KFHC is required for any more services. Care in a hospital after the member’s emergency condition has stabilized is called “post-stabilization” care.

Follow-up Care

After receiving emergency or urgent care, you need to call your PCP for follow-up care.
Non-Covered Services
Kern Family Health Care (KFHC) does not cover medical services that are received in an emergency or urgent care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or urgent care situation did not exist. You will have to pay for these services.

Benefits
Benefits under this health plan are limited to those services and supplies covered under the Medi-Cal Program that are described in KFHC’s Medi-Cal contract with DHCS as being KFHC’s coverage responsibility. Please read the “Exclusions and Limitations” section of this handbook and within each benefit description for a description of exclusions and limitations of coverage.

Inpatient Hospital Services
Non-emergency care needs prior authorization of coverage from KFHC. Non-emergency care must be performed by a participating provider in a participating facility.

If you have a mastectomy, your doctor will talk to you and help you decide how long you stay in the hospital. KFHC does not need to prior authorize coverage for the number of days you stay in the hospital after the mastectomy.

The following services and items are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:

- Hospital services in a room of two or more persons
- Meals, including medically necessary special diets
- Nursing care
- Use of operating room
- Intensive care unit
- Drugs
- Blood and blood products
- Anesthesia and oxygen
- Diagnostic, lab and x-ray services
- Physical, occupational and speech therapy
- Respiratory therapy
- Diagnostic, therapeutic and rehabilitative services

Exclusions:
- Personal or comfort items
- Private room unless medically necessary
- Services of dentists or oral surgeons for dental procedures

Outpatient Hospital Services
Non-emergency care needs prior authorization of coverage from KFHC. Non-emergency care must be performed by a participating provider in a participating facility.

The following outpatient hospital services and items are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:

- Diagnostic, therapeutic and surgical services
- Physical, speech, and occupational therapy
- Services and supplies in connection with outpatient services including operating room, treatment room, ancillary services and medications

KFHC will cover general anesthesia and related facility charges in connection with dental procedures when the use of a hospital or surgery center is required because of your medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to members under seven years of age, the developmentally disabled of any age, and members of any age whose health is compromised and general anesthesia is medically necessary. KFHC will coordinate services with your dental plan.

Exclusions:
- Services of dentists or oral surgeons for dental procedures are not covered. This exclusion does not apply to medical services that are medically necessary.

Professional Services
Except as stated below, professional services need prior authorization of coverage from KFHC and must be performed by a participating provider in a participating facility in order to be covered. The following services do not need prior authorization of coverage from KFHC:

- Emergency care
- Urgent care
- Services of your PCP
- Preventive care
- Maternity care services
- Family planning services
- Abortion services
- Sexually transmitted disease treatment
- HIV/AIDS testing and counseling
- Services performed at an Indian Health Service Center

The following services are covered when they are medically necessary and meet KFHC authorization requirements.
of coverage and utilization review requirements:

- Professional services and consultations by a physician or other licensed provider
- Surgery, assistant surgery and anesthesia (inpatient or outpatient)
- Mastectomies and care for any resulting complications
- Office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy and dialysis treatment
- Audiology services to measure the extent of hearing loss and an evaluation to determine the make and model of hearing aid
- Hearing aids: Monaural or binaural hearing aids including ear molds, the initial battery, cords and other ancillary equipment
- Hearing aid batteries on a quarterly basis for hearing aids covered under the EPSDT (Early Periodic Screening, Diagnosis and Treatment) Program for children
- Podiatry services

Limitations:
- Replacement hearing aids are covered only if the prior hearing aid has been lost, stolen or significantly damaged due to circumstances beyond your control
- Replacement hearing aids are covered when the prior hearing aid no longer meets your medical need

Exclusions:
- Purchase of batteries (except those covered under the EPSDT Program for children) or other ancillary equipment, except those covered under the initial hearing aid purchase, and charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss
- Surgically implanted hearing devices
- Routine nail trimming

Preventive Health Services

Preventive health services do not need prior authorization of coverage from KFHC. These services must be performed by a participating provider. Immunizations must be performed by a participating provider or the Kern County Department of Public Health.

- Checkups for adults
- Checkups and preventive services for children as recommended by the American Academy of Pediatrics and/or the Childhood Disability Prevention Program
- EPSDT Services and EPSDT Supplemental Services for children
- Immunizations

- Well-baby care during the first two years of life, including newborn hospital visits, health exams and blood lead screening
- Vision and hearing screening by your PCP
- Fluoride varnish for members under six years old when provided by the member’s PCP. They can also get this treatment from their Denti-Cal dentist and it is covered by Denti-Cal.
- Sexually transmitted disease (STD) testing
- Cytology exams on a reasonable periodic basis
- Yearly pelvic exam, Pap smear and breast exam, and other gynecological services from a participating nurse midwife, your PCP or participating OB/GYN provider (PCP approval not required)
- Cancer screening tests including breast, prostate, colorectal and cervical cancer screening
- HPV Series vaccines for females aged 9 to 26 and males aged 9 to 18
- Health education services, including education about personal health behavior and health care
- Complete health assessments will be covered before the next regularly scheduled physical examination is due when the following situation exist:
  - There is a need for a sports camp physical examination
  - The individual is in foster care or out-of-home placement
  - There is a need for a school or preschool entrance examination
  - There is a need for providing additional anticipatory guidance to the individual or the parent or legal guardian
  - There is a history of perinatal problems
  - There is evidence of significant developmental disability

Exclusions:
- Immunizations required for travel or as a requirement of employment are not covered
- You cannot get exams for non-medical needs. Here are some examples of non-medical needs:
  - Getting or keeping a job
  - Getting a license
  - Getting insurance

Diagnostic X-Ray, Imaging and Lab Services

Some imaging and lab services need prior authorization of coverage from KFHC. These services must be performed by a participating provider in a participating facility.

The following services and items are covered when they are medically necessary and meet KFHC prior
authorization of coverage and utilization review requirements:
• Diagnostic lab, imaging and therapeutic radiological services
• Lab tests including those for the management of diabetes

Diabetic Care
Some diabetic services need prior authorization of coverage from KFHC. These services must be performed by a participating provider in a participating facility.

KFHC covers equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes.

The following items are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:
• Blood glucose monitors and blood glucose testing strips
• Insulin pumps and supplies
• Ketone urine testing strips
• Lancets and lancet puncture devices
• Pen delivery systems for the administration of insulin
• Podiatric services to prevent or treat diabetes-related complications
• Insulin syringes and needles
• Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
• Insulin
• Drugs for diabetes
• Outpatient self-management training, education and medical nutrition therapy.

Prescription Drugs
Formulary drugs do not need prior authorization of coverage from KFHC. The following drugs need prior authorization of coverage from KFHC:
• Non-formulary drugs
• Replacement of stolen or lost drugs

Most drugs must be prescribed by a participating provider. KFHC will cover the following drugs when they are prescribed by a non-participating provider:
• Emergency contraception. You may receive emergency contraception from any provider or pharmacist who has met the State’s requirements to provide emergency contraception.
• Covered drugs prescribed by your dentist
• Some mental health drugs prescribed by your mental health provider

With the exception of emergency contraception, drugs must be dispensed by a participating pharmacy in order to be covered.

Prescription drugs are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements. Covered drugs include:
• Injectable drugs, needles and syringes needed to administer the injectable drug
• Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin
• Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes
• Disposable devices for administration of covered drugs, such as spacers and inhalers for aerosol drugs and syringes for self-injectable outpatient drugs. The term “disposable” includes devices that may be used more than once
• Prenatal vitamins and fluoride supplements
• Drugs used while a member is a patient in a nursing home or similar facility when prescribed by a participating physician for a covered service and obtained through a participating pharmacy
• Oral and injectable contraceptive drugs, pills, devices, creams, foams, jellies, supplies, prescription contraceptive devices, emergency contraception drug therapy and internally implanted time-release contraceptives

Exclusions:
• Drugs prescribed solely for cosmetic purposes
• Drugs not requiring a written prescription
• Dietary supplements (except for formulas or special food products, when medically necessary, including for phenylketonuria), appetite suppressants or other diet drugs, unless medically necessary for morbid obesity
• Replacement of stolen or lost controlled drugs
• Most psychotherapeutic drugs
• Most drugs for the treatment of HIV or AIDS. These drugs are covered by the Medi-Cal Program.
• Most drugs for the treatment of substance abuse. Some of these drugs are covered by the Medi-Cal Program.
• Experimental or investigational drugs. If KFHC denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please
refer to KFHC’s Grievance and Appeals Process on page 26.

Durable Medical Equipment

Durable medical equipment needs prior authorization for coverage from KFHC. It must be ordered by your PCP or a participating provider and supplied by a participating provider.

Durable medical equipment is covered when the items are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements. It is medical equipment appropriate for use mostly in the home which

1. Is primarily used for a medical purpose,
2. Is intended for repeated use, and
3. Is generally not useful to a person in the absence of illness or injury

KFHC may decide whether to rent or purchase standard equipment. Repair or replacement is covered unless caused by misuse or loss. Durable medical equipment includes:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes
- Insulin pumps and supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Apnea monitors
- Podiatric devices to prevent or treat diabetes complications
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, related supplies, spacer devices for metered dose inhalers, and peak flow meters
- Wheelchairs and scooters
- Breast pumps and breast pump kits

Exclusions:

- Modification of automobiles or other vehicles
- Books or other educational items
- Air conditioners, air filters or heaters
- Food blenders
- Reading lamps or other lighting devices
- Bicycles, tricycles or exercise equipment
- Television sets
- Orthopedic mattresses, recliners, rockers, seat lift chairs and other furniture items
- Waterbeds
- Household items
- Other items not generally used primarily for health care and which are used by persons who do not have a specific medical need.

Medical Supplies

Medical supplies are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements. They must be ordered by your PCP or approved participating provider. They must be supplied by a participating provider. Covered medical supplies include:

- Ostomy bags and urinary catheters and supplies
- Incontinence supplies, such as diapers and pads
- Incontinence creams and washes
- Supplies for the treatment of diabetes as described under “Diabetic Care” on page 12
- Contraceptive supplies as described under “Prescription Drugs” on page 12
- Supplies related to covered skilled nursing care as described under “Skilled Nursing Care” on page 16
- Hospice supplies as described under “Hospice” on page 18
- Supplies related to covered outpatient hospital services as described under “Outpatient Hospital Services” on page 10

Orthotics and Prosthetics

Orthotics and prosthetics need prior authorization of coverage from KFHC. They must be prescribed by a participating provider and dispensed by a participating provider.

Orthotics and prosthetics are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements. Covered orthotics and prosthetics include:

- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetics
- Orthopedic shoes and one-sided orthotic heel lift/arch supports when at least one of the shoes will be attached to a prosthesis or brace
- Prosthetic devices to restore and achieve symmetry incident to mastectomy
- Repairs are covered unless caused by misuse or loss
- KFHC may replace or repair an item

Exclusions:

- Shoe inserts and arch supports, except for therapeutic footwear and inserts for individuals with diabetes
- Non-rigid devices, such as elastic knee supports, corsets, elastic stockings and garter belts
- Dental appliances
• More than one device for the same part of the body

Eye Exams by Optometrist and Eyeglasses
KFHC contracts with Vision Service Plan (VSP) for the management and administration of optometric needs of Medi-Cal members. If you have any questions for VSP, please call 1-800-877-7195.

A yearly routine screening is available through the member’s PCP.

Eye exams for glasses are covered every other year (once in 24 months) if the services are performed by a participating eye-doctor. To choose an eye doctor, look in the Vision Care section of our Provider Directory.

Eyeglasses do not need prior authorization of coverage from KFHC. Replacement eyeglasses need prior authorization of coverage from KFHC. All other eye appliances also need prior authorization for coverage from KFHC. Eyeglasses and other eye appliances must be prescribed and dispensed by a participating provider.

The following items are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:
• Replacement eyeglasses
• Contact lenses if your doctor decides that you can’t wear eyeglasses
• Low vision optical aids, but not electronic devices

Limitations:
Replacement eyewear is covered only if the prior eyewear has been lost, stolen or significantly damaged due to circumstances beyond your control. Eyewear to supplement existing eyewear, regardless of the source of the existing eyewear is limited to the following:
• Two pairs of single vision glasses, one for distance vision and one for near vision, in lieu of multifocal eyeglasses when there are indications that multifocal lenses cannot be worn
• Low vision aids, including single vision eyeglasses prescribed as a low vision aid
• Ptosis crutches, occluders, bandage contact lenses, prosthetic eyes and prosthetic scleral shells
• Overcorrection single vision or bifocal eyeglasses for concurrent use with contact lenses
• Eyeglasses for alternative use by a person who is able to wear contact lenses are not covered
• Contact lenses are not covered after a member has been provided eyeglasses

Exclusions:
• Eyeglasses used primarily for protective, cosmetic, occupational or vocational purposes
• Eyeglasses prescribed for other than the correction of refractive errors or binocularity anomalies
• Double segment bifocal or no-line multifocal lenses
• Multifocal contact lenses

Maternity Care
Maternity care does not need prior authorization of coverage from KFHC. Non-emergency maternity care must be performed by a participating provider in a participating facility.

The following services are covered when they are medically necessary and meet KFHC utilization review requirements:
• Prenatal and postpartum care, including complications of pregnancy
• Newborn exams and nursery care while the mother is hospitalized
• Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy
• Counseling for nutrition, health education and social support needs
• Labor and delivery care, including midwifery services

Inpatient hospital care will be covered for 48 hours following a normal vaginal delivery and 96 hours following delivery by cesarean section, unless an extended stay is approved by KFHC. You do not need specific approval to stay in the hospital 48 hours after a vaginal delivery or 96 hours after a C-section. You may remain in the hospital for these time periods unless you and your doctor decide otherwise. If, after talking with you, your doctor decides to discharge you before the 48- or 96-hour time period, KFHC will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by your doctor. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor’s office depending on what is best for you.

Family Planning Services
Family planning services do not require prior authorization of coverage from KFHC. Our participating PCPs and OB/GYNs are available for family planning services. You may also get these...
services from non-participating providers. You can call the State Office of Family Planning at 1-800-942-1054 for help finding non-participating family planning providers.

Family planning services are covered for members of childbearing age to enable them to determine the number and spacing of children. These services include birth control methods approved by the FDA. Voluntary family planning services are covered, including:

- Health education and counseling to help you make informed choices and understand contraceptive methods
- A limited history and physical exam
- Lab tests that are medically necessary to decide which contraceptive method you should use
- Follow-up care for complications from a contraceptive
- Tubal ligations and vasectomies
- Contraceptive pills, devices, creams, foams, jellies and supplies
- Pregnancy testing and counseling

Exclusions:

- Hysterectomy performed solely or primarily for the purpose of making a woman permanently sterile. A hysterectomy will be covered if it is determined to be medically necessary.
- Routine infertility studies or procedures
- Reversal of voluntary sterilization

Note: Some hospitals and other providers do not provide one or more of the following services: family planning, contraceptive services, sterilization, tubal ligation at the time of labor and delivery, infertility treatment or abortion. Call your provider to learn if they provide the family planning services that you want.

Abortion

KFHC covers abortions. You do not need the permission of your parents or guardian to get an abortion. You may obtain outpatient abortion services from a participating provider or from a qualified non-participating provider. If you need help finding someone to perform the abortion, you may call Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). You can also call the State Office of Family Planning at 1-800-942-1054 for nearby family planning clinics.

Sexually Transmitted Disease (STD) Treatment

STD treatment does not require prior authorization of coverage from KFHC. STD treatment is available from the following providers:

- Participating PCPs and Obstetrician/Gynecologists
- Local Health Department Clinics
- Family Planning Clinics
- Non-participating community STD treatment providers. But you can only see this type of provider once for each STD episode. You will have to go to a participating provider, local health department clinic or family planning clinic for any follow-up care.

The following services are covered when medically necessary:

- STD testing and diagnosis
- STD treatment

HIV/AIDS Testing and Counseling

HIV/AIDS testing and counseling do not require prior authorization of coverage from KFHC. They are covered when provided by:

- Participating PCPs and Obstetrician/Gynecologists
- Local Health Department Clinics
- Family Planning Clinics

Medical Transportation Services

Emergency medical transportation does not require prior authorization of coverage from KFHC. Emergency medical transportation may be provided by any licensed emergency medical transportation provider. Non-emergency medical transportation needs prior authorization of coverage from KFHC. Non-emergency medical transportation must be provided by a participating provider.

Emergency ambulance transportation to the nearest hospital for emergency care is covered.

Non-emergency medical transportation for the transfer of a member from a hospital to another hospital or facility, or facility to home is covered when:

- Medically necessary, and
- Requested by a participating provider, and
- Authorized in advance by KFHC

Exclusions:

- Transport by public airplane, car, taxi or any other non-medical form is not covered
- KFHC will not cover ambulance services if the member did not reasonably believe that (1) an emergency medical condition existed, and (2) the condition required ambulance transport services

Non-Medical Transportation Services

Non-medical transportation is not a covered benefit. Non-medical transportation assistance is provided for
medical appointments. Many providers’ offices are linked to Golden Empire Transit (GET) bus service. In many cases, you can ride a bus to your provider’s office. Call GET at (661) 869-2438 for a schedule and routes. For service outside of Bakersfield, call Kern Regional Transit at 1-800-560-1733. KFHC provides free GET and Kern Regional Transit passes for medical appointments. If you qualify for GET-A-Lift, KFHC provides free Get-A-Lift passes for medical appointments. If you are referred to some tertiary facilities outside of Kern County for specialty services, KFHC also provides free Greyhound bus passes. Please call Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

Emergency Care
Emergency care does not need prior authorization of coverage from KFHC. Emergency care may be provided by participating or non-participating providers. Emergency care is covered if it is provided in the United States. Emergency care requiring hospitalization is covered if it is provided in Canada or Mexico. Emergency care provided in any other country, or while at sea is not covered.

Treatment of an emergency medical condition is available on a 24-hour basis. An emergency medical condition is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the member’s health in serious jeopardy (or, in case of a pregnant woman, the health of the woman or her unborn child)
- Causing serious impairment to the member’s bodily functions
- Causing serious dysfunction of any of the member’s bodily organs or parts

Home Health Care
Home health care needs prior authorization of coverage from KFHC. Home health care must be prescribed and provided by a participating provider.

The following services are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:

- Visits by RNs, LVNs and home health aides
- Physical therapy and occupational therapy
- Speech therapy
- Respiratory therapy
- Medical social services
- Medical supplies (other than drugs and biologicals) and the use of approved medical appliances

Limitations:
- If a health service can be provided in more than one medically appropriate setting, your PCP or participating provider will choose where you will get the care

Exclusion:
- Custodial care is not covered.

Community Based Adult Services (CBAS)
CBAS is a service you may qualify for if you have health problems that make it hard for you to take care of yourself and you need extra help. To receive this benefit, you must receive prior authorization from a participating KFHC provider. If you qualify to get CBAS, Kern Family Health Care (KFHC) will send you to the center that best meets your needs. If there is no center near you, KFHC will make sure you get the services you need from other providers.

At the CBAS center you can get different services. They include:

- Skilled nursing care
- Social services
- Meals
- Physical therapy
- Speech therapy
- Occupational therapy

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

You may qualify for CBAS if:

- You used to get these services from an Adult Day Health Care (ADHC) center and you were approved to get CBAS
- Your primary care doctor refers you for CBAS and you are approved to get CBAS by KFHC
- You are referred for CBAS by a hospital, skilled nursing facility or community agency and you are approved to get CBAS by KFHC

Skilled Nursing Care
Skilled nursing care needs prior authorization of coverage from KFHC. It must be ordered by your PCP or a participating provider and be provided at a participating facility.

The following services and items are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:

- Skilled nursing
- Bed and board
• X-ray and lab procedures
• Respiratory therapy
• Physical and occupational therapy
• Speech therapy
• Medical social services
• Prescribed drugs
• Medical supplies
• Appliances and equipment ordinarily furnished by the skilled nursing facility

Limitation:
• Skilled nursing care is covered for the month of admission plus the following month. Care required longer than this time is called “Long Term Care”. See “Long Term Care” on page 21 for more information on Long Term Care.

Exclusion:
• Custodial care is not covered.

Physical, Occupational and Speech Therapy
Physical, occupational and speech therapy need prior authorization of coverage from KFHC. They must be performed by a participating provider.

The following services are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements.

• Physical therapy: Includes physical therapy evaluation, treatment planning, treatment, instruction, consultative services and application of topical drugs.
• Occupational therapy: Includes occupational therapy evaluation, treatment planning, treatment, instruction and consultative services.
• Speech therapy.
• Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. KFHC may require periodic evaluations as long as therapy is provided.

Exclusions:
• The use of electricity or cauterization for surgical procedures

Outpatient Mental Health Services
Outpatient mental health services need prior authorization of coverage from KFHC. Outpatient mental health services must be prescribed and provided by a participating provider.

The following services are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements. These services are for the treatment of mild to moderate mental health conditions, which include:

• Individual and group mental health testing and treatment (psychotherapy)
• Psychological testing to evaluate a mental health condition
• Outpatient services to monitor drug therapy
• Outpatient services that include lab work, drugs, and supplies
• Psychiatric consultation

You can still get specialty mental health services from the County Mental Health Department. Please see page 20 for more information about Specialty Mental Health Services and Substance Use Disorder. For emergency mental health concerns, you can always call the Kern County Mental Health Crisis Hotline at 1-800-991-5272.

Exclusion:
• Mental health services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems*.

* As defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV).

Substance Use Disorder Preventive Services
Alcohol misuse screening services are covered by KFHC for all members ages 18 and older. These services need prior authorization of coverage from KFHC and must be prescribed and provided by a participating provider. These services for alcohol misuse cover*:

• One expanded screening for risky alcohol use per year
• Three 15-minute brief intervention sessions to address risky alcohol use per year

Exclusion:
• KFHC does not cover services for major alcohol problems, but you may be referred to the County Alcohol and Drug Program.

* Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Blood and Blood Products
Blood and blood products are covered when they are medically necessary and meet KFHC utilization review requirements, including:

• Processing
• Storage and administration of blood and blood products
• Collection and storage of autologous blood
Health Education
Health education services need prior authorization of coverage from KFHC. They must be performed by KFHC or a participating provider.

Benefit includes health education services, education regarding personal health behavior and health care, and recommendations regarding the optimal use of health services arranged by KFHC.

Our audio health library has taped information on health topics like asthma, diabetes and nutrition. You can listen to the messages from your home 24-hours a day. To reach the library call our 24-Hours Advice Nurse Line at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) and ask to be connected to the audio health library. You can also learn more about health topics on our website: kernfamilyhealthcare.com. Go to the Members section, Member Resources, Advice Nurse Line page. Follow the prompts to the library.

Hospice
Hospice care needs prior authorization of coverage from KFHC. Hospice services must be ordered and provided by a participating provider.

The hospice benefit is provided to members who have a terminal illness with a life expectancy of 12 months or less and who choose hospice care for the illness instead of the traditional services covered by KFHC. The following items are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:
• Nursing care
• Medical social services
• Home health aide services
• Physician services, drugs, medical supplies and appliances
• Counseling and bereavement services
• Pain control and symptom management

A member may choose to stop receiving hospice services and start receiving traditional services at any time.

Limitations:
• Members who choose hospice care cannot get coverage for any other service for the terminal illness as long as they continue to choose to get hospice services.
• Members will continue to get covered services not related to the terminal illness.
• Respite care is covered on an occasional basis for no more than five days in a row.

Organ Transplants
Except for kidney and corneal transplants, other organ transplants are not covered under this health plan, but are covered under the Medi-Cal Fee-For-Service Program for adults and the CCS Program for members under 21 years of age. Except for kidney and corneal transplants, KFHC will initiate disenrollment of a member to the Medi-Cal Fee-For-Service Program when a member’s transplant has been authorized by the DHCS or the CCS Program. Kidney and corneal transplants for members 21 years and older are covered under this health plan and kidney and corneal transplants for members under 21 years of age are covered under the CCS Program. Medically necessary medical and hospital expenses of a donor for a covered kidney or cornea transplant are covered if directly related to the transplant of the member.

If KFHC denies your kidney transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to KFHC’s Grievance Process on page 26.

Reconstructive Surgery
Reconstructive surgery needs prior authorization of coverage from KFHC. It must be performed by a participating provider at a participating facility.

The following services are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements.
• Reconstructive surgical services performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors or disease for the purpose of improving function or creating a normal appearance to the extent possible.
• Reconstructive surgery to restore and achieve symmetry incident to mastectomy.

Exclusion:
• Cosmetic surgery to alter or reshape normal structures of the body in order to improve appearance is not covered.

Phenylketonuria (PKU)
PKU screening and treatment does not need prior authorization of coverage from KFHC. It must be performed by a participating provider.

The following services and items are covered when they are medically necessary and meet KFHC utilization review requirements:
• Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a physician and managed by a provider in consultation with a participating physician who specializes in the treatment of metabolic disease, provided the diet is medically necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

**Tuberculosis**

Tuberculosis screening and care from your PCP does not require prior authorization of coverage from KFHC. Except for services provided by the county Direct Observed Therapy (DOT) Program, tuberculosis care that is performed by another provider needs prior authorization of coverage. Tuberculosis screening and care must be performed by a participating provider or a provider of the DOT Program. If you need care for tuberculosis, you will be referred to the DOT Program run by the Kern County Health Department.

The following services are covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:

• Tuberculosis screening and diagnosis
• Tuberculosis treatment and follow-up care

**Clinical Cancer Trials**

Services provided as part of a clinical cancer trial need prior authorization of coverage from KFHC. Services must be provided by an approved provider at an approved facility.

Participation in a cancer clinical trial, phase I through IV is covered when the member’s participating physician has recommended participation in the trial, and the member meets the following requirements:

• Is diagnosed with cancer
• Is accepted into a phase I, II, III or IV clinical trial for cancer
• Member’s treating participating physician must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the member, and
• The trial must meet the following requirements:
  1. Trials must have a therapeutic intent with documentation provided by the treating physician, and
  2. Treatment provided must be approved by one of the following: 1) the National Institute of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs related to the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for cancer clinical trials include health care for:

• the provision of the investigational drug, item, device or service
• the clinically appropriate monitoring of the investigational drug, item, device or service
• the prevention of complications arising from the provision of the investigational drug, item, device or service
• the reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including diagnosis or treatment of complications

These services will be covered and paid for by the CCS Program if the member is found to be eligible for CCS services. For more information about the CCS Program, see “California Children’s Services (CCS)” on page 20.

**Exclusions:**

• Provision of non-FDA-approved drugs or devices that are the subject of the trial
• Services other than health services, such as travel, housing and other non-clinical expenses that a member may incur due to participation in the trial
• Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient
• Health services that are not a specified benefit of this health plan (other than those excluded on the basis that they are investigational or experimental)
• Health services that are customarily provided by the research sponsors free of charge for any enrollee in the trial
• Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California

**Getting Services That Are Not Covered by KFHC (Carve Out Services)**

“Carve out” services are certain services that are not covered under this health plan, but are covered by
the Medi-Cal Fee-For-Service Program or other State program. KFHC will assist you in obtaining these services through the applicable State program and provider.

**Medicare Part D Drug Program**

If you are a Medicare beneficiary, you will receive drug coverage from your Medicare Drug Plan. This health plan is not a Medicare Drug Plan.

For help in picking a Medicare drug plan:
- Ask your pharmacy which plans they accept
- Talk to your doctor about which plans work best with the prescriptions you take
- Call a Medicare HICAP counselor at 1-800-434-0222. The counselor can help you choose a Medicare drug plan.
- Call 1-800-MEDICARE (TTY users, call 1-877-486-2048)
- See www.medicare.gov

If you belong to a Medicare Drug Plan and have coverage questions, please contact your Medicare Drug Plan.

**California Children’s Services (CCS)**

The CCS Program provides health and case management services for certain serious medical conditions for members under 21 years of age. If your child has a serious medical condition, he or she may be eligible for care under CCS.

KFHC does not cover health care for CCS-eligible conditions that CCS has authorized, but it is covered under the CCS Program. If your child has a CCS-eligible condition, he or she will remain enrolled in KFHC and receive coverage for services not related to the CCS condition. KFHC and your child’s PCP will help your child receive services through CCS. You may also contact your local CCS Program. If your child’s PCP thinks your child has a CCS-eligible condition, the PCP will send a referral to CCS. If CCS determines that your child has a CCS-eligible condition, CCS is responsible to provide all care for the CCS condition. In order for your child to receive health care for a CCS condition, you must agree to your child receiving care from CCS providers and cooperate with the requirements of the CCS Program.

If your child already receives care from the CCS Program, inform your child’s PCP. If you have questions about CCS services, talk to your child’s PCP.

Phenylketonuria services are provided by CCS for eligible members.

More information about the CCS Program can be obtained by calling KFHC Member Services at 661-632-1590 (Bakersfield), or 1-800-391-2000 (outside of Bakersfield) or by calling the County CCS Program at 661-868-0531.

**Dental Services**

Your PCP will perform dental screenings and recommend that you see a dentist if you need dental services. Dental services, other than application of dental fluoride varnish for children under the age of six by your child’s PCP, are not covered by KFHC. Dental services are covered by Denti-Cal Program for members under the age of 21.

KFHC will pay for covered drugs prescribed by your dentist. KFHC will pay for certain medical services that are needed to support a dental procedure, such as anesthesia in a dentist office, hospital or surgery center, if appropriate for long procedures or when the member has a medical condition that needs these services.

Call Denti-Cal at 1-800-322-6384 to find a Denti-Cal dentist.

**Specialty Mental Health Services**

Your PCP will treat you for mental health conditions that are within his or her scope of practice. Some Outpatient Mental Health Services are covered by KFHC (see page 17). For other conditions, you will be referred to the Kern County Mental Health Department. Services provided by the County Mental Health Department are covered under the Medi-Cal Fee-For-Service Program and are not covered by KFHC. You can receive these services while you are a KFHC member. You do not need to disenroll.

Most mental health drugs are not covered by KFHC but are covered by the Medi-Cal Fee-For-Service Program.

If you think you need mental health services, call your PCP or the County Mental Health Department at 661-868-8000. For emergency mental health concerns, you can always call the Kern County Mental Health Crisis Hotline at 1-800-991-5272.

**Substance Use Disorder**

Medi-Cal covers most Substance Use Disorder services, through county alcohol and drug programs, including:
- Voluntary Inpatient Detoxification
- Intensive Outpatient Treatment Services
- Residential Treatment Services
- Outpatient Drug Free Services
• Narcotic Treatment Services

These services are covered under the Medi-Cal Fee-For-Service Program and are not covered by KFHC. You can receive these services while you are a KFHC member. You do not need to disenroll.

You can call the Kern County Mental Health Department at: (661) 868-8000 for these services or you can ask your PCP if he or she thinks you need substance use services. If so, you will be referred to the treatment program of the Kern County Mental Health Department.

Developmental Disabilities Services

You can call the Kern Regional Center for developmental disabilities services or you can ask your PCP if he or she thinks you need treatment for developmental disabilities. If so, you will be referred to Kern Regional Center. These services are part of the Medi-Cal Fee-For-Service Program and are not covered by KFHC. You can receive these services while you are a KFHC member. You do not need to disenroll.

If you think you need services for a developmental disability, call your PCP or Kern Regional Center.

Long Term Care

Your PCP or participating specialist will decide if you need Long Term Care. If so, you will be referred to a Medi-Cal Long Term Care provider. Long Term Care facilities include Skilled Nursing Facilities, subacute facilities, pediatric subacute facilities and Intermediate Care Facilities. KFHC covers the month of admission plus the following month for these services. If you require care beyond that time, the State is required to disenroll you from this health plan and provide you coverage under the Medi-Cal Fee-for-Service Program.

Organ Transplants

Except for kidney and corneal transplants, major organ transplants are not covered under this health plan, but are covered under the Medi-Cal Fee-For-Service Program for adults and the CCS Program for members under 21 years of age. KFHC will initiate disenrollment of a member to the Medi-Cal Fee-For-Service Program when a member’s transplant has been authorized by the DHCS or the CCS Program. Kidney transplants for members 21 years and older are covered under this health plan and kidney transplants for members under 21 years of age are covered under the CCS Program. KFHC does not initiate disenrollment of Members receiving kidney or corneal transplants.

Spiritual Healing

Spiritual healing is not covered by KFHC but may be covered by the Medi-Cal Fee-For-Service Program. You can receive these services while you are a KFHC member. You do not need to disenroll. To get this care, find a Medi-Cal provider who offers the services. Make an appointment with the provider. Take your Medi-Cal ID Card with you.

Other Carve Out Services

Although the following services are not covered under this health plan, KFHC assists members in obtaining the services provided by various government programs:

• Waiver program services, such as Home and Community Based Services Waiver Program, AIDS, and Senior Services
• Alpha Feto Protein (AFP) screening
• Local Education Agency Services
• Childhood lead poisoning case management services
• Women, Infants, and Children (WIC) Supplemental Nutrition Program

Help Us Stop Fraud

You can help us stop health care fraud. Here are some kinds of fraud:

• Letting someone use a member ID Card that doesn’t belong to him or her
• Giving wrong information on forms
• Trying to get benefits that a person shouldn’t receive
• Trying to get medicines that a doctor didn’t order
• A doctor giving treatments that are not necessary

If you think someone may be misusing benefits or not telling the truth in order to get health services, call us at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). If you tell us when you think someone is doing something wrong, we will investigate. With your help, we can protect people from fraud.

Special Information For American Indians

American Indians do not have to enroll in a Medi-Cal Plan. American Indians may get services from Indian Health Service Centers, even if they are not participating providers. Like all of our members, American Indians can request to disenroll from KFHC at any time and for any reason.
Member Rights and Responsibilities

As a member, you have the right to:

- Be treated with respect and dignity
- Choose your primary care provider from our Provider Directory
- Get appointments within a reasonable amount of time
- Take part in discussions and decisions about your health care, including proper or medically necessary treatment choices for your conditions
- Have confidential communications with your providers
- Have your records kept confidential. We will not share your health care information without your written approval or unless it is allowed by law.
- Voice your concerns about KFHC, or about health services you received, to KFHC
- Request a State Fair Hearing
- Get information about KFHC, our services and participating providers
- Make recommendations about your rights and responsibilities
- See, correct and get a copy of your medical records
- Request your medical records in an electronic format. You may also have the medical record sent to a designee provided that choice is clear and specific.
- Get family planning services, services at Federally Qualified Health Centers, sexually transmitted disease services, and emergency care from non-participating providers as stated in Federal law.
- Ask for an interpreter at no charge to you
- Use interpreters who are not your family members or friends
- Get your member materials in different formats including Braille, large size print, and audio format upon request
- File a complaint if your linguistic needs are not met
- Disenroll from KFHC
- Get minor consent services

Your responsibilities are to:

- Give your providers and KFHC correct information
- Understand your health problems and take part in making treatment goals with your provider
- Let your provider know you are a KFHC member. Make sure you take your member ID Card to your appointments. Show it to the office staff when you check in.
- Use the emergency room only when you have an emergency or when your provider tells you to do so. If you are unsure whether you have an emergency you can call our 24-Hour Advice Nurse at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).
- Make and keep medical appointments. Let your provider know you need to cancel an appointment at least 24 hours before the appointment is scheduled.
- Ask questions about any medical condition. Make sure you understand your provider’s explanations and instructions.
- Help KFHC keep accurate and current records by letting us know when you change your address or family status or have other health care coverage
- Notify KFHC as soon as possible if you receive a bill or have a complaint
- Treat KFHC personnel and health care providers respectfully and courteously

Your Right to Make Decisions About Medical Treatment

This section explains your right to make health care decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future. A federal law requires us to give you this information. You have the right to be informed by KFHC of the California law regarding advance directives. You also have the right to receive information on any changes in that law as soon as possible, but no later than 90 days after the effective date of the change. We hope this information will help increase your control over your medical treatment.

Who decides about my treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You can say “Yes” to treatments you want. You can say “No” to any treatment that you don’t want – even if the treatment might keep you alive longer.

How do I know what I want?

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have “side effects”. Your doctor must offer you information about problems that medical treatment is likely to cause you. Often, more than one treatment might help you – and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can’t choose for you. That choice is yours to make and depends on what is important to you.
Can other people help with my decisions?  
Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

Can I choose a relative or friend to make health care decisions for me?  
Yes. You may tell your doctor that you want someone else to make health care decisions for you. Ask the doctor to list that person as your health care “surrogate” in your medical record. The surrogate’s control over your medical decisions is effective only during treatment of your current illness or injury or, if you are in a medical facility, until you leave the facility.

What if I become too sick to make my own healthcare decisions?  
If you haven’t named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn’t agree about what to do. That’s why it is helpful if you can say in advance what you want to happen if you can’t speak for yourself.

Do I have to wait until I am sick to express my wishes about health care?  
No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other health-care facility. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatments you want. These documents are called “advance” because you prepare one before health care decisions need to be made. They are called “directives” because they state who will speak on your behalf and what should be done.

In California, the part of an advance directive you can use to appoint an agent to make health care decisions is called a Power of Attorney for Health Care. The part where you can express what you want done is called an Individual Health Care Instruction.

Who can make an advance directive?  
You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

Who can I name as my agent?  
You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

When does my agent begin making my medical decisions?  
Usually, a health care agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the Power of Attorney for Health Care that you want the agent to begin making decisions immediately.

How does my agent know what I would want?  
After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

What if I don’t want to name an agent?  
You can still write your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief for any other type of medical treatment.

Even if you have not filled out a written Individual Health Care Instruction, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will probably be easier to follow your wishes if you write them down.

What if I change my mind?  
You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your health care decisions, you must sign a statement or tell the doctor in charge of your care.

What happens when someone else makes decisions about my treatment?  
The same rules apply to anyone who makes health care decisions on your behalf – a health care agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your Health Care Instructions, or if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest. The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the
provider must make a reasonable effort to find another health care provider to take over your treatment.

Will I still be treated if I don’t make an advance directive?
Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you.

Remember that a Power of Attorney for Health Care lets you name an agent to make decisions for you. Your agent can make most medical decisions for you – not just those about life sustaining treatment – when you can’t speak for yourself. You can also let your agent make decisions earlier, if you wish.

You can create an Individual Health Care Instruction by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an Instruction provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf.

These two types of Advance Health Care Directives may be used together or separately.

To implement Public Law 101-508, the California Consortium on Patient Self-Determination prepared this section in 1991; it was revised in 2000 by the California Department of Health Services, with input from members of the consortium and other interested parties, to reflect changes in state law.

How can I get more information about making an advance directive?
Ask your doctor, nurse, social worker or health care provider to get more information for you. You can have a lawyer write an advance directive for you or you can complete an advance directive by filling in the blanks on a form.

Exclusions and Limitations

General Exclusions and Limitations

• Benefits under this health plan are limited to those services and supplies covered under the Medi-Cal Fee-For-Service Program that are described in KFHC’s Medi-Cal Agreement with DHCS as KFHC’s coverage responsibility. If the California legislature passes a law to eliminate or reduce a service that was covered under the Agreement, benefits under this health plan may be similarly eliminated or reduced upon the effective date of the change.
• Services or items specifically excluded in the Benefits section are not covered.
• Benefits in excess of limits specified in the Benefits section are not covered.
• Services, supplies, items, procedures or equipment that are not medically necessary are not covered, unless otherwise specified in the Benefits section.
• Services, supplies, items, procedures or equipment which are not appropriately authorized are not covered unless provided in an emergency or as otherwise described in this handbook.
• In order for services to be covered, they must be provided by a participating provider and coordinated by your PCP, except for emergency care, urgent care, family planning services, nurse midwife services, sexually transmitted disease treatment and HIV testing and counseling services.
• Medical services that are received in an emergency care setting for conditions that are not emergencies if you reasonably should have known that an emergency care situation did not exist are not covered.
• Drugs, biological products, insulin and insulin supplies, and smoking cessation drugs that are covered under the Medicare Program or by a Medicare health plan are not covered under this health plan.
• In order for drugs to be covered, the drug must be approved by the FDA, prescribed by a participating provider, and dispensed at a participating pharmacy. However, mental health drugs prescribed by a psychiatrist that are not excluded under this health plan do not need to be prescribed by a participating provider in order to be covered, but they must be dispensed by a participating pharmacy. You may also be entitled to an Independent Medical Review through the DMHC when we deny coverage for treatment of a drug we have determined to be experimental or investigational. Please see the section entitled “Independent Medical Review (IMR) for Denials of Experimental/Investigational Therapies on page 28 for further information.
• Coverage is limited to generic drugs when an equivalent generic drug is available. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and efficacy. Generic drugs will generally be
dispensed when available. This health plan will cover a brand name drug when it has been determined to be medically necessary where a generic drug has been demonstrated to be medically contraindicated.

- This health plan limits coverage to those drugs that are described in KFHC’s drug formulary. If relevant alternative drugs on the formulary have already been tried or are clinically contraindicated and usage criteria have been satisfied, an authorization for coverage will be issued for the drug that is not on, or is restricted by, the formulary. The health plan will respond to a physician request for prior authorization of coverage of a medication within 24 hours or one business day. This health plan will cover the continued use of a single-source drug by a member if it is part of a prescribed therapy in effect immediately prior to the date of the member’s enrollment in this health plan; provided that the drug is not one of the mental health, AIDS or HIV medications that are excluded from coverage under this health plan. To verify coverage for specific drugs, or to obtain the drugs in the formulary, call the Member Services Department at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

- The drug benefit is limited to a maximum 30-day supply of the drug at a time.

- Coverage for hospice services is limited to terminal ill members with a life expectancy of 12 months or less. Coverage is provided in accordance with the hospice benefit and terms and conditions of eligibility and coverage under the Medi-Cal Program, and is subject to all exclusions and limitations of coverage under this health plan. If a member elects to receive hospice benefits under this health plan, the member waives all rights to all other benefits for the terminal illness under this health plan for the duration of the hospice election.

- Newborn coverage is limited to the month of birth and the following month if the child is not enrolled in this health plan. Call your Medi-Cal eligibility worker to establish eligibility for the newborn and enroll the child to ensure his or her continuous coverage under this health plan.

The following services are not covered under this health plan but are covered under the Medi-Cal Fee-For-Service Program or CCS Program (this health plan will assist you in getting these services through the Medi-Cal Fee-For-Service Program):

- California Children Services (CCS) Program services.
- Some medications to treat mental conditions, HIV and AIDS are not covered under this health plan but are covered under the Medi-Cal Fee-For-Service Program. These excluded medications are certain anti-psychotic, anti-manic, and anti-Parkinson’s medications, and HIV and AIDS medications classified as Nucleoside Analog, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors. The Medi-Cal Fee-For-Service Program will cover these medications whether they are provided by a pharmacy contracting with KFHC or by a Medi-Cal participating pharmacy that does not contract with KFHC.

- Except for kidney and corneal transplants, other organ transplants are not covered under this health plan, but are covered under the Medi-Cal Fee-For-Service Program for adults and the CCS Program for members under 21 years of age.

- Inpatient and outpatient mental health services and services to treat mental health conditions are not covered under this health plan but are covered under the Medi-Cal Fee-For-Service Program via the County Mental Health Department. The following mental health services are not covered under this health plan:
  - psychiatric inpatient hospital services
  - EPSDT supplemental specialty mental health services
  - psychiatric nursing facility services
  - licensed clinical social worker services
  - marriage, family and child counselor services
  - other specialty mental health provider services
  - rehabilitative services
  - services for Early Start Program and Regional Center clients

- Alcohol and drug treatment services* and outpatient heroin detoxification services, including:
  - Voluntary Inpatient Detoxification
  - Intensive Outpatient Treatment Services
  - Residential Treatment Services
  - Outpatient Drug Free Services
  - Narcotic Treatment Services.

*These services are covered under the Medi-Cal Fee-For-Service Program and are not covered by KFHC. You can call the Kern County Mental Health Department at: (661) 868-8000 for these services or you can ask your PCP if he or she thinks you need substance use services. If so, you will be referred to the treatment program of the Kern County Mental Health Department.

- Services for members who are institutionalized past the month after the month of admission in a skilled nursing facility or an intermediate care or long-term care facility. This exclusion
does not apply to members who have elected hospice services in a nursing facility.
- Dental services and EPSDT supplemental dental services
- Waiver program services (Home and Community Based Services, AIDS, and Senior Services).
- Direct observed treatment for tuberculosis
- Alpha Feto Protein (AFP) screening
- Local Education Agency Services
- KFHC will make reasonable attempts to arrange covered services but it is not responsible to do so under the following circumstances: (1) delay or failure to render service due to major disaster or epidemic affecting facilities or personnel; or (2) interruption of services due to war or riot, labor disputes, or destruction of facilities. Under these circumstances, members are advised to access available medical services.

The following services are not covered under this health plan or the Medi-Cal Fee-For-Service Program:

- Experimental or investigational procedures
- This health plan covers reconstructive surgery to correct serious disfigurement. Reconstructive surgery means surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (1) to improve function, or (2) to create a normal appearance, to the extent possible. This health plan does not cover cosmetic surgery. Cosmetic surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
- Personal comfort or convenience items
- Services and supplies that are not primarily medical in purpose or which are common household items
- Custodial care while confined in a facility or home
- Non-medically necessary services to reverse surgically induced infertility
- Non-medically necessary private duty nurses
- Chronic kidney dialysis is not covered when it is covered under the Medicare Program
- Coverage for clinical trials does not include the following items:
  - Drugs or devices that are not approved by the FDA;
  - Services other than health care services, including but not limited to cost of travel, or costs of other non-clinical expenses;
  - Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Items and services provided free of charge by the research sponsors to Members in the trial; and
- Services for treatment of a condition that is eligible for coverage under the California Children Services (CCS) Program for members under 21 years of age.
- Drugs and therapies to treat erectile dysfunction.
- Treatment for any injury or sickness arising from any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker’s compensation benefit plan
- Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan
- Orthoptics and Pleoptics
- Mental health services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems.

Medi-Cal Optional Benefits that Kern Family Health Care will cover:

Some optional Medi-Cal benefits were terminated by the Department of Health Care Services (DHCS) due to changes in state law. Kern Family Health Care will cover the following optional Medi-Cal benefits for adult members 21 years of age and older that were cut by the DHCS:
- Audiology services by audiologists
- Speech Therapy services by speech therapists
- Incontinence creams and washes if medically necessary
- Podiatry services
- Frames and lenses

Grievance Process

Our goal is for you to get good care and be treated well by our participating providers and employees.

If you have questions about the services you receive from a participating provider, we recommend that you talk to your provider first. If you still have a concern about any service you received, call KFHC Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) (TDD/TTY for the hearing impaired at 711). We will talk to you about your concerns and work with you through the grievance process.

Grievance

If a member receives a Notice of Action from KFHC, the member has three options. A Notice of Action is
a formal letter telling you that a medical service has been denied, deferred or modified.

- Members have 90 days from the date on the Notice of Action to file an appeal of the Notice of Action with KFHC.
- Members may request a State Hearing regarding the Notice of Action from the Department of Social Services (DSS) within 90 days.
- Members may request an Independent Medical Review (IMR) regarding the Notice of Action from the Department of Managed Health Care (DMHC).

Members may also file a grievance regarding dissatisfaction of care and/or services received. Members must file a grievance within 180 days from the date the incident or action occurred which caused the member to be dissatisfied.

You can get KFHC’s Grievance Policy by calling our Member Service number in the above paragraph. To begin the grievance process, you can call, write, contact us online or fax us at:

Grievance Coordinator
Kern Family Health Care
Mailing Address Only: 9700 Stockdale Highway
Bakersfield, CA 93311
661-632-1590 (Bakersfield)
1-800-391-2000 (outside of Bakersfield)
www.kernfamilyhealthcare.com
Fax Number: 661-664-5179

We have created a form called a “Member Report of Grievance” to help you put your grievance in writing. You can get these at your provider’s office or from KFHC. We recommend that you use this form, but you do not have to. You may contact Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) if you need help filing a grievance.

KFHC will let you know we received your grievance within five days of receipt. We will resolve your grievance within 30 days. We will send you a letter that lets you know how we resolved your grievance.

If your grievance involves an imminent and serious threat to your health, including severe pain, potential loss of life, limb or major bodily function, you or your provider may request that KFHC expedite its grievance review. KFHC will review your request for an expedited review and, if your grievance qualifies as an urgent grievance, we will send you a notice regarding the disposition or pending status of your grievance within three days from receipt of your request.

If your grievance involves services that we have authorized coverage, you will be able to continue getting those services while your grievance is being resolved.

You are not required to file a grievance with KFHC before asking the California Department of Managed Health Care (DMHC) to review your case on an expedited review basis. If you decide to file a grievance with KFHC in which you ask for an expedited review, KFHC will immediately notify you in writing that:

1. You have the right to notify the DMHC about your grievance involving an imminent and serious threat to health, and
2. We will respond to you and the DMHC with a written statement on the status or disposition of the grievance no later than 72 hours from receipt of your request to expedite review of your grievance.

You may ask for a State Fair Hearing to resolve a grievance concerning Medi-Cal eligibility or benefits at any time before, during or after utilizing the KFHC grievance resolution process. The hearing will not involve KFHC if the grievance concerns something that is not a benefit of this health plan, such as CCS, mental health services not provided by KFHC, dental or other carve out services. Members may not request a hearing for a grievance concerning a non-benefit issue, such as quality of care or service.

You may ask for a State Hearing in writing. A written request may be sent to:

California Department of Social Services
State Hearing Division
PO Box 944243
Mail Station 9-17-37
Sacramento, CA 94244-2430
Fax to: 1-916-651-5210 or 1-916-651-2789

Or, you may call 1-800-952-5253 to ask for a State Hearing. This number can be busy so you may get a message to call back later. If you have trouble hearing or speaking, you can call TDD 1-800-952-8349.

You must ask for a State Fair Hearing within 90 days from the date a requested service was denied,
Grievance Process, continued...

delayed or modified. If you and your provider want to keep a treatment going that is the subject of the State Fair Hearing, you must ask for a State Hearing within 10 days from the date the Notice of Action letter was postmarked or personally delivered to you, or before the effective date of the action which you are disputing. Please state that you want to keep getting your treatment during the hearing process.

Your request for a State Fair Hearing needs to include your name, address, phone number, Social Security Number and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address and phone number to the form or letter. If you need a free interpreter, include what language you speak.

After you ask for a hearing, it could take up to 90 days for your case to be decided and an answer sent to you. If you believe waiting that long will seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, ask your doctor for a letter. The letter must explain how waiting for up to 90 days for your case to be decided will seriously jeopardize your life or health or ability to attain, maintain or regain maximum function. Then ask for an expedited hearing and provide the letter with your request for hearing.

Independent Medical Review (IMR)

If medical care that is requested for you is denied, delayed or modified by KFHC or a participating provider, you may be eligible for an IMR. If so, you will receive a formal Notice of Action letter from KFHC stating you may request an IMR with the DMHC. You may not take part in the IMR process if you have filed for or completed the State Fair Hearing process. If your case is eligible and you submit a request for an IMR to the DMHC, information about your case will be sent to a medical specialist who will review the information and make an independent decision. You will receive a copy of the decision. If the IMR specialist so determines, KFHC will provide coverage for the health services. KFHC will cover the service through participating providers.

An IMR is available in the following situations:
1. (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have received urgent care or emergency care that a provider determined was medically necessary, or
   (c) You have been seen by a participating provider for the diagnosis or treatment of the medical condition for which you seek independent review; and
2. The disputed health care service has been denied, modified or delayed by KFHC or one of its participating providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with KFHC and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

If your grievance qualifies for expedited review, you are not required to file a grievance with KFHC prior to requesting an IMR. Also, the DMHC may waive the requirement that you follow KFHC’s grievance process in extraordinary and compelling cases.

For cases that are not urgent, the IMR organization chosen by DMHC will provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including severe pain, potential loss of life, limb or major bodily function, the IMR organization will provide its determination within three business days. At the request of the experts, the deadline can be extended by up to three days if there is a delay in getting all necessary documents.

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to give up any statutory right to pursue legal action against the plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call KFHC Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) (TDD/TTY for the hearing impaired at 711).

Independent Medical Review (IMR) for Denials of Experimental/Investigational Therapies

You may also be entitled to an IMR, through the DMHC, when we deny coverage for treatment we have determined to be experimental or investigational. You may not participate in the IMR process if you have filed for or completed the State Fair Hearing process.

We will notify you in writing that you can request an IMR of a decision denying an experimental/investigational therapy within five business days of the decision to deny coverage.

You are not required to take part in the KFHC
grievance process prior to seeking an IMR of our decision to deny coverage of an experimental/investigational therapy. If a physician indicates that the proposed therapy would be much less effective if not promptly initiated, the IMR decision shall be rendered within seven days of the completed request for an expedited review.

Review by the Medi-Cal Managed Care Division (MMCD) Office of the Ombudsman
The MMCD Office of the Ombudsman is available to you if you have concerns or questions that cannot be answered or resolved by KFHC. For more information, contact the MMCD Office of the Ombudsman at 1-888-452-8609. The hearing and speech impaired may use the California Relay Service’s (TTY) toll-free telephone number (1-800-735-2929).

Review by the Department of Managed Health Care
The Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against KFHC, you should first telephone KFHC at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) (TDD/TTY for the hearing impaired at 711) and use KFHC’s grievance process before contacting the Department of Managed Health Care. Using this grievance procedure does not prohibit any 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 KFHC, 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 IMR. If you are eligible for an IMR, the IMR process will provide an impartial view 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 and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, 1-888-HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use the Department of Managed Health Care’s TDD line (1-877-688-9891). The Department of Managed Health Care’s Internet website (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

KFHC’s grievance process and Department of Managed Health Care’s complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Eligibility, Commencement of Coverage, Disenrollment and Termination of Benefits

Eligibility and Commencement of Coverage
Eligibility for this health plan is determined by the County Department of Human Services, not KFHC. The date of a new member’s first day of coverage under this health plan is determined by the DHCS.

If you are a member of KFHC when your baby is born, we cover your new baby’s care for the month of birth to the end of the following month. To continue coverage of your baby’s care you must apply for Medi-Cal for your baby through the Kern County Department of Human Services. Call your caseworker at 661-631-6000 for information. Call our Member Services Department at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) so we can send you an enrollment form and help you pick a doctor for your baby.

Transitional Medi-Cal (TMC)
Transitional Medi-Cal (TMC) is for California families who lose cash aid and Medi-Cal (or who would have been eligible for cash under the old rules) but are no longer eligible because of higher earnings from work. If you are the principal earner or caretaker and get a job or your job pays you more money, you may get no-cost Medi-Cal for up to 12 months. After the first year of TMC, working parents may get 12 more months, for a total of 24 months, and their children may get other Medi-Cal or Healthy Families program coverage. If you need information about TMC, call Member Services, and we will help put you in contact with the right people.

Loss of Eligibility
If you lose Medi-Cal eligibility, you will not be eligible to receive coverage for medical care from KFHC until such eligibility is re-established. Questions about your Medi-Cal eligibility can be answered by your County Department of Human Services.

Disenrollment and Termination of Benefits
You may decide at any time that you no longer want to be a member of KFHC and disenroll. Please call us at 661-632-1590 (Bakersfield), or 1-800-391-2000 (outside of Bakersfield) or call Health Care Options at 1-800-430-4263 for help with this.

KFHC cannot disenroll a member because disenrollments are subject to the determination of the DHCS.
KFHC is required to request the DHCS to disenroll you from this health plan in any of the following situations:

• You request to be disenrolled
• Your Medi-Cal aid code category changes to one that is not eligible for Medi-Cal Managed Care
• You are no longer eligible for Medi-Cal
• You requested during the enrollment process to be enrolled in another available Medi-Cal Plan or you have other HMO coverage
• You are enrolled in violation of State law
• You move outside of Kern County
• You need Long Term Care. Long Term Care is care provided in a skilled nursing or intermediate care facility for longer than the month of admission plus the following month. This type of care is covered by the Medi-Cal Fee-For-Service Program.
• You need a major organ transplant that involves more than just the kidney. This care is covered by the Medi-Cal Fee-For-Service Program.

If you move or lose your Medi-Cal eligibility, please call us right away. We want to help you with your care. You can come back to us if things change and you become eligible again.

KFHC may also ask DHCS to disenroll you from our health plan for the following reasons:

• You are verbally or physically abusive to providers, their staff, other members or KFHC employees
• You act in a disruptive manner while getting care or dealing with KFHC
• You often use non-participating providers for non-emergency care without KFHC prior authorization of coverage
• You let someone else use your KFHC ID Card
• You commit or allow health care or insurance fraud
• You often fail to follow your provider’s instructions or medical advice

If we ask DHCS to disenroll you, we will send you a letter letting you know about our decision. You will have 20 days to respond to the letter. We will notify you of the disenrollment after we receive approval from DHCS. Disenrollment for any of the above reasons may or may not affect your Medi-Cal eligibility. Re-enrollment with KFHC may be decided by the DHCS.

Disenrollments are effective when determined by the DHCS.

Expedited disenrollments are effective on the first day of the month in which the request is processed.

You or your provider should contact Health Care Options to find out what information needs to be sent with your request. The following situations are processed as expedited disenrollments if you have not received services during the month for which the disenrollment is requested:

• You are an American Indian, a member of an American Indian household, or choose to receive services from an Indian Health Service Facility
• The member is receiving services under the Foster Care or Adoption Assistance Program or has been placed in the care of Child Protective Services
• You have a complex medical condition
• You are enrolled in a Medi-Cal Waiver Program
• You are taking part in certain State pilot projects
• You requested during the enrollment process to be enrolled in another available Medi-Cal Managed Care Plan or you have other HMO coverage
• You move outside of Kern County
• Your disenrollment is related to an irreconcilable breakdown in your relationship with your provider
• You are enrolled in violation of State regulations
• You need Long Term Care (Hospice care is not considered Long Term Care)

If you think you were disenrolled unfairly because of your health condition or because of the services you require, you can contact the DMHC and ask for a review. See “Review by the Department of Managed Health Care” on page 29 for additional information on how to contact the DMHC.

General Information

Other Health Insurance (coordination of coverage)

Make sure you let your provider and KFHC know about any other health insurance you have. Your KFHC benefits will be coordinated with other insurance coverage you have. The other insurance is “primary”. This means it will be used before your KFHC benefits. You are required to assign payment of medical benefits covered under other insurance policies and from other sources to KFHC and to inform KFHC of medical services that may be covered under another health plan or program. For further information, contact KFHC Member Services.

Third Party Liability

KFHC will not make a claim for recovery of the value of Covered Services provided to a Member when such recovery would result from an action involving the tort liability of a third party or casualty...
liability insurance, including Workers’ Compensation awards and uninsured motorist coverage. However, KFHC will notify the DHCS of such potential cases, and will help the DHCS in pursuing the State’s right to reimbursement of such recoveries. Members are obligated to assist KFHC and the DHCS in this regard.

Provider Payment
The provider payment arrangement between KFHC and participating providers encourages accessible, preventive and cost-effective health services for members. Participating providers are required to provide medically necessary services in a quality manner in accordance with professional, legal and contractual requirements. Participating providers are paid based on the services they provide. This is called a fee-for-service (FFS) basis. PCPs, hospitals, pharmacies and some specialty providers take part in an incentive bonus plan. KFHC does not use compensation arrangements that unduly influence or incent a participating provider to withhold medically necessary care. KFHC does not have a contract with a participating provider that contains an incentive plan that includes specific payment to the provider as an inducement to deny, reduce, limit, or delay medically necessary and appropriate services with respect to a member. If you have questions about how participating providers are paid, you may call Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). Upon request, we will provide you with a written description of the incentive bonus plan.

Reimbursement Provisions – If You Receive a Bill
If you receive a bill for or have paid for a covered service, call Member Services and request an Emergency Claim Form. Complete the form and return it with the bill and any receipt showing your payment to the following address:

Member Services
Kern Family Health Care
Mailing Address Only: 9700 Stockdale Highway
Bakersfield, CA 93311

We will process your claim within 45 working days after we receive the documents. If we need more information, we will inform you. If you don’t answer us, we may not pay the claim. We will not pay a provider for a claim for services that were provided more than six months after the month of service. There is no time limit for submission of a claim for reimbursement of a bill for covered services that was paid by a member. If the care meets the terms and conditions of coverage under this health plan, we will either pay the provider directly or we will send payment to you if you provide us with proof of your payment to the provider. If we deny either part or all of your claim, we will send you a letter to let you know your claim was denied. If you disagree with our decision, you may file a grievance. For more information on the KFHC grievance process see “Grievance Process” on page 26.

Public Policy Participation
We are always looking for members that would like to join our Public Policy Committee. In this Committee, we talk about things that we can do to improve the way you receive your health care and actions performed by KFHC and its employees to assure the comfort, dignity and convenience of members who rely on participating providers to receive health care. If an adult member is interested in being a member of this Committee, he or she can call Member Services to express interest.

Member Liability for Payment
If KFHC fails to pay a participating provider for covered services, you will not be held liable for the money owed. This statement and/or provision becomes invalid when services were obtained without prior authorization of coverage by KFHC. You will be liable for the cost of service provided by non-participating providers if coverage for that care requires authorization by KFHC and authorization was not obtained, and was not a case where emergency care was required. Emergency care does not require authorization. You may also have to pay for non-covered services, whether received from a participating or non-participating provider. Members are not required to pay copayments or deductibles for covered services.

Independent Contractors
KFHC participating providers are not agents or employees of KFHC, but are independent contractors. Participating providers maintain the patient relationship with members, and are solely responsible for the services they provide. In no event shall KFHC be liable for the negligence, wrongful acts or omissions of any person who provides services to members, including any physician, hospital, or other provider or their employees.

Non-discrimination
KFHC does not unlawfully discriminate under this health plan or in its employment practices on the basis of race, color, national origin, ancestry, religion, age, sex, marital status, sexual orientation or physical or mental disability.

Organ and Tissue Donation
Donating organs and tissues provides many societal benefits. Organ and tissue donation allows
recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants exceeds availability. If you are interested in organ donation, please talk to your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The State’s website www.organdonor.gov has information on donating organs and tissues.

**Notifying You of Changes in the Plan**
KFHC or the State may send you notices about changes in this health plan. This can include State notices, and updates to the Provider Directory and this handbook.

**Notice of Privacy Practices**
**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 agree to follow the terms of this Notice of Privacy Practices. We have the right to change the terms of this notice, and to make the new notice effective for all health information we hold. If we need to make any changes, we will mail you an updated notice.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be forwarded to you upon request.

**Why is this notice included in this handbook?**
KFHC is required by law to make your health information private. We are also required to let you know how we secure your protected health information (PHI).

**How does KFHC use and share my health information?**
KFHC stores health-related records about you, which includes your:
- claims history,
- health plan enrollment information,
- case management records, and
- prior authorizations of coverage for health services.

We use this information and share it with others for the following reasons:
- Treatment. KFHC uses your health information to plan your health care. For example, we share your health information with hospitals, clinics, physicians and other health care providers to help them provide services to you.
- Payment. KFHC uses and shares your health information to pay for health services you receive. For example, we tell providers that you are a member of KFHC, and tell them about your benefits.
- Health Care Operations. KFHC uses and shares your health information, when needed, to help us run our health plan. For example, we use our members’ claims data for our internal accounting activities, and for quality purposes.
- Contractors and Agents. We share health information with our contractors and agents who help us in the tasks listed above. We do obtain confidentiality agreements before we share information for payment or business purposes. For example, companies that provide or maintain our computer services may have access to computerized health information when providing services to us.
- Contacting You. We may contact you to provide appointment reminders or information about treatments open to you. We may also contact you about other health-related services.

**Can others involved in my care get information about me?**
Yes, if we feel it is needed, we may release medical information to a friend or family member who is involved in your care, or is paying for your care. This includes responding to phone calls about eligibility and claim status.

**Can my health information ever be released without my permission?**
Yes, we may share health information without your consent. In addition to the reasons already listed, health information can be shared with government agencies and others at times where we are required or authorized by law. The following is a list of instances when we may be required or allowed to share health information without your consent:
- Disclosures that are required by State or federal law
- To agencies responsible for governing the health care system, for audits, inspections or investigations
- Upon receipt of a court order or to a court, investigator, or lawyer for cases about the operation of Medi-Cal. This may involve fraud or actions to recover money from others when Medi-Cal has paid your medical claims.

**Are there any times when my PHI is not released?**
Your health information may be covered under laws that may limit or prevent some uses or disclosures.
For example, there are limitations on the sharing of health information relating to
• HIV/AIDS status,
• mental health treatment,
• psychotherapy notes,
• developmental disabilities, and
• drug and alcohol abuse treatment.

We comply with these limits in our use of your health information.

We will not allow the sale of PHI or other sharing or uses of your health information without your written consent.

**What rights do I have as a KFHC member?**

As a member you have the following rights:

• You have the right to be notified in case of a breach of unsecured PHI.
• You have the right to ask us to limit certain sharing and uses of your health information. However, KFHC is not required to agree to any restrictions requested by its members.
• You have the right to ask us to contact you only in writing or at a different address, post office box, or by telephone. We will accept reasonable request when necessary to protect your privacy.
• You have the right to see and copy your health records that KFHC holds. We must receive your request in writing. We will answer your request within 30 days. If your records are stored in another location, please allow 60 days for us to respond. We may charge a fee to cover the cost of copying your records. KFHC may deny your request. If your request is denied, we will tell you the reason why in writing. You have the right to appeal the denial.
• If you believe the information in our records is wrong, you have the right to ask us to change it. We may deny your request. If your request is denied, you have the right to submit a statement to be placed in the record.
• You have the right to get a report of non-routine sharing of your health information that we have made. Your request may be up to six years prior from the date of your request (but not earlier than April 14, 2003). There are some limitations. For example, we do not have records of:
  • information shared with your consent;
  • information shared for the purposes of health care treatment, checking payment for health services, or conducting the health plan operations of KFHC;
  • information shared with you; and
  • certain other disclosures.

**How do I exercise these rights?**

You can practice any of your rights by sending a written letter to our Privacy Official at the address listed below. To assist with the processing of your request, call us at the phone number listed below as well.

**How do I file a grievance if my privacy rights are violated?**

You have the right to file a grievance with our Privacy Officer. You may also file a complaint with the Secretary of Health and Human Services.

KFHC will not hold anything against you in any way for filing a grievance. Filing a grievance will not affect the quality health services you receive as a KFHC member.

**Contact KFHC at:**

Privacy Officer, Kern Family Health Care  
Mailing address: 9700 Stockdale Highway,  
Bakersfield, CA 93311  
Telephone Number: 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield)

**Contact the DHCS at:**

Privacy Officer  
c/o Office of Legal Services  
California Department of Health Care Services  
PO Box 997413, MS0011  
Sacramento, CA 95899-7413  
Telephone: 916-440-7750  
Email: 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

**Program Transitions to Medi-Cal**

If your child has moved to Medi-Cal as a result of a program change, and you would like information about your child’s Medi-Cal services and benefits, call Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). They can tell you who your child’s doctor is or help you find a new doctor. They can also answer your questions about Kern Family Health Care.

If you have been told you have to pay a premium, you may visit your county office or call Medi-Cal Eligibility at 916-552-9200 for more information.

If you have questions about your child’s Medi-Cal eligibility or about when your child has to renew his or her eligibility, please call the Medi-Cal office in your area. The phone number is 1-877-410-8812.