ALAMEDA Alliance FOR HEALTH

Member Handbook

What you need to know about your benefits

Alameda Alliance for Health
Combined Evidence of Coverage (EOC) and Disclosure Form

2023

Alameda County

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. We provide written translations from qualified translators. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at (TTY 1-800-735-2929 or 711). The call is toll-free. There are many self-service features available to you through the Alliance Member Portal. You can select your primary care provider (PCP), request a replacement member ID card, and view your eligibility with the plan by logging into your Member Portal account. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

Other formats

You can get this information in other formats, such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). The call is toll-free.

Interpreter services

Alameda Alliance for Health (Alliance) provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. Interpreter, linguistic and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this handbook in a different language, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). The call is toll-free.

English Tagline

ATTENTION: If you need help in your language call 1-877-932-2738 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in Braille and large print are also available. Call 1-877-932-2738 (TTY: 1-800-735-2929). These services are at no cost.

الشعار بالعربية(Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-877-932-2738 (TTY: 1-800-735-2929). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-877-932-2738 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-877-932-2738 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-877-932-2738 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:1-877-932-27381-877-932-2738.

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电1-877-932-2738 (TTY: 1-800-735-2929)。另外还提供针对残疾人士的帮助和服务，例如文盲和需要较大字体阅读，也是方便取用的。请致电1-877-932-2738 (TTY: 1-800-735-2929)。这些服务都是免费的。

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Eastern Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-877-932-27381-877-932-2738 1-877-932-2738 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-877-932-2738 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-877-932-2738 (TTY: 1-800-735-2929) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-877-932-2738 (TTY: 1-800-735-2929) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-877-932-2738 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-877-932-2738 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-877-932-2738 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-877-932-2738 (TTY: 1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は 1-877-932-2738 (TTY: 1-800-735-2929) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-877-932-2738 (TTY: 1-800-735-2929) へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-877-932-2738 (TTY: 1-800-735-2929) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-877-932-2738 (TTY: 1-800-735-2929) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແຈກໄລພາສາລາວ (Laotian)

ປະກາດ:ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃ
ຫ້ໂທຫາເບີ1-877-932-2738 (TTY:1-800-735-2929).
ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສຳລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່
ໃຫ້ໂທຫາເບີ1-877-932-2738 (TTY:1-800-735-2929).
ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-877-932-2738 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-877-932-2738 (TTY: 1-800-735-2929). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Mon-Khmer Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម
ទូរស័ព្ទទៅលេខ 1-877-932-2738 (TTY: 1-800-735-2929)។
ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ
ដូចជាឯកសារសរសេរជាអក្សរធុំស សម្រាប់ជនពិការភ្នែក
ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។
ទូរស័ព្ទមកលេខ 1-877-932-2738 (TTY: 1-800-735-2929) ។
សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។1-877-932-2738 1-877-932-2738.

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-877-932-2738 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-877-932-2738 (линия TTY: 1-800-735-2929). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-877-932-2738 (TTY: 1-800-735-2929). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-877-932-2738 (TTY: 1-800-735-2929). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-877-932-2738 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-877-932-2738 (TTY: 1-800-735-2929). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-877-932-2738 (TTY: 1-800-735-2929) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-877-932-2738 (TTY: 1-800-735-2929) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-877-932-2738 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-877-932-2738 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

Khẩu Hiệu Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-877-932-2738 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-877-932-2738 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.

Welcome to the Alliance!

Thank you for joining Alameda Alliance for Health (Alliance). The Alliance is a health plan for people who have Medi-Cal. The Alliance works with the State of California to help you get the health care you need.

Member Handbook

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

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. It is a summary of the Alliance rules and policies and based on the contract between the Alliance and Department of Health Care Services (DHCS). If you would like more information, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) to ask for a copy of the contract between the Alliance and DHCS. You may also ask for another copy of the Member Handbook at no cost to you or visit the Alliance website at www.alamedaalliance.org to view the Member Handbook. You may also request, at no cost to you, a copy of the Alliance non-proprietary clinical and administrative policies and procedures, or how to access this information on the Alliance website.

Contact us

The Alliance is here to help. If you have questions, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). The Alliance is here Monday through Friday, 8 a.m. – 5 p.m. The call is toll-free.

You can also visit online at any time at www.alamedaalliance.org.

Thank you,

Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Table of Contents

1. Getting started as a member

How to get help

The Alliance wants you to be happy with your health care. If you have any questions or concerns about your care, the Alliance wants to hear from you!

Member services

The Alliance Member Services Department is here to help you.

The Alliance can:

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

If you need help, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). The Alliance is here Monday through Friday, 8 a.m. to 5 p.m. The call is toll-free. The Alliance must make sure that you wait less than 10 minutes when calling.

You can also visit online at any time at www.alamedaalliance.org.

Alliance members can access the Alliance Member Portal by visiting us at www.alamedaalliance.org. You can also use the secure Alliance Member Portal to order or print a new ID card or change your doctor. You will need to create a Member Portal account to use it the first time. To access the Alliance Member Portal, please visit www.alamedaalliance.org.

Who can become a member

You qualify for the Alliance because you qualify for Medi-Cal and live in Alameda County. You may contact the Alameda County Social Services office by calling toll-free at 1-800-698-1118. You may also qualify for Medi-Cal through Social Security because you are receiving SSI/SSP.

For questions about enrollment, call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711). Or visit www.healthcareoptions.dhcs.ca.gov. For questions about Social Security, call the Social Security Administration toll-free at 1-800-772-1213. Or visit www.ssa.gov/locator.

Transitional Medi-Cal

Transitional Medi-Cal is also called “Medi-Cal for working people.”

You may be able to get Transitional Medi-Cal if you stop getting Medi-Cal because:

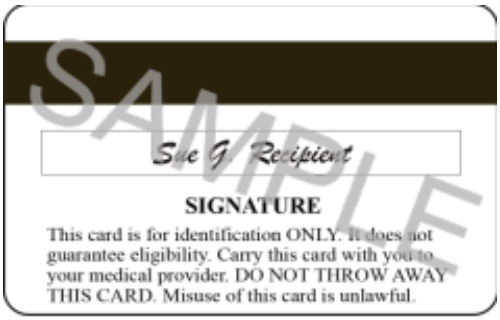
- You started earning more money.
- Your family started receiving more child or spousal support.

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

Identification (ID) cards

As a member of the Alliance, you will get an Alliance member ID card. You must show your Alliance member ID card and your Medi-Cal Benefits Identification Card (BIC), that the State of California sent you, when you get any health care services or prescriptions. You should carry all health cards with you at all times.

Here are sample BIC and Alliance member ID cards to show you what yours will look like:



ALAMEDA Alliance FOR HEALTH

Member ID Card
Jane Doe RxBIN: 003585
Member ID: 000000000-01 RxPCN: 56350
DOB: 00/00/0000
Sex: F Language: English
CIN: 90000000A
Primary Care: Dr. Johnson
Phone: (510) 000-0000
Effective: 12/09/2014 Group: MCAL

This card does not guarantee eligibility.
<Provider Group (CHCN/CFMG)>
Provider Inquiries: (510) 000-0000
Claims: P.O. Box 0000
Alameda, CA 94501
Copays: OV $0 ER $0 RX $0
Mental Health Care: Medi-Cal 1-800-491-9099
www.alamedaalliance.org

For Physicians, Medical Staff, & Pharmacy:

This card is for identification only.
To verify eligibility, check
www.alamedalliance.org
or call (510) 747-4505

Out-of-network emergency services will be reimbursed without prior authorization.

For Members:
Always carry this card with you. For day or after-hours and weekend care, call your doctor's office listed on the front of this card.
Member Services can answer your questions and help you find or change your doctor. Call (510) 747-4567 (TTY 711 or 1-800-735-2929)
Emergency Care:
If you think you have an emergency, go to the closest emergency room or call 911. An emergency is a sudden health problem with severe symptoms that needs treatment right away.

If you do not get your Alliance member ID card within a few weeks after your enrollment date, or if your card is damaged, lost or stolen, call member services right away. The Alliance will send you a new card at no cost to you. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711)

Call the Alliance Member Services Department at 1-877-932-2738 (TTY 1-800-735-2929). The Alliance is here Monday through Friday, 8 a.m. to 5 p.m. The call is toll-free. Or call the California Relay Line at 711.
Visit online at **www.alamedaalliance.org**.

2. About your health plan

Health plan overview

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

You may talk with one of the Alliance member services representatives to learn more about the health plan and how to make it work for you. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

When your coverage starts and ends

When you enroll in the Alliance, we will send you an Alliance member ID card within two weeks of your enrollment date. You must show your Alliance member ID card and your Medi-Cal Benefits Identification Card (BIC) when you get any health care services or prescriptions.

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

You may ask to end your Alliance coverage and choose another health plan at any time. For help choosing a new plan, call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711). Or visit www.healthcareoptions.dhcs.ca.gov. You can also ask to end your Medi-Cal.

The Alliance is a health plan for Medi-Cal members in Alameda County. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Alliance eligibility may end if any of the following is true:

- You move out of Alameda County
- You no longer have Medi-Cal
- If you become eligible for a waiver program that requires you to be enrolled in FFS Medi-Cal
- You are in jail or prison

If you lose your Alliance Medi-Cal coverage, you may still be eligible for FFS Medi-Cal coverage. If you are not sure if you are still covered by the Alliance, please call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Special considerations for American Indians in managed care

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

If you are an American Indian, you have the right to get health care services from an Indian Health Care Provider (IHCP). You may also stay with or disenroll from the Alliance while getting health care services from these locations. For information on enrollment and disenrollment call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

How your plan works

The Alliance is a managed care health plan contracted with DHCS. The Alliance works with doctors, hospitals, and other health care providers in the Alliance service area to give health care to you, the member. While you are a member of the Alliance, you may be eligible to get some additional services provided through FFS Medi-Cal. These include outpatient prescriptions, non-prescription drugs, and some medical supplies through FFS Medi-Cal Rx.

The Alliance Member Services Department will tell you how the Alliance works, how to get the care you need, how to schedule provider appointments within standard access times, how to request no-cost interpreting services, and how to find out if you qualify for transportation services.

To learn more, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You can also find member service information online at www.alamedaalliance.org.

Changing health plans

You may leave the Alliance and join another health plan in your county of residence at any time. Call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711) to choose a new plan. You can call between 8:00 a.m. and 6:00 p.m, Monday through Friday. Or visit https://www.healthcareoptions.dhcs.ca.gov/.

It takes up to 30 days to process your request to leave the Alliance and enroll in another plan in your county if there are no issues with the request. To find out the status of your request, call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

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

Members who can request expedited disenrollment include, but are not limited to, children receiving services under the Foster Care or Adoption Assistance programs, members with special health care needs, and members already enrolled in Medicare or another Medi-Cal or commercial managed care plan.

You may ask to leave the Alliance in person at your local county health and human services office. Find your local office at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx. Or call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

Students who move to a new county or out of California

Emergency services and urgent care are available to all Medi-Cal enrollees statewide regardless of county of residence. Routine and preventive care are covered only in your county of residence. If you move to a new county in California to attend higher education, including college, the Alliance will cover emergency room and urgent care services in your new county. You can also receive routine or preventive care in your new county but must notify the Alliance. See below for further details.

If you are enrolled in Medi-Cal and are a student in a county that is different from your residence in California, you do not need to apply for Medi-Cal in that county.

If you temporarily move away from home to be a student in another county in California there are two options available to you. You may:

- Notify Alameda County Social Services that you are temporarily moving to attend an institution of higher education and provide your address in the new county. The county will update the case records with your new address and county code in the State's database. Use this choice if you want to get routine or preventive care in your new county. You may have to change health plans if the Alliance does not operate in the county where you will attend college. For questions and to prevent any delay in enrolling in the new health plan, call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

  OR

- Choose not to change your health plan when you temporarily move to attend college in a different county. You will only be able to access emergency room and urgent care services in the new county for some conditions. To learn more, go to Chapter 3, "How to get care." For routine or preventive health care, you would need to use the Alliance's regular network of providers located in the head of the household's county of residence.

If you are leaving California temporarily to be a student in another state and you want to keep your Medi-Cal coverage, contact your eligibility worker at Alameda County Social Services. As long as you are eligible, Medi-Cal will cover emergency services and urgent care in another state. Medi-Cal will also cover emergency care that requires hospitalization in Canada and Mexico if the service is approved and the doctor and hospital meet Medi-Cal rules. Routine and preventive care services, including prescription drugs, are not covered outside of California. If you want Medicaid in another state, you will need to apply in that state. You will not be eligible for Medi-Cal and the Alliance will not pay for your health care. Medi-Cal does not cover emergency, urgent, or any other health care services outside of the United States, except for Canada and Mexico as noted in Chapter 3.

Continuity of care

Continuity of Care for a non-plan Provider

As a member of the Alliance, you will get your health care from providers in the Alliance network. To find out whether the health care provider is in the Alliance network please see the Provider Directory online at www.alamedaalliance.org. You can also call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). If the provider is not listed they may not be in the Alliance network.

In some cases, you may be able to go to providers who are not in the Alliance network if you have moved from another plan or fee-for-service (FFS) or a provider who was in-network is now out-of-network. This is called continuity of care.

Call the Alliance and tell us if you need to visit a provider who is out-of-network. We will tell you if you have the right to continuity of care.

You may be able to use continuity of care, for up to 12 months, or more in some cases, if all of the following are true:

- You have an ongoing relationship with the non-plan provider, prior to enrollment in the Alliance
- You were seen by the non-plan provider at least once during the twelve (12) months prior to your enrollment with the Alliance for a non-emergency visit
- The non-plan provider is willing to work with the Alliance and agrees to the Alliance's contractual requirements and payment for services
- The non-plan provider meets the Alliance's professional standards

Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

If your providers do not join the Alliance network by the end of 12 months, do not agree to the Alliance payment rates, or do not meet the quality of care requirements, you will need to switch to providers in the Alliance network. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) to discuss your options.

Continuity of Care for services

As a member of the Alliance, you will get your Medi-Cal services from providers in the Alliance network. In some cases, you may be able to get continued access to Medi-Cal services if you are being treated for certain health conditions and the non-plan provider is not willing to continue to provide services or does not agree to the Alliance's contractual requirements, payment, or other terms for providing care, then you will not be able to receive continued care from the provider. However, you may be able to keep getting services from a different provider in the Alliance network.

Services the Alliance provides for continuity of care include but are not limited to:

- Acute conditions (a medical issue that needs fast attention) – for as long as the condition lasts.
- Chronic physical and behavioral conditions (a health care issue you have for a long time) – for an amount of time required to finish the course of treatment and to arrange for a safe transfer to a new doctor in the Alliance network.
- Pregnancy – during the pregnancy and for up to 12 months after the end of pregnancy.
- Maternal mental health services for up to 12 months from the diagnosis or from the end of pregnancy, whichever is later.
- Care of a newborn child between birth and age 36 months for up to 12 months from the start date of the coverage or the date the provider's contract ends with the Alliance.
- Terminal illness (a life-threatening medical issue) – for as long as the illness lasts. Completion of covered services may exceed 12 months from the time the provider stops working with the Alliance.
- Performance of a surgery or other medical procedure from a non-plan provider as long as it is covered, medically necessary, and is authorized by the Alliance as part of a documented course of treatment, and has been recommended and documented by the provider – surgery or other medical procedure to take place within 180 days of the provider's contract termination date or 180 days from the effective date of coverage of a new member.

For other conditions that may qualify, contact the Alliance Member Services Department.

Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) for help selecting a contracted provider to continue with your care or if you have any questions or problems in receiving covered services from a provider who is no longer part of the Alliance.

The Alliance is not required to provide continuity of care for services not covered by Medi-Cal, durable medical equipment, transportation, other ancillary services and carved-out service providers. To learn more about continuity of care and eligibility qualifications, and to hear about all available services, call the Alliance Member Services Department.

Costs

Member costs

The Alliance serves people who qualify for Medi-Cal. In most cases, Alliance members do not have to pay for covered services, premiums, or deductibles. Members enrolled in California Children's Health Insurance Program (CCHIP) in Santa Clara, San Francisco and San Mateo counties and members in the Medi-Cal for Families Program may have a monthly premium and copayments. Except for emergency care, urgent care, or sensitive care, you must get pre-approval from the Alliance before you visit a provider outside the Alliance network. If you do not get pre-approval and you go to a provider outside of the network for care that is not emergency care, urgent care or sensitive care, you may have to pay for care from providers who are out of the network. For a list of covered services, go to "Benefits and services." You can also find the Provider Directory on the Alliance website at www.alamedaalliance.org.

For members with long-term care and a share of cost

You may have to pay a share of cost each month for your long-term care services. The amount of your share of cost depends on your income and resources. Each month you will pay your own health care bills, including but not limited to Managed Long-Term Support Service (MLTSS) bills, until the amount that you have paid equals your share of cost. After that, your long-term care will be covered by the Alliance for that month. You will not be covered by the Alliance until you have paid your entire long-term care share of cost for the month.

How a provider gets paid

The Alliance pays providers in these ways:

- Capitation payments
    - The Alliance pays some providers a set amount of money every month for each Alliance member. This is called a capitation payment. The Alliance and providers work together to decide on the payment amount.
- FFS payments
    - Some providers give care to Alliance members and then send the Alliance a bill for the services they provided. This is called an FFS payment. The Alliance and providers work together to decide how much each service costs.

To learn more about how the Alliance pays providers, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Our 2022 Pay-for-Performance (P4P) program offers performance-based incentive payments for delivered services. Through this program, PCPs and PCP Groups are rewarded for superior performance and yearly improvement.

If you receive a bill from a health care provider

Covered services are health care services that the Alliance is responsible to pay for. If you get a bill for support services fees, copayments, or registration fees for a covered service, do not pay the bill. Call member services right away at the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Asking the Alliance to pay you back for expenses

If you paid for services you already received, you may qualify to be reimbursed (paid back) if you meet **all** of the following conditions:

- The service you received is a covered service that the Alliance is responsible to pay for. The Alliance will not reimburse you for a service that is not covered by the Alliance.
- You received the covered service after you became an eligible Alliance member.
- You ask to be paid back within one year from the date you received the covered service.

- You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
- You received the covered service from a Medi-Cal-enrolled provider in the Alliance network. You do not need to meet this condition if you received emergency services, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval.
- If the covered service normally requires pre-approval, you provide proof from the provider that shows a medical need for the covered service.

The Alliance will tell you of its decision to reimburse you in a letter called a Notice of Action. If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, the Alliance will pay you back for the full amount you paid. We must reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal, but is not in the Alliance network and refuses to pay you back, the Alliance will pay you back, but only up to the amount that FFS Medi-Cal would pay. The Alliance will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you do not meet one of the above conditions, the Alliance will not pay you back.

The Alliance will not pay you back if:

- You asked for and received services that are not covered by Medi-Cal, such as cosmetic services.
- The service is not a covered service for the Alliance.
- You have an unmet Medi-Cal Share of Cost.
- You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- If you have Medicare Part D, copayments for prescriptions covered by your Medicare Part D plan.

If you pay for a service that you think the Alliance should cover, you will need to complete a Member Request for Reimbursement Form and tell the Alliance in writing why you had to pay. You will need to include a copy of the itemized bill and proof of payment (such as receipts) with your request. The Alliance will review your request to see if you can get your money back.

The Alliance will accept and review requests for reimbursement for a health expense that is received within one (1) year after the date the bill was paid. The Alliance cannot accept bills received more than one (1) year after the date the bill was paid. If the provider is not contracted with the Alliance, reimbursement will be limited to the Medi-Cal rate for the service(s) provided. This rate may be less than the amount you paid or the amount the provider billed for the service.

To request a reimbursement form, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You can also download and print a copy of the Member Request for Reimbursement Form from the Alliance website at www.alamedaalliance.org.

3. How to get care

Getting health care services

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

You can begin to get health care services on your effective date of enrollment. Always carry your Alliance member ID card, Medi-Cal Benefits Identification Card (BIC), and any other health insurance cards you have with you. Never let anyone else use your BIC or Alliance member ID card.

New members with Medi-Cal coverage only must choose a primary care provider (PCP) in the Alliance network. New members with Medi-Cal and comprehensive other health coverage do not have to choose a PCP. The Alliance network is a group of doctors, hospitals, and other providers who work with the Alliance. You must choose a PCP within 30 days from the time you become a member of the Alliance. If you do not choose a PCP, the Alliance will choose one for you.

You may choose the same PCP or different PCPs for all family members in the Alliance, as long as the PCP is available.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in the Provider Directory. It has a list of all PCPs in the Alliance network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You can also find the Provider Directory on the Alliance website at www.alamedaalliance.org.

If you cannot get the care you need from a participating provider in the Alliance network, your PCP must ask the Alliance for approval to send you to an out-of-network provider. This is called a referral. You do not need approval to go to an out-of-network provider to get sensitive services that are described under the “Sensitive care” later in this chapter.

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

Pharmacy benefits are now administered through the Fee-For-Service (FFS) Medi-Cal Rx program. To learn more, read the "Other Medi-Cal programs and services" section in Chapter 4.

Primary care provider (PCP)

You must choose a PCP within 30 days of enrolling in the Alliance. Depending on your age and sex, you may choose a general practitioner, OB/GYN, family practitioner, internist or pediatrician as your primary care provider (PCP). A nurse practitioner (NP), physician assistant (PA) or certified nurse midwife may also act as your PCP. If you choose an NP, PA or certified nurse midwife, you may be assigned a doctor to oversee your care. If you are in both Medicare and Medi-Cal, or if you have comprehensive other health care insurance, you do not have to choose a PCP.

You can choose an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as your PCP. Depending on the type of provider, you may be able to choose one PCP for your entire family who are members of the Alliance, as long as the PCP is available.

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

If you do not choose a PCP within 30 days of enrollment, the Alliance will assign you to a PCP. If you are assigned to a PCP and want to change, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). The change happens the first day of the next month.

Your PCP will:

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

You can look in the Provider Directory to find a PCP in the Alliance network. The Provider Directory has a list of IHCPs, FQHCs and RHCs that work with the Alliance.

You can find the Alliance Provider Directory online at www.alamedaalliance.org. Or you can request a Provider Directory to be mailed to you by calling the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

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

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

Your new choice will become your PCP on the first day of the next month after you make the change.

To change your PCP, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You can also request to change your PCP online when you log into your Alliance Member Portal account at www.alamedaalliance.org.

The Alliance may change your PCP if the PCP is not taking new patients, has left the Alliance network, does not give care to patients your age, or if there are quality concerns with the PCP that are pending resolution. The Alliance or your PCP may also ask you to change to a new PCP if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If the Alliance needs to change your PCP, the Alliance will tell you in writing.

If your PCP changes, you will get a letter and new Alliance member ID card in the mail. It will have the name of your new PCP. If you have questions about getting a new Alliance member ID card, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Some things to think about when picking a PCP:

- Does the PCP take care of children?
- Does the PCP work at a clinic I like to use?

- Is the PCP's office close to my home, work or children's school?
- Is the PCP's office near where I live and is it easy to get to the PCP's office?
- Do the doctors and staff speak my language?
- Does the PCP work with a hospital that I like?
- Does the PCP provide the services that I may need?
- Do the PCP's office hours fit my schedule?

Initial health assessment (IHA)

The Alliance recommends that, as a new member, you visit your new PCP within the first 120 days for an initial health assessment (IHA). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP may ask you some questions about your health history or may ask you to complete a questionnaire. Your PCP will also tell you about health education counseling and classes that may help you.

When you call to schedule your IHA appointment, tell the person who answers the phone that you are a member of the Alliance. Give your Alliance member ID number.

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

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

If you have questions about IHA, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups and health education and counseling. Children are able to receive much needed early preventive services like hearing and vision screenings, assessments of-developmental process and many more services that are recommended by pediatricians' Bright Futures guidelines (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf). In addition to preventive care, routine care also includes care when you are sick. The Alliance covers routine care from your PCP.

Your PCP will:

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

When you need routine care, you will call your doctor for an appointment. Be sure to call your PCP before you get medical care, unless it is an emergency. For an emergency, call **911** or go to the nearest emergency room.

To learn more about health care and services your plan covers, and what it does not cover, read “Benefits and services” and “Child and youth well care” in this handbook.

All Alliance providers can use aids and services to communicate with people with disabilities. They can also communicate with you in another language or format. Tell your provider or the Alliance what you need.

Provider network

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

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

If your PCP, hospital, or other provider has a moral objection to providing you with a covered service, such as family planning or abortion, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). For more about moral objections, read the “Moral objection” section later in this chapter.

If your provider has a moral objection, they can help you find another provider who will give you the services you need. The Alliance can also help you find a provider who will perform the service.

Additional service providers

The Alliance contracts with other provider groups to provide certain services.

Below are providers that the Alliance contracts with for listed services:

- Durable medical equipment (DME) and medical supplies are provided by the Alliance's contractor, California Home Medical Equipment (CHME).
- Outpatient mental health services are covered services and provided by the Alliance.
- Speci/alty mental health services (SMHS) are obtained through Alameda County Behavioral Health Plan (ACCESS Program).
- Transportation services are offered through the Alliance's transportation provider, ModivCare (formerly LogistiCare).
- Vision benefits are offered through the Alliance's vision network provider, MARCH Vision.

If you need services at any of these provider networks, please call the provider and let them know that you are an Alliance Medi-Cal member and are calling to schedule an exam or appointment. The provider will need to confirm that you are eligible and will get approval to provide services to you. If you go to an out-of-network provider or get services without approval, you will need to pay in full for those services. If you have questions about these services, please call the Alliance Member Services Department, Monday – Friday, 8 a.m. – 5 p.m., at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

In-network providers

You will use providers in the Alliance network for most of your health care needs. You will get preventive and routine care from in-network providers. You will also use specialists, hospitals, and other providers in the Alliance network.

To get a Provider Directory of in-network providers, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You can also find the Provider Directory online at www.alamedaalliance.org. To get a copy of the Contract Drug List, call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711). Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

You must get pre-approval (prior authorization) from the Alliance before you visit a provider outside the Alliance network, including inside the Alliance service area, except in the following situations:

- You need emergency services, in which case dial 911 or go to the nearest hospital
- You are outside the Alliance service area and need urgent care, in which case you can go to any urgent care facility
- You need family planning services, in which case you can go to any Medi-Cal provider without pre-approval
- You need mental health services, in which case you can go to either an in-network provider or a county mental health plan provider without pre-approval

If you are not in one of these situations, and you do not get pre-approval and get care from a provider outside of the network, you may have to pay for the care from providers who are out-of-network.

Out-of-network providers who are inside the service area

Out-of-network providers are those who do not have an agreement to work with the Alliance. Except for emergency care, you may have to pay for care from providers who are out of the network. If you need covered health care services, you may be able to get them out of the network at no cost to you as long as they are medically necessary and not available in the network.

The Alliance may approve a referral to an out-of-network provider if the services you need are not available in-network or are located very far from your home. If we give you a referral to an out-of-network provider, we will pay for your care.

For urgent care inside the Alliance service area, you must visit an Alliance network urgent care provider. You do not need pre-approval to get urgent care from an in-network provider. If you do not get pre-approval, you may have to pay for the urgent care you get from an out-of-network provider inside the Alliance service area. For more information on emergency care, urgent care and sensitive care services, go to those headings in this chapter.

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

If you need help with out-of-network services, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Outside the service area

If you are outside of the Alliance service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

If you paid for emergency services requiring hospitalization in Canada or Mexico, you can ask the Alliance to pay you back. The Alliance will review your request.

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

If you are outside of California and have an emergency need to fill outpatient prescription drugs, then please have the pharmacy call Medi-Cal Rx at 800-977-2273 for assistance.

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

If you have questions about out-of-network or out-of-service-area care, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). If the office is closed and you want help from a representative, call the 24/7 Advice Nurse Line toll-free at 1-888-433-1876.

If you need urgent care out of the Alliance service area, go to the nearest urgent care facility. If you are traveling outside the United States and need urgent care, the Alliance will not cover your care. For more information on urgent care, go to the Urgent care heading later in this chapter.

The Alliance contracts with the following medical groups: Alameda Health System (AHS), Community Health Center Network (CHCN), Children First Medical Group (CFMG), and Kaiser Permanente (Kaiser). You may be eligible to select one of these provider groups as your primary care provider (PCP). If you are assigned to one of these medical groups, you may need to use their contracted doctors and specialists.

You may be able to select Kaiser as your health care provider if you are a Medi-Cal member of the Alliance and if you meet certain requirements.

These include:

- Having continuity of care medical needs, or
- You must be a qualified, immediate family member living in the same home as a current Kaiser member. A family addition may include:
    - A spouse
    - An unmarried dependent child younger than 21 years of age
    - A disabled dependent older than 21 years of age (legal conservatorship required)
    - Married or unmarried parents or stepparents of children younger than 21 years of age
    - Foster child, stepchild, or legal guardian; or
- You have been a Kaiser member within the past six (6) months. You must be within six (6) months of the termination date of the prior Kaiser membership.

To select Kaiser as your PCP, you must call the Alliance Member Services Department, Monday – Friday, 8 a.m. – 5 p.m., at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Let us know you want Kaiser to be your health care provider. You will then be screened to see if you meet the criteria. It can take up to **30 days** for your Kaiser coverage to start after you tell us that you would like to select Kaiser as your health care provider.

Please note that if you are approved, your Kaiser coverage generally begins on the first day of the following month. If you do not call us to choose Kaiser as your PCP, we cannot guarantee that services will be covered, even if Kaiser agrees to see you for an appointment.

Doctors

You will choose your doctor to be your primary care provider (PCP) from the Alliance Provider Directory. The doctor you choose must be an in-network provider. To get a copy of the Alliance Provider Directory, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Or find it online at www.alamedaalliance.org.

If you are choosing a new doctor, you should also call to make sure the PCP you want is taking new patients.

If you had a doctor before you were a member of the Alliance, and that doctor is not part of the Alliance network, you may be able to keep that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

Remember, if you do not choose a PCP, the Alliance will choose one for you, unless you have comprehensive other health coverage in addition to Medi-Cal. You know your health care needs best, so it is best if you choose. If you are in both Medicare and Medi-Cal, or if you have other health care insurance, you do not have to choose a PCP.

If you want to change your PCP, you must choose a PCP from the Alliance Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You can also request to change your PCP online when you log into your Alliance Member Portal account at www.alamedaalliance.org.

Hospitals

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

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

Women's health specialists

You may go to a women's health specialist within the Alliance network for covered care necessary to provide women's routine and preventive health care services. You do not need a referral from your PCP to get these services. For help finding a women's health specialist, you can call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You may also call the 24/7 Advice Nurse Line toll-free at 1-888-433-1876.

Provider Directory

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

The Alliance Provider Directory lists hospitals, PCPs, specialists, family planning providers, Federally Qualified Health Centers (FQHCs), OB/GYNs, outpatient mental health providers, managed long-term services and supports (MLTSS), Freestanding Birth Centers (FBCs), Indian Health Care Providers (IHCPs) and Rural Health Clinics (RHCs).

The Provider Directory has Alliance in-network provider names, specialties, addresses, phone numbers, business hours and languages spoken. It tells if the provider is taking new patients. It also gives the level of physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars. If you want information about a doctor's education, training, and board certification, please call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

You can find the online Provider Directory at www.alamedaalliance.org.

If you need a printed Provider Directory, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at https://medi-calrx.dhcs.ca.gov/home. You can also find a pharmacy near you by calling Medi-Cal Rx at 1-800-977-2273 (TTY 800-977-2273 and press 5 or 711).

Timely access to care

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

Sometimes waiting longer for care is not a problem. Your provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health.

Appointment type	You should be able to get an appointment within:
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent (routine) primary care appointments	10 business days
Non-urgent (routine) specialist care appointments	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days
Non-urgent (routine) mental health provider (non-doctor) follow-up care appointments	10 business days of last appointment
Non-urgent (routine) appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness, or other health condition	15 business days

Other wait time standards	You should be able to get connected within:
Member services telephone wait times during normal business hours	10 minutes
Telephone wait times for Advice Nurse Line	30 minutes (connected to nurse)

Travel time or distance to care

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

If the Alliance is not able to provide care to you within these travel time or distance standards, DHCS may approve a different standard, called an alternative access standard. For the Alliance's time or distance standards for where you live, visit www.alamedaalliance.org. Or call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

If you need care from a provider and that provider is located far from where you live, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). They can help you find care with a provider located closer to you. If the Alliance cannot find care for you with a closer provider, you can ask the Alliance to arrange transportation for you to go to your provider, even if that provider is located far from where you live. If you need help with pharmacy providers, please call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711).

It is considered far if you cannot get to that provider within the Alliance's travel time or distance standards for your county, regardless of any alternative access standard the Alliance may use for your ZIP Code.

Appointments

When you need health care:

- Call your PCP
- Have your Alliance member ID number ready on the call
- Leave a message with your name and phone number if the office is closed
- Take your BIC and Alliance member ID card to your appointment
- Ask for transportation to your appointment, if needed
- Ask for language assistance or interpreting services before your appointment to have the services at the time of your visit, if needed
- Be on time for your appointment, arriving a few minutes early to sign in, fill out forms and answer any questions your PCP may have
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

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

Getting to your appointment

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

Go to the section "Transportation benefits for situations that are not emergencies" for more information.

Canceling and rescheduling

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

Payment

You do **not** have to pay for covered services. In most cases, you will not get a bill from a provider. You must show your Alliance member ID card and your Medi-Cal BIC when you get any health care services or prescriptions, so your provider knows who to bill. You may get an Explanation of Benefits (EOB) or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). If you get a bill for prescriptions, call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711). Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home. Tell the Alliance the amount charged, the date of service and the reason for the bill. You are **not** responsible to pay a provider for any amount owed by the Alliance for any covered service.

You must get pre-approval (prior authorization) from the Alliance before you visit a provider outside the Alliance network, including inside the Alliance service area, except in the following situations:

- You need emergency services, in which case dial 911 or go to the nearest hospital
- You need family planning services or services related to testing for sexually transmitted infections, in which case you can go to any Medi-Cal provider without pre-approval
- You need mental health services, in which case you can go to either an in-network provider or a county mental health plan provider without pre-approval

If you do not get pre-approval, you may have to pay for care from providers who are not in the network. If you need covered health care services, you may be able to get them at an out-of-network provider at no cost to you, as long as they are medically necessary, not available in the network and pre-approved by the Alliance. For more information about emergency care, urgent care, and sensitive services, go to those headings in this chapter.

If you get a bill or are asked to pay a copay that you think you did not have to pay, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). If you pay the bill, you can file a claim form with the Alliance. You will need to tell the Alliance in writing why you had to pay for the item or service. The Alliance will read your claim and decide if you can get your money back. For questions or to ask for a claim form, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

The Alliance will not pay you back if:

- The services are not covered by Medi-Cal such as cosmetic services.
- You have an unmet Medi-Cal Share of Cost.
- You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- You asked to be paid back for co-pays for prescriptions covered by your Medicare Part D plan.

Referrals

Your PCP or another specialist will provide you a referral to visit a specialist within the time frame listed in the “Timely access to care” section in this handbook if you need one. A specialist is a doctor who has extra education in one area of medicine. Your PCP will work with you to choose a specialist. Your PCP’s office can help you set up a time to go to the specialist.

Other services that might need a referral include in-office procedures, X-rays, and lab work.

Your PCP may give you a form to take to the specialist. The specialist will fill out the form and send it back to your PCP. The specialist will treat you for as long as they think you need treatment.

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

If you have trouble getting a standing referral or want a copy of the Alliance referral policy, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

You do not need a referral for:

- PCP visits
- Obstetrics/Gynecology (OB/GYN) visits
- Urgent or emergency care visits
- Adult sensitive services, such as sexual assault care
- Family planning services (to learn more, call Office of Family Planning Information and Referral Service at 1-800-942-1054)
- HIV testing and counseling (12 years or older)
- Sexually transmitted infection services (12 years or older)
- Chiropractic services (a referral may be required when provided by out-of-network FQHCs, RHCs, and IHCPs)
- Initial mental health assessment

Minors can also get certain outpatient mental health services, sensitive services, and substance use disorder services without parent's consent. For more information read "Minor consent services" and "Substance use disorder treatment services" in this handbook.

Ready to quit smoking? Call English: 1-800-300-8086 or Spanish: 1-800-600-8191 to find out how. Or go to www.kickitca.org.

Pre-approval (prior authorization)

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

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

The following services always need pre-approval (prior authorization), even if you get them from a provider in the Alliance network:

- Hospitalization, if not an emergency
- Services out of the Alliance service area, if not an emergency or urgent
- Outpatient surgery
- Long-term care or skilled nursing services at a nursing facility
- Specialized treatments, imaging, testing, and procedures
- Office visits and consultation at highly specialized care centers, for example, UCSF or Stanford
- Medical transportation services when it is not an emergency. Emergency ambulance services do not require pre-approval

Under Health and Safety Code Section 1367.01(h)(1), the Alliance will decide routine pre-approvals (prior authorizations) within 5 working days of when the Alliance gets the information reasonably needed to decide.

For requests in which a provider indicates or the Alliance determines that following the standard timeframe could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, the Alliance will make an expedited (fast) pre-approval (prior authorization) decision. The Alliance will give you notice as quickly as your health condition requires and no later than 72 hours after getting the request for services.

Pre-approval (prior authorization) requests are reviewed by clinical or medical staff, such as doctors, nurses, and pharmacists.

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

The Alliance will contact you if the Alliance needs more information or more time to review your request.

You never need pre-approval (prior authorization) for emergency care, even if it is out of the network and out of your service area. This includes labor and delivery if you are pregnant. You do not need pre-approval for certain sensitive care services. To learn more about sensitive care services, go to “Sensitive care” later in this chapter.

For questions about pre-approval (prior authorization), call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Second opinions

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

If you want to get a second opinion, we will refer you to a qualified network provider who can give you a second opinion. For help choosing a provider, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

The Alliance will pay for a second opinion if you or your network provider asks for it and you get the second opinion from a network provider. You do not need permission from the Alliance to get a second opinion from a network provider. However, if you need a referral, your network provider can help you get a referral for a second opinion if you need one.

If there is no provider in the Alliance network to give you a second opinion, the Alliance will pay for a second opinion from an out-of-network provider. The Alliance will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic, severe or serious illness, or face an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, the Alliance will tell you in writing within 72 hours.

If the Alliance denies your request for a second opinion, you may file a grievance. To learn more about grievances, go to the “Complaints” heading in the Chapter titled “Reporting and Solving Problems” in this handbook.

Sensitive care

Minor consent services

If you are under age 18, you can receive some services without a parent or guardian’s permission. These services are called minor consent services.

You may get the following services without your parent or guardian’s permission:

- Sexual assault services, including outpatient mental health care
- Pregnancy
- Family planning and birth control
- Abortion services

If you are 12 years old or older, you may also get these services without your parent’s or guardian’s permission:

- Outpatient mental health care for:
    - Sexual assault
    - Incest
    - Physical assault
    - Child abuse
    - When you have thoughts of hurting yourself or others

- HIV/AIDS prevention, testing, and treatment
- Sexually transmitted infections prevention, testing, and treatment
- Substance use disorder treatment
    - For more information, go to “Substance use disorder treatment services” in this handbook.

For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be part of the Alliance network. You can choose any Medi-Cal provider and go to them for these services without a referral or pre-approval (prior authorization). For minor consent services that are not specialty mental health services, you can go to an in-network provider without a referral and pre-approval. Your PCP does not have to refer you and you do not need to get pre-approval from the Alliance to get minor consent services that are covered under this Member Handbook.

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

Minors can talk to a representative in private about their health concerns by calling the 24/7 Advice Nurse Line toll-free at **1-888-433-1876**.

The Alliance will not send information about getting sensitive services to parents or guardians. Please refer to the “Notice of Privacy Practices” section for information about how to request for confidential communications related to sensitive services.

Adult sensitive care services

As an adult (18 years or older), you may not want to go to your PCP for certain sensitive or private care.

If so, you may choose any doctor or clinic for the following types of care:

- Family planning and birth control (including sterilization for adults 21 and older)
- Pregnancy testing and counseling
- HIV/AIDS prevention and testing
- Sexually transmitted infections prevention, testing and treatment
- Sexual assault care
- Outpatient abortion services

The doctor or clinic does not have to be part of the Alliance network. You can choose any Medi-Cal provider and go to them without a referral or pre-approval (prior authorization) for these services. Services from an out-of-network provider not related to sensitive care may not be covered. For help finding a doctor or clinic giving these services, or for help getting to these services (including transportation), you can call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You may also call the 24/7 Advice Nurse Line toll-free at 1-888-433-1876.

The Alliance will not send information about getting sensitive services to other household members. Please refer to the “Notice of Privacy Practices” section for information about how to request for confidential communications related to sensitive services.

Moral objection

Some providers have a moral objection to some covered services. This means they have a right to **not** offer some covered services if they morally disagree with the services. If your provider has a moral objection, they will help you find another provider for the needed services. The Alliance can also work with you to find a provider.

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

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

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) to ensure that you can obtain the health care services that you need.

These services are available and the Alliance must ensure you or your family member sees a provider or is admitted to a hospital that will perform the covered services. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) if you have questions or need help finding a provider.

Urgent care

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

For urgent care, call your PCP. If you cannot reach your PCP, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Or you can call the 24/7 Advice Nurse Line toll-free at 1-888-433-1876, to learn the level of care that is best for you.

If you need urgent care out of the area, go to the nearest urgent care facility.

Urgent care needs could be:

- Cold
- Sore throat
- Fever
- Ear pain
- Sprained muscle
- Maternity services

You must get urgent care services from an in-network provider when you are inside the Alliance's service area. You do not need pre-approval (prior authorization) for urgent care from in-network providers inside the Alliance's service area. If you are outside the Alliance service area, but inside the United States, you do not need pre-approval to get urgent care. Go to the nearest urgent care facility. Medi-Cal does not cover urgent care services outside the United States. If you are traveling outside the United States and need urgent care, we will not cover your care.

If you need mental health urgent care, call your county mental health plan or the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

You may call your county mental health plan or your Alliance Behavioral Health Organization any time, 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, visit www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Your urgent care provider might give you medication as part of your urgent care visit. If you get medications as part of your visit, the Alliance will cover the medications as part of your covered urgent care. If your urgent care provider gives you a prescription to take to a pharmacy, the Medi-Cal Rx program will cover the medications. To learn more about Medi-Cal Rx, go to the "Prescription drugs covered by Medi-Cal Rx" heading in the section "Other Medi-Cal programs and services" in Chapter 4.

Emergency care

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

Inside the United States, including any U.S. Territories, you have the right to use any hospital or other setting for emergency care.

Outside the U.S., only emergency services requiring hospitalization in Canada and Mexico are covered. Emergency care and other care in other countries are not covered.

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, you would place your health (or your unborn baby's health) in serious danger, or you risk serious harm to your bodily functions, body organs, or body parts.

Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain
- Trouble breathing
- Severe burn
- Drug overdose
- Fainting

- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts (may be covered by county mental health plans)

Do not go to the ER for routine care or care that is not needed right away. You should get routine care from your PCP, who knows you best. If you are not sure if your medical condition is an emergency, call your PCP. You may also call the 24/7 Advice Nurse Line toll-free at 1-888-433-1876.

If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in the Alliance network. If you go to an ER, ask them to call the Alliance. You or the hospital to which you were admitted should call the Alliance within 24 hours after you get emergency care. If you are traveling outside the U.S., other than to Canada or Mexico, and need emergency care, the Alliance will **not** cover your care.

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

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

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

The Advice Nurse Line gives you free medical information and advice 24 hours a day, every day of the year. Call toll-free 1-888-433-1876 (TTY or 711).

Advice Nurse Line

The Advice Nurse Line gives you free medical information and advice 24 hours a day, every day of the year. Call toll-free at 1-888-433-1876 (TTY or 711) to:

- Talk to a nurse who will answer medical questions, give care advice, and help you decide if you should visit a provider right away.
- Get help with medical conditions such as diabetes or asthma, including advice about what kind of provider may be right for your condition.

The Advice Nurse Line **cannot** help with clinic appointments or medication refills. Call your provider's office if you need help with these services. The Advice Nurse Line has translation services available if needed.

Advance directives

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

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

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

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

You can call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) for more information.

Organ and tissue donation

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

4. Benefits and services

What your health plan covers

This chapter explains your covered services as a member of the Alliance. Your covered services are free as long as they are medically necessary and provided by a network provider. You must ask us for pre-approval (prior authorization) if the care is out-of-network except for certain sensitive services, emergency care, and urgent care. Your health plan may cover medically necessary services from an out-of-network provider. But you must ask the Alliance for pre-approval (prior authorization) for this. Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For Members under the age of 21, Medi-Cal services include care that is medically necessary to fix or help relieve a physical or mental illness or condition. For more details on your covered services, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Members under 21 years old get extra benefits and services. Read Chapter 5: Child and youth well care for more information.

Some of the basic health benefits the Alliance offers are listed below. Benefits with a star (*) may need pre-approval.

- Acupuncture*
- Acute (short-term treatment) home health therapies and services
- Adult immunizations
- Allergy care
- Anesthesiologist services
- Asthma prevention
- Audiology (hearing)*
- Basic care management
- Behavioral health treatments (BHT)*
- Biomarker testing
- California Children's Services (CCS)
- Cardiac rehabilitation
- Chiropractic services*
- Clinical trials

- Cognitive health assessments
- Community health worker (CHW) services
- Community Supports
- Dental services
- Diabetes Prevention Program (DPP)
- Dialysis and hemodialysis services
- Doula services
- Durable medical equipment (DME)*
- Dyadic care services
- Emergency room visits
- Emergency transportation services
- Enhanced Care Management (ECM) services
- Enteral and parenteral nutrition*
- Family therapy
- Hearing aids
- Home health services*
- Hospice care*
- Inpatient and outpatient services needed to treat a medical emergency
- Inpatient medical and surgical care*
- Inpatient hospital services
- Institutional long-term care*
- Laboratory and radiology services*
- Long-term care services and supports (custodial care)*
- Long-term home health therapies and services*
- Major organ transplant*
- Maternity and newborn care
- Medical supplies, equipment, and appliances
- Medical transportation
- Non-medical transportation
- Occupational therapy*
- Office visits and consultation at highly specialized care centers, for example, UCSF or Stanford*
- Orthotics/prostheses*
- Ostomy and urological supplies
- Outpatient hospital services
- Outpatient mental health services
- Outpatient surgery*
- Palliative care*
- PCP visits
- Pediatric services
- Pharmacies
- Physical therapy*
- Physician services
- Podiatry (foot) services*
- Postpartum Care Extension (PPCE) Program
- Prescription drugs covered by Medi-Cal Rx
- Preventive and wellness services and chronic disease management
- Pulmonary rehabilitation
- Rapid Whole Genome Sequencing (rWGS)
- Reconstructive services
- Rehabilitative and habilitative (therapy) services and devices*
- Skilled nursing facility services
- Specialist visits
- Specialty mental health services (SMHS)
- Speech therapy*
- Substance use disorder screening services
- Substance use disorder treatment services

- Surgical services
- Telehealth services
- Transgender (gender-affirming) services*
- Treatment therapies
- Urgent care
- Vision services*
- Women's health services

Definitions and descriptions of covered services can be found in Chapter 8, "Important numbers and words to know."

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness or injury.

Medically necessary services include those services that are necessary for age-appropriate growth and development, or to attain, maintain, or regain functional capacity.

For Members under 21 years of age, a service is medically necessary if it is necessary to correct or ameliorate defects and physical and mental illnesses or conditions under the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This includes care that is necessary to fix or help relieve a physical or mental illness or condition or maintain the member's condition to keep it from getting worse.

Medically necessary services do not include:

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

The Alliance will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not the Alliance.

Medically necessary services include covered services that are reasonable and necessary to:

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

For Members less than 21 years of age, medically necessary services include all covered services identified above, and any other necessary health care, diagnostic services, treatments, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions, as required by the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

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

The Alliance will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not the Alliance.

Medi-Cal benefits covered by the Alliance

Outpatient (ambulatory) services

Adult immunizations

You can get adult immunizations (shots) from a network provider without pre-approval (prior authorization). The Alliance covers those shots recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), including shots you need when you travel.

You can also get some adult immunization (shots) services in a pharmacy through Medi-Cal Rx. To learn more about the Medi-Cal Rx program, read the Other Medi-Cal programs and services section in this chapter.

Allergy care

The Alliance covers allergy testing and treatment, including allergy desensitization, hypo-sensitization or immunotherapy.

Anesthesiologist services

The Alliance covers anesthesia services that are medically necessary when you get outpatient care. This may include anesthesia for dental procedures when provided by an anesthesiologist who may require pre-approval (prior authorization).

Chiropractic services

The Alliance covers chiropractic services, limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to two services per month in combination with acupuncture, audiology, occupational therapy, and speech therapy services (limits do not apply to children under age 21). The Alliance may pre-approve other services as medically necessary.

The following members are eligible for chiropractic services:

- Children under age 21
- Pregnant people through the end of the month that includes 60-days following the end of a pregnancy
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility
- All members when services are provided at county hospital outpatient departments, outpatient clinics, FQHCs or RHCs that are in the Alliance's network. Not all FQHCs, RHCs or county hospitals offer outpatient chiropractic services.

Cognitive health assessments

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

Community health worker services

The Alliance covers community health worker (CHW) services for individuals when recommended by a physician or other licensed practitioner to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency.

Services may include:

- Health education and training, including control and prevention of chronic or infectious diseases; behavioral, perinatal and oral health conditions; and injury prevention
- Health promotion and coaching, including goal setting and creating action plans to address disease prevention and management

Dialysis and hemodialysis services

The Alliance covers dialysis treatments. The Alliance also covers hemodialysis (chronic dialysis) services if your doctor submits a request and the Alliance approves it.

Medi-Cal coverage does not include:

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

Doula services

The Alliance covers doula services to include personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period.

Dyadic care services

The Alliance covers dyadic care services for members and their caregivers that are medically necessary.

Family Therapy

The Alliance covers family therapy when medically necessary and composed of at least two family members.

Examples of family therapy include but are not limited to:

- Child-parent psychotherapy (ages 0 through 5)

- Parent-child interactive therapy (ages 2 through 12)
- Cognitive-behavioral couple therapy (adults)

Outpatient surgery

The Alliance covers outpatient surgical procedures. Those needed for diagnostic purposes, procedures considered to be elective, and specified outpatient medical or dental procedures must have pre-approval (prior authorization).

Physician services

The Alliance covers physician services that are medically necessary.

Podiatry (foot) services

The Alliance covers podiatry services as medically necessary for diagnosis and medical, surgical, mechanical, manipulative, and electrical treatment of the human foot. This includes the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg controlling the functions of the foot.

Treatment therapies

The Alliance covers different treatment therapies, including:

- Chemotherapy
- Radiation therapy

Maternity and newborn care

The Alliance covers these maternity and newborn care services:

- Breastfeeding education and aids
- Delivery and postpartum care
- Breast pumps and supplies
- Prenatal care
- Birthing center services
- Certified Nurse Midwife (CNM)
- Licensed Midwife (LM)
- Diagnosis of fetal genetic disorders and counseling
- Newborn care services

Telehealth services

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

Mental health services

Outpatient mental health services

The Alliance covers a member for an initial mental health assessment without needing pre-approval (prior authorization). You may get a mental health assessment at any time from a licensed mental health provider in the Alliance network without a referral.

Your PCP or mental health provider may make a referral for additional mental health screening to a specialist within the Alliance network to determine your level of impairment. If your mental health screening results determine you are in mild or moderate distress or have impairment of mental, emotional or behavioral functioning, the Alliance can provide mental health services for you.

The Alliance covers mental health services such as:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory, and problem solving
- Outpatient services for the purposes of monitoring medication therapy
- Outpatient laboratory, medications that are not already covered under the Medi-Cal Rx Contract Drug List (https://medi-calrx.dhcs.ca.gov/home/), supplies and supplements
- Psychiatric consultation
- Family Therapy

For help finding more information on mental health services provided by the Alliance, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

If your PCP or mental health provider cannot provide you treatment for a mental health disorder available in the Alliance network and within the times listed above in the "Timely access to care" section, the Alliance will cover and help you arrange out-of-network services.

If your mental health screening results determine you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider will refer you to the county mental health plan to get an assessment and help you connect with the next step in the process.

To learn more, read "Other Medi-Cal programs and services" on page 77 under, "Specialty mental health services."

Emergency services

Inpatient and outpatient services needed to treat a medical emergency

The Alliance covers all services that are needed to treat a medical emergency that happens in the U.S. (including territories such as Puerto Rico, U.S. Virgin Islands, etc.). The Alliance also covers emergency care that requires hospitalization in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent layperson could expect it to result in:

- Serious risk to your health; ***or***
- Serious harm to bodily functions; ***or***
- Serious dysfunction of any bodily organ or part; ***or***
- In the case of a pregnant person in active labor, meaning labor at a time when either of the following would occur:
    - There is not enough time to safely transfer you to another hospital before delivery.
    - The transfer may pose a threat to your health or safety or to that of your unborn child.

If a hospital emergency room gives you up to a 72-hour supply of an outpatient prescription drug as part of your treatment, the prescription drug will be covered as part of your covered Emergency Services. If a hospital emergency room provider gives you a prescription that you have to take to an outpatient pharmacy to be filled, Medi-Cal Rx will be responsible for the coverage of that prescription.

If a pharmacist at an outpatient pharmacy gives you an emergency supply of a medication, that emergency supply will be covered by Medi-Cal Rx and not the Alliance. Have the pharmacy call Medi-Cal Rx at 800-977-2273 if they need help in giving you an emergency medication supply.

Emergency transportation services

The Alliance covers ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico. If you receive emergency ambulance services in Canada or Mexico and you are not hospitalized during that episode of care, your ambulance services will not be covered by the Alliance.

Hospice and palliative care

The Alliance covers hospice care and palliative care for children and adults, which help reduce physical, emotional, social and spiritual discomforts. Adults age 21 or older may not receive both hospice care and palliative care services at the same time.

Hospice care

Hospice care is a benefit that services terminally ill members. Hospice care requires the member to have a life expectancy of 6 months or less. It is an intervention that focuses mainly on pain and symptom management rather than on a cure to prolong life.

Hospice care includes:

- Nursing services
- Physical, occupational or speech services
- Medical social services
- Home health aide and homemaker services
- Medical supplies and appliances

- Some drugs and biological services (some may be available through FFS Medi-Cal Rx)
- Counselling services
- Continuous nursing services on a 24-hour basis during periods of crisis and as necessary to maintain the terminally ill member at home
- Inpatient respite care for up to five consecutive days at a time in a hospital, skilled nursing facility or hospice facility
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing facility or hospice facility

Palliative care

Palliative care is patient and family-centered care that improves the quality of life by anticipating, preventing and treating suffering. Palliative care does not require the member to have a life expectancy of six months or less. Palliative care may be provided at the same time as curative care.

Palliative care includes:

- Advance care planning
- Palliative care assessment and consultation
- Plan of care including all authorized palliative and curative care
- Plan of care team including, but not limited to:
    - Doctor of medicine or osteopathy
    - Physician assistant
    - Registered nurse
    - Licensed vocational nurse or nurse practitioner
    - Social worker
    - Chaplain
- Care coordination
- Pain and symptom management
- Mental health and medical social services

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

Hospitalization

Anesthesiologist services

The Alliance covers medically necessary anesthesiologist services during covered hospital stays. An anesthesiologist is a provider who specializes in giving patients anesthesia. Anesthesia is a type of medicine used during some medical or dental procedures.

Inpatient hospital services

The Alliance covers medically necessary inpatient hospital care when you are admitted to the hospital.

Rapid Whole Genome Sequencing

Rapid Whole Genome Sequencing (rWGS) is a covered benefit for any Medi-Cal member who is one year of age or younger and is getting inpatient hospital services in an intensive care unit. It includes individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing. rWGS is a new way to diagnose conditions in time to affect ICU care of children one year of age or younger.

Surgical services

The Alliance covers medically necessary surgeries performed in a hospital.

The Postpartum Care Extension Program

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

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

Rehabilitative and habilitative (therapy) services and devices

This benefit includes services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

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

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

You receive the services at an in-network facility, unless an in-network doctor determines that it is medically necessary for you to receive the services in another location, or an in-network facility is not available to treat your health condition.

The plan covers:

Acupuncture

The Alliance covers acupuncture services to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of needles) are limited to four (4) services per month, (limits do not apply to children under age 21). The Alliance may pre-approve (prior authorize) additional services if medically necessary.

Audiology (hearing)

The Alliance covers audiology services. Outpatient audiology is limited to two services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services (limits do not apply to children under age 21). The Alliance may pre-approve (prior authorize) additional services as medically necessary.

Behavioral health treatments

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

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

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

Cardiac rehabilitation

The Alliance covers inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment (DME)

The Alliance covers the purchase or rental of DME supplies, equipment and other services with a prescription from a doctor, physician assistant, nurse practitioner, and clinical nurse specialist. Prescribed DME items may be covered as medically necessary to preserve bodily functions essential to activities of daily living or to prevent major physical disability.

Generally, the Alliance does not cover the following:

- Comfort, convenience or luxury equipment, features and supplies, except for retail-grade breast pumps as described under “Breast pumps and supplies” under the heading “Maternity and newborn care” in this chapter
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment, except when medically necessary for a Member under age 21
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (however diabetes blood glucose monitors, continuous glucose monitors, test strips and lancets are covered by Medi-Cal Rx)
- Electronic monitors of the heart or lungs except for infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse, except when medically necessary for a member under age 21

- Other items not generally used primarily for health care

However, in some cases, these items may be approved with Prior Authorization (Pre-Approval) submitted by your doctor.

Enteral and parenteral nutrition

These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. Enteral nutrition formulas and parenteral nutrition products may be covered through Medi-Cal Rx, when medically necessary. The Alliance may cover enteral and parenteral pumps and tubing, when medically necessary.

Hearing aids

The Alliance covers hearing aids if you are tested for hearing loss, the hearing aids are medically necessary, and have a prescription from your doctor. Coverage is limited to the lowest-cost aid that meets your medical needs. The Alliance will cover one hearing aid unless an aid for each ear is needed for results significantly better than you can get with one aid.

Hearing aids for Members under age 21

State law requires children who need a hearing aid to be referred to the California Children's Services (CCS) program to determine if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for medically necessary hearing aids. If the child is not eligible for CCS, we will cover medically necessary hearing aids as part of Medi-Cal coverage.

Hearing aids for Members age 21 and older

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

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

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

- Your hearing loss is such that your current hearing aid is not able to correct it

- Your hearing aid is lost, stolen, or broken and cannot be fixed and it was not your fault. You must give us a note that tells us how this happened.

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

- Replacement hearing aid batteries

Home health services

The Alliance covers health services provided in your home, when prescribed by your doctor and found to be medically necessary.

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

- Part-time skilled nursing care
- Part-time home health aide
- Skilled physical, occupational and speech therapy
- Medical social services
- Medical supplies

Medical supplies, equipment and appliances

The Alliance covers medical supplies that are prescribed by doctors, physician assistants, nurse practitioners, and clinical nurse specialists. Some medical supplies are covered through FFS Medi-Cal Rx and not the Alliance.

Medi-Cal coverage does not include the following:

- Common household items including, but not limited to:
    - Adhesive tape (all types)
    - Rubbing alcohol
    - Cosmetics
    - Cotton balls and swabs
    - Dusting powders
    - Tissue wipes
    - Witch hazel
- Common household remedies including, but not limited to:
    - White petrolatum
    - Dry skin oils and lotions
    - Talc and talc combination products
    - Oxidizing agents such as hydrogen peroxide

    - Carbamide peroxide and sodium perborate
- Non-prescription shampoos
- Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid and zinc oxide paste
- Other items not generally used primarily for health care and which are regularly and primarily used by persons who do not have a specific medical need for them.

Occupational therapy

The Alliance covers occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction and consultative services. Occupational therapy services are limited to two services per month in combination with acupuncture, audiology, chiropractic and speech therapy services (limits do not apply to children under age 21). The Alliance may pre-approve (prior authorize) additional services as medically necessary.

Orthotics/prostheses

The Alliance covers orthotic and prosthetic devices and services that are medically necessary and prescribed by your doctor, podiatrist, dentist, or non-physician medical provider. This includes implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part.

Ostomy and urological supplies

The Alliance covers ostomy bags, urinary catheters, draining bags, irrigation supplies and adhesives. This does not include supplies that are for comfort, convenience or luxury equipment or features.

Physical therapy

The Alliance covers medically necessary physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services and application of topical medications.

Pulmonary rehabilitation

The Alliance covers pulmonary rehabilitation that is medically necessary and prescribed by a doctor.

Skilled nursing facility services

The Alliance covers skilled nursing facility services as medically necessary if you are disabled and need a high level of care. These services include room and board in a licensed facility with skilled nursing care on a 24-hour basis. The Alliance will cover your care in a long-term care facility if authorized.

Speech therapy

The Alliance covers speech therapy that is medically necessary. Speech therapy services are limited to two services per month, in combination with acupuncture, audiology, chiropractic and occupational therapy services (limits do not apply to children under age 21). The alliance may pre-approve (prior authorize) additional services as medically necessary.

Transgender services

The Alliance covers transgender (gender-affirming services) as a benefit when they are medically necessary or when the services meet the criteria for reconstructive surgery.

Clinical trials

The Alliance covers routine patient care costs for patients accepted into Phase I, Phase II, Phase III or Phase IV clinical trials if it is related to the prevention, detection, or treatment of cancer or other life-threatening conditions and if the study meets all requirements under Health and Safety Code 1370.6(d)(1). Medi-Cal Rx, a Medi-Cal FFS program, covers most outpatient prescription drugs. Read the “Outpatient prescription drugs” section later in this chapter for more information.

Laboratory and radiology services

The Alliance covers outpatient and inpatient laboratory and X-ray services when medically necessary. Various advanced imaging procedures, such as CT scans, MRI and PET scans, are covered based on medical necessity.

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services

- American Academy of Pediatrics Bright Futures recommendations (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Asthma prevention services
- Preventive services for women recommended by the American College of Obstetricians and Gynecologists
- Help to quit smoking, also called smoking cessation services
- The United States Preventive Services Task Force Grade A and B recommended preventive services

Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the FDA. The Alliance's PCP and OB/GYN specialists are available for family planning services.

For family planning services, you may also choose a Medi-Cal doctor or clinic not connected with the Alliance without having to get pre-approval (prior authorization) from the Alliance. Services from an out-of-network provider not related to family planning may not be covered. To learn more, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Read Chapter 5: Child and youth well care for preventive care information for youth 20 years old and younger.

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program. This 12-month program is focused on lifestyle changes and designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. Members who meet the criteria may qualify for a second year. The program provides education and group support.

Techniques include, but are not limited to:

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

Members must meet program eligibility requirements to join DPP. Call the Alliance to learn more about the program and eligibility.

Reconstructive services

The Alliance covers surgery to correct or repair abnormal structures of the body to improve or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease, or breast reconstruction after a mastectomy. Some limitations and exceptions may apply.

Substance use disorder screening services

The plan covers:

- Alcohol misuse screenings and illicit-drug screenings

Go to “Substance use disorder treatment services” later in this chapter for treatment coverage through the county.

Vision benefits

The plan covers:

- Routine eye exam once every 24 months; additional or more frequent eye exams are covered if medically necessary for members, such as those with diabetes.
- Eyeglasses (frames and lenses) once every 24 months; when you have a valid prescription.
- Replacement eyeglasses within 24 months if you have a change in prescription or your eyeglasses are lost, stolen, or broken (and cannot be fixed), and it was not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken.
- Low vision devices for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine, or surgery that interferes with a person’s ability to perform everyday activities (i.e., age-related macular degeneration).
- Medically necessary contact lenses
  Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (i.e., missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus.

Transportation benefits for situations that are not emergencies

You are entitled to medical transportation if you have medical needs that do not allow you to use a car, bus or taxi to your appointments. Medical transportation can be provided for covered services and Medi-Cal-covered pharmacy appointments. If you need medical transportation, you can request this by speaking to your doctor, dentist, podiatrist, or mental health or substance use disorder provider. Your provider will decide the correct type of transportation to meet your needs. If they find that you need medical transportation, they will prescribe it by completing a form and submitting it to the Alliance. Once approved, the approval is good for 12 months depending on the medical need. Additionally, there are no limits for how many rides you can get. Your doctor will need to reassess your medical need for medical transportation and re-approve every 12 months.

Medical transportation is an ambulance, litter van, wheelchair van or air transport. The Alliance allows the lowest cost of medical transportation for your medical needs when you need a ride to your appointment. That means, for example, if you can physically or medically be transported by a wheelchair van, the Alliance will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Medical transportation must be used when:

- It is physically or medically needed as determined with a written authorization by a doctor or other provider because you are not able to physically or medically able to use a bus, taxi, car or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle or place of treatment due to a physical or mental disability.

To ask for medical transportation that your doctor has prescribed for non-urgent (routine) appointments, please call Alliance transportation services toll-free at 1-855-891-7171 or the Alliance Case Management Department toll-free at 1-877-251-9612 at least three (3) business days (Monday-Friday) before your appointment. For urgent appointments, please call as soon as possible. Please have your Alliance member ID card ready when you call.

Limits of medical transportation: The Alliance provides the lowest-cost medical transportation that meets your medical needs to the closest provider from your home where an appointment is available. Medical transportation will not be provided if the service is not covered by Medi-Cal. If the appointment type is covered by Medi-Cal but not through the health plan, the Alliance will help you schedule your transportation. A list of covered services is in this Member Handbook. Transportation is not covered outside of the network or service area unless pre-authorized by the Alliance. For more information or to ask for medical transportation, please call ModivCare toll-free at 1-855-891-7171 or the Alliance Case Management Department toll-free at 1-877-251-9612.

Cost to member: There is no cost when transportation is arranged by the Alliance.

How to get non-medical transportation

Your benefits include getting a ride to your appointments when the appointment is for a Medi-Cal covered service and you do not have any access to transportation.

You can get a ride, at no cost to you, when you have tried all other ways to get transportation and are:

- Traveling to and from an appointment for a Medi-Cal service authorized by your provider; or
- Picking up prescriptions and medical supplies

The Alliance allows you to use a car, taxi, bus or other public/private way of getting to your medical appointment for Medi-Cal covered services. The Alliance will cover the lowest cost non-medical transportation type that meets your needs. Sometimes, the Alliance can give reimbursement for rides in a private vehicle that you arrange. This must be approved by the Alliance before you get the ride, and you must tell us why you cannot get a ride any other way, like the bus. You can tell us by calling us, by emailing, or in person. You cannot drive yourself and be reimbursed.

Mileage reimbursement requires all of the following:

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

To request a ride for services that have been authorized, call ModivCare toll-free at 1-855-891-7171 or the Alliance Case Management Department toll-free at 1-877-251-9612 at least three (3) business days (Monday-Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have your Alliance member ID card ready when you call.

Note: American Indians may contact their local Indian Health Clinic to request non-medical transportation.

Limits of non-medical transportation: The Alliance provides the lowest cost non-medical transportation that meets your needs to the closest provider from your home where an appointment is available. Members cannot drive themselves or be reimbursed directly. For more information, please call ModivCare toll-free at 1-855-891-7171 or the Alliance Case Management Department toll-free at 1-877-251-9612.

Non-medical transportation does not apply if:

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

Cost to member: There is no cost when non-medical transportation is arranged by the Alliance.

Travel expenses: In certain instances, the Alliance may cover travel expenses such as meals, hotel stays, and other related expenses if you have to travel for doctor's appointments that are not available near your home. This can also be covered for an accompanying attendant and a major organ transplant donor, if applicable. You need to request pre-approval (prior authorization) for these services by contacting ModivCare toll-free at 1-855-891-7171 or the Alliance Case Management Department toll-free at 1-877-251-9612.

Other Alliance covered benefits and programs

Long-term care services and supports

The Alliance covers these long-term care benefits for members who qualify:

- Long-term care facility services as approved by the Alliance
- Skilled nursing facility services as approved by the Alliance
- Institutional long-term care as approved by the Alliance

If you qualify for long-term care services, the Alliance will make sure you are placed in a health care facility that provides the level of care most appropriate to your medical needs. The Alliance covers long-term care in a nursing home if requested by your doctor and approved by the Alliance.

If you have questions about long-term care services, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Basic care management

The Alliance will help coordinate and manage your health care needs and services at no cost to you. The Alliance will coordinate your health care services to help ensure that you receive all medically necessary services, including prescription drugs, and behavioral health care services, even if those services are covered by another program and not the Alliance. This includes care coordination across settings, such as if you need hospitalization and are discharged to your home or a skilled nursing facility.

If you have questions or concerns about your health or the health of your child, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Enhanced Care Management

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

If you qualify, you may be contacted about ECM services. You can also call the Alliance to find out if and when you can receive ECM. Or talk to your health care provider who can find out if you qualify for ECM and when and how you can receive it.

Covered ECM services

If you qualify for ECM, you will have your own care team, including a Lead Care Manager. This person will talk to you and your doctors, specialists, pharmacists, case managers, social services providers and others to make sure everyone works together to get you the care you need. A Lead Care Manager can also help you find and apply for other services in your community.

ECM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

To find out if ECM may be right for you, talk to your Alliance representative or health care provider.

Cost to member

There is no cost to the member for ECM services.

Community Supports

Community Supports may be available under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for Members to receive. If you qualify, these services may help you live more independently. They do not replace benefits that you already get under Medi-Cal.

The Alliance offers the following Community Supports:

- Services for homeless people.

- Medically supportive food/meals or medically tailored meals for people with health conditions that can be helped by getting proper, healthy foods.
- Asthma remediation for members who go to the emergency room or hospitals with asthma attacks. Services are meant to prevent asthma attacks and include things like dust covers, air filters, and cleaning supplies.

If you need help or would like to find out what Community Supports may be available for you, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) or call your health care provider.

Major Organ Transplant

Transplants for children under age 21

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

Transplants for adults age 21 and older

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

The following major organ transplants covered by the Alliance include but are not limited to:

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

Other Medi-Cal programs and services

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

Sometimes the Alliance does not cover services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. The Alliance will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not the Alliance. This section lists some of these services. To learn more, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Outpatient prescription drugs

Prescription drugs covered by Medi-Cal Rx

Prescription drugs given by a pharmacy are covered by Medi-Cal Rx, a Medi-Cal FFS program. Some drugs given by a provider in an office or clinic may be covered by the Alliance. Your provider can prescribe you drugs that are on the Medi-Cal Rx Contract Drugs List.

Sometimes, a drug is needed and is not on the Contract Drug List. These drugs will need to be approved before they can be filled at the pharmacy. Medi-Cal Rx will review and decide these requests within 24 hours.

- A pharmacist at your outpatient pharmacy may give you a 72-hour emergency supply if they think you need it. Medi-Cal Rx will pay for the emergency medication supply given by an outpatient pharmacy.
- Medi-Cal Rx may say no to a non-emergency request. If they say no, they will send you a letter to tell you why. They will tell you what your choices are. Go to the “Complaints” section in Chapter 6 Reporting and solving problems for more information.

To find out if a drug is on the Contract Drug List or to get a copy of the Contract Drug List, call Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711), visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home.

Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with Medi-Cal Rx. You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at https://medi-calrx.dhcs.ca.gov/home. You can also find a pharmacy near you or a pharmacy that can mail your prescription to you by calling Medi-Cal Rx at 800-977-2273 (TTY 800-977-2273 and press 5 or 711).

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

Members may also receive transportation services from the Alliance to get to pharmacies. To learn more about transportation services, read “Transportation benefits for situations that are not emergencies” in this handbook.

Specialty mental health services

Some mental health services are provided by county mental health plans instead of the Alliance. These include specialty mental health services (SMHS) for Medi-Cal members who meet criteria for SMHS. SMHS may include these outpatient, residential and inpatient services:

Outpatient services:

- Mental health services
- Medication support services
- Day treatment intensive services
- Day rehabilitation services
- Crisis intervention services
- Crisis stabilization services
- Targeted case management services
- Therapeutic behavioral services (covered for members under 21 years old)
- Intensive care coordination (ICC) (covered for members under 21 years old)
- Intensive home-based services (IHBS) (covered for members under 21 years old)
- Therapeutic foster care (TFC) (covered for members under 21 years old)

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

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

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

If the Alliance determines that you will need services from the county mental health plan, the Alliance will help you connect with the county mental health plan services.

Substance use disorder treatment services

The county provides substance use disorder services to Medi-Cal members who meet the criteria for these services. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. To find all counties' telephone numbers online, visit dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

Dental services

Medi-Cal Dental Program is the same as Fee-for-Service (FFS) Medi-Cal for your dental services. Before you get dental services, you must show your BIC to the dental provider and make sure the provider takes FFS Dental.

Medi-Cal Dental covers some dental services, including:

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

- Scaling and root planing
- Complete and partial dentures
- Orthodontics for children who qualify
- Topical fluoride

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

California Children's Services (CCS)

CCS is a Medi-Cal program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems and who meet the CCS program rules. If the Alliance or your PCP believes your child has a CCS-eligible condition, they will be referred to the CCS county program to be assessed for eligibility.

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

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

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

CCS covers children with health conditions such as:

- Congenital heart disease
- Cancers
- Tumors
- Hemophilia
- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts

- Cerebral palsy
- Seizures under certain circumstances
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

Medi-Cal pays for CCS services. If your child is not eligible for CCS program services, they will keep getting medically necessary care from the Alliance.

To learn more about CCS, you can visit the CCS web page at www.dhcs.ca.gov/services/ccs. Or call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Institutional Long-Term Care

The Alliance covers long-term care in a nursing home if requested by your doctor and approved by the Alliance.

To learn more, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) .

Services you cannot get through the Alliance or Medi-Cal

There are some services that neither the Alliance nor Medi-Cal will cover, including, but not limited to:

- In vitro fertilization (IVF), including but not limited to infertility studies or procedures to diagnose or treat infertility
- Fertility preservation
- Experimental services
- Home modifications
- Vehicle modifications
- Cosmetic surgery

The Alliance may cover a non-benefit if medical necessity is established. Your provider must submit a Prior Authorization to the Alliance Utilization Management Department with the reasons why the non-benefit is medically needed.

To learn more call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Evaluation of new and existing technologies

The Alliance has a process to review new medications or procedures, or new uses of current medications or procedures.

Our goal is to ensure that Alliance members receive safe and effective care through the following ways:

1. The Alliance gathers and reviews information about the new medication or procedure. This can come from government agencies, published scientific research, and experts in the technology.
2. The Alliance Health Care Quality Committee and the Pharmacy and Therapeutics Committee discuss and decide whether to include the new technology as a covered benefit.
3. The Alliance will then tell its providers about the new benefit and how to request approval.

5. Child and youth well care

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

Pediatric services (Children under age 21)

Members under 21 years old are covered for needed care. The following list includes medically necessary services to treat or ameliorate defects and physical or mental diagnoses.

Covered services include but are not limited to the list below:

- Well-child visits and teen check-ups (Important visits children need)
- Immunizations (shots)
- Behavioral health assessment and treatment
- Mental health evaluation and treatment, including individual, group and family psychotherapy (specialty mental health services are covered by the county)
- Lab tests, including blood lead poisoning screening
- Health and preventive education
- Vision services
- Dental services (covered under Medi-Cal Dental)
- Hearing services (covered by CCS for children who qualify. The Alliance will cover services for children who do not qualify for CCS)

These services are called Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. EPSDT services that are recommended by pediatricians' Bright Futures guidelines (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf) to help you or your child stay healthy are covered at no cost to you.

Well-child health check-ups and preventive care

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

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

Your child should get check-ups at these ages:

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

Well-child health check-ups include:

- A complete history and head-to-toe physical exam
- Age-appropriate shots (California follows the American Academy of Pediatrics Bright Futures Periodicity schedule https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Lab tests, including blood lead poisoning screening
- Health education
- Vision and hearing screening
- Oral health screening
- Behavioral health assessment

When a physical problem or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem. If the care is medically necessary and the Alliance is responsible for paying for the care, then the Alliance covers the care at no cost to you.

These services include:

- Doctor, nurse practitioner and hospital care
- Shots to keep your child healthy
- Physical, speech/language and occupational therapies
- Home health services, which could be medical equipment, supplies and appliances
- Treatment for vision problems, including eyeglasses
- Treatment for hearing problems, including hearing aids when they are not covered by CCS
- Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
- Case management and health education
- Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance

Blood lead poisoning screening

All children enrolled in the Alliance should get blood lead poisoning screening at 12 and 24 months or between the ages of 36 and 72 months if they were not tested earlier.

Help getting child and youth well-care services

The Alliance will help members under 21 years old and their families get the services they need.

An Alliance care coordinator can:

- Tell you about available services
- Help find network providers or out-of-network providers, when needed
- Help make appointments
- Arrange medical transportation so children can get to their appointments

- Help coordinate care for services that are available through FFS Medi-Cal, such as:
    - Treatment and rehabilitative services for mental health and substance use disorders
    - Treatment for dental issues, including orthodontics

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

Dental check-ups

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

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

Babies ages 1-4

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

Kids ages 5-12

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

Kids ages 13-20

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

*Sedation and general anesthesia should be considered when it is documented why local anesthesia is not appropriate or contraindicated, and the dental treatment is pre-approved or does not need pre-approval (prior authorization).

Contraindications include, but are not limited to:

- Physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment
- Extensive restorative or surgical procedures
- An uncooperative child
- An acute infection at an injection site
- Failure of a local anesthetic to control pain

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

Additional preventive education referral services

If you are worried that your child is having a hard time taking part and learning at school, talk to your child's Primary Care Doctor, teachers or administrators at the school. In addition to your medical benefits covered by the Alliance, there are services that the school must provide to help your child learn and not fall behind.

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

- Speech and Language Services
- Psychological Services
- Physical Therapy
- Occupational Therapy

- Assistive Technology
- Social Work Services
- Counseling Services
- School Nurse Services
- Transportation to and from school

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

6. Reporting and solving problems

There are two ways to report and solve problems:

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

You have the right to file grievances and appeals with the Alliance to tell us about your problem. This does not take away any of your legal rights and remedies. We will not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all members.

You should always contact the Alliance Member Services Department first to let us know about your problem. Call us Monday through Friday, 8 a.m. to 5 p.m., at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Tell us about your problem.

You can file a grievance by phone, in writing, in person, or electronically:

- **By phone**: Contact us Monday through Friday, 8 a.m. to 5 p.m. by calling 1-510-747-4567 or toll-free at 1-877-932-2738. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711 to use the California Relay Service.
- **In writing**: Fill out a complaint form or write a letter and send it to:

  Alameda Alliance for Health
  ATTN: Alliance Grievance and Appeals Department
  1240 South Loop Road
  Alameda, CA 94502

- **In person:** Visit your doctor's office or the Alliance and say you want to file a grievance.

- **Electronically:** Visit the Alliance website at **www.alamedaalliance.org**.

If your grievance or appeal is still not resolved after 30 days, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC) and ask them to review your complaint or conduct an Independent Medical Review. You can call the DMHC at 1-888-466-2219 (TTY 1-877-688-9891 or 711) or visit the DMHC website for more information: https://www.dmhc.ca.gov.

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

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

To report incorrect information about your additional health insurance, please call Medi-Cal Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-800-541-5555.

Complaints

A complaint (or grievance) is when you have a problem or are unhappy with the services you are receiving from the Alliance or a provider. There is no time limit to file a complaint. You can file a complaint with the Alliance at any time by phone, in writing or online.

- **By phone:** Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711), Monday through Friday, 8 a.m. to 5 p.m. Give your Alliance member ID number, your name, and the reason for your complaint.
- **By mail:** Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the reason for your complaint. Tell us what happened and how we can help you.

Mail the form to:

Alameda Alliance for Health
ATTN: Grievance and Appeals Department
1240 South Loop Road
Alameda, CA 94502

Your doctor's office will have complaint forms available.

- **Online:** Visit the Alliance website. Go to www.alamedaalliance.org.

If you need help filing your complaint, we can help you. We can give you free language services. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Within 5 calendar days of getting your complaint, we will send you a letter telling you we got it. Within 30 days, we will send you another letter that tells you how we resolved your problem. If you call the Alliance about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and your grievance is resolved by the end of the next business day, you may not get a letter.

If you have an urgent matter involving a serious health concern, we will start an expedited (fast) review and provide you with a decision within 72 hours. To ask for an expedited review, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Within 72 hours of receiving your complaint, we will make a decision about how we will handle your complaint and whether we will expedite your complaint. If we determine that we will not expedite your complaint, we will let you know that we will resolve your complaint within 30 days. You may contact the DMHC directly for any reason, including if you believe your concern qualifies for expedited review, or if the Alliance does not respond to you within the 72-hour period.

Complaints related to Medi-Cal Rx pharmacy benefits are not subject to the Alliance grievance process or eligible for Independent Medical Review. Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling 800-977-2273 (TTY 800-977-2273 and press 5 or 711) or going to https://medi-calrx.dhcs.ca.gov/home/.

However, complaints related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1-877-688-9891. You can find the Independent Medical Review/ Complaint form and instructions online at the DMHC's website: www.dmhc.ca.gov.

Appeals

An appeal is different from a complaint. An appeal is a request for us to review and change a decision we made about your service(s). If we sent you a Notice of Action (NOA) letter telling you that we are denying, delaying, changing or ending a service(s), and you do not agree with our decision, you can ask us for an appeal. Your PCP or another provider can also ask us for an appeal for you with your written permission.

You must ask for an appeal within 60 days from the date on the NOA you got from us. If we decided to reduce, suspend, or stop a service(s) you are getting now, you can continue getting that service(s) while you wait for your appeal to be decided. This is called Aid Paid Pending. To receive Aid Paid Pending, you must ask us for an appeal within 10 days from the date on the NOA or before the date we said your service(s) will stop, whichever is later. When you request an appeal under these circumstances, the service(s) will continue.

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

- **By phone:** Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711), Monday through Friday, 8 a.m. to 5 p.m. Give your name, health plan ID number, and the service you are appealing.
- **By mail:** Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number, and the service you are appealing.

  Mail the form to:

  Alameda Alliance for Health
  ATTN: Grievance and Appeals Department
  1240 South Loop Road
  Alameda, CA 94502

Your doctor's office will have appeal forms available.
- **Online:** Visit the Alliance website. Go to www.alamedaalliance.org.

If you need help asking for an appeal or with Aid Paid Pending, we can help you. We can give you free language services. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Within 5 days of getting your appeal, we will send you a letter telling you we got it. Within 30 days, we will tell you our appeal decision and send you a Notice of Appeal Resolution (NAR) letter. If we do not provide you with our appeal decision within 30 days, you can request a State Hearing and an IMR with the DMHC. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has final say.

If you or your doctor wants us to make a fast decision because the time it takes to decide your appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). We will make a decision within 72 hours of receiving your appeal.

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

If you requested an appeal and got a NAR letter telling you we did not change our decision, or you never got a NAR letter and it has been past 30 days, you can:

- Ask for a **State Hearing** from the California Department of Social Services (CDSS), and a judge will review your case.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have the Alliance's decision reviewed or ask for an **Independent Medical Review (IMR)** from the DMHC. During DMHC's IMR, an outside doctor who is not part of the Alliance will review your case. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1-877-688-9891. You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: https://www.dmhc.ca.gov.

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

You are entitled to both a State Hearing and an IMR. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say.

The sections below have more information on how to ask for a State Hearing and an IMR.

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by the Alliance. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY 800-977-2273 and press 5 or 711). However, complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review.

If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing. **Medi-Cal Rx pharmacy benefit decisions are not subject to the IMR process with the DMHC.**

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

An IMR is when an outside doctor who is not related to your health plan reviews your case. If you want an IMR, you must first file an appeal with the Alliance. If you do not hear from your health plan within 30 calendar days, or if you are unhappy with your health plan's decision, then you may request an IMR. You must ask for an IMR within 6 months from the date on the notice telling you of the appeal decision, but you only have 120 days to request a State Hearing so if you want an IMR and a State Hearing file your complaint as soon as you can. Remember, if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say.

You may be able to get an IMR right away without filing an appeal first. This is in cases where your health concern is urgent, such as those involving a serious threat to your health.

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

Here is how to ask for an IMR:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **https://www.dmhc.ca.gov/** has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with people from the California Department of Social Services (CDSS). A judge will help to resolve your problem or tell you that we made the correct decision. You have the right to ask for a State Hearing if you have already asked for an appeal with us and you are still not happy with our decision, or if you did not get a decision on your appeal after 30 days.

You must ask for a State Hearing within 120 days from the date on our NAR letter. However, if we gave you Aid Paid Pending during your appeal, and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 days of our NAR letter, or before the date we said your service(s) will stop, whichever is later. If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, contact the Alliance Monday through Friday, 8 a.m. to 5 p.m. by calling 1-510-747-4567 or toll-free at 1-877-932-2738. If you cannot hear or speak well, please call 1-800-735-2929. Your PCP can ask for a State Hearing for you with your written permission.

Sometimes you can ask for a State Hearing without completing our appeal process.

For example, you can request a State Hearing without having to complete our appeal process if we did not notify you correctly or on time about your service(s). This is called Deemed Exhaustion.

Here are some examples of Deemed Exhaustion:

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

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

- **By phone:** Call the CDSS Public Response Unit at 1-800-952-5253 (TTY 1-800-952-8349 or 711).
- **By mail**: Fill out the form provided with your appeals resolution notice. Send it to:

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

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

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

Fraud, waste and abuse

If you suspect that a provider or a person who gets Medi-Cal has committed fraud, waste, or abuse, it is your right to report it by calling the confidential toll-free number 1-800-822-6222 or submitting a complaint online at https://www.dhcs.ca.gov/.

Provider fraud, waste and abuse include:

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

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

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

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

Send your report to:

Alameda Alliance for Health
ATTN: Compliance Department
1240 South Loop Road
Alameda, CA 94502

Anonymous Compliance Hotline: 1-855-587-0810
Phone Number: 1-510-747-4500
People with hearing and speaking impairments (CRS/TTY): 711/1-800-735-2929

7. Rights and responsibilities

As a member of the Alliance, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of the Alliance.

Your rights

These are your rights as a member of the Alliance:

1. To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain the confidentiality of your medical information.
2. To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
3. To receive fully translated written member information in your preferred language, including all grievance and appeals notices.
4. To make recommendations about the Alliance's member rights and responsibilities policy.
5. To be able to choose a primary care provider within the Alliance network.
6. To have timely access to network providers.
7. To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
8. To voice grievances, either verbally or in writing, about the organization or the care you got.
9. To know the medical reason for the Alliance's decision to deny, delay, terminate or change a request for medical care.
10. To get care coordination.
11. To ask for an appeal of decisions to deny, defer, or limit services or benefits.
12. To get no-cost interpreting services for your language.
13. To get free legal help at your local legal aid office or other groups.
14. To formulate advance directives.

15. To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with the Alliance and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
16. To disenroll from the Alliance and change to another health plan in the county upon request.
17. To access minor consent services.
18. To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
19. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
20. To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
21. To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
22. Freedom to exercise these rights without adversely affecting how you are treated by the Alliance, your providers or the State.
23. To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside the Alliance's network pursuant to the federal law.
24. To access the Advice Nurse Line, anytime, 24 hours a day, 7 days a week. Medi-Cal members can call toll-free at 1-888-433-1876.
25. To access your medical records. You have the right to share the records of any telehealth services provided with your primary care doctor. These records will be shared with your primary care doctor, unless you object.

Your responsibilities

Alliance members have these responsibilities:

1. To treat all the Alliance staff and health care staff with respect and courtesy.
2. To give your doctors and the Alliance correct information.

3. To work with your doctor. Learn about your health, and help to set goals for your health. Follow care plans and advice for care that you have agreed to with your doctors.
4. To always present your Alliance member identification (ID) card to receive services.
5. To ask questions about any medical condition, and make sure you understand your doctor's reasons and instructions.
6. To help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
7. To make and keep medical appointments and inform your doctor at least **24 hours** in advance when you need to cancel an appointment.
8. To use the emergency room only in the case of an emergency or as directed by your doctor.

Notice of non-discrimination

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

The Alliance provides:

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

If you need these services, contact the Alliance Member Services Department Monday through Friday, 8 a.m. to 5 p.m. by calling 1-510-747-4567 or toll-free at 1-877-932-2738. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711 to use the California Relay Service.

How to file a grievance

If you believe that the Alliance has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with the Alliance Member Services Department.

You can file a grievance in writing, in person, or electronically:

- **By phone**: Contact the Alliance Monday through Friday, 8 a.m. to 5 p.m. by calling 1-510-747-4567 or toll-free at 1-877-932-2738. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711 to use the California Relay Service.
- **In writing:** Fill out a complaint form or write a letter and send it to:

  Alameda Alliance for Health
  ATTN: Grievance and Appeals Department
  1240 South Loop Road
  Alameda, CA 94502

- **In person:** Visit your doctor's office or the Alliance and say you want to file a grievance.
- **Electronically:** Visit the Alliance website at www.alamedaalliance.org.

Office of Civil Rights – California Department of Health Care Services

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

- **By phone:** Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- **In writing:** Fill out a complaint form or send a letter to:

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

- Complaint forms are available at https://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- **Electronically:** Send an email to CivilRights@dhcs.ca.gov.

Office of Civil Rights – U.S. Department of Health and Human Services

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

- **By phone:** Call 1-800-368-1019. If you cannot speak or hear well, please call TTY 1-800-537-7697 or 711 to use the California Relay Service.
- **In writing:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, DC 20201

- Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.
- **Electronically:** Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/cp.

Ways to get involved as a member

The Alliance wants to hear from you. Each quarter, the Alliance has meetings to talk about what is working well and how the Alliance can improve. Members are invited to attend. Come to a meeting!

Alliance Consumer Advisory Committee (CAC)

The Alliance has a group called the Consumer Advisory Committee (CAC), also known as the Member Advisory Committee (MAC). This group is made up of eligible members, member advocates, providers, and community partners. You can join this group if you would like. The group talks about how to improve Alliance policies and is responsible for:

- Providing a link between the Alliance and the community
- Advising on cultural, linguistic, and policy concerns
- Offering a member's point of view about the needs and concerns of special groups such as:
  - Older adults and persons with disabilities
  - Families with children

- People who speak a primary language other than English

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

Notice of privacy practices

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

Members who may consent to receive sensitive services are not required to obtain any other member's authorization to receive sensitive services or to submit a claim for sensitive services. The Alliance will direct communications regarding sensitive services to a member's alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. The Alliance will not disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. The Alliance will accommodate requests for confidential communication in the form and format requested, if it is readily producible in the requested form and format, or at alternative locations. A member's request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

We at Alameda Alliance for Health (Alliance) are committed to keeping your information confidential. By law we must keep your information private. By law we must provide you with notice of our legal duties and privacy practices about your information. This notice lets you know how we may use and share your information. It also lets you know your rights and our legal obligations with respect to your information.

If you have any questions about this Notice, please contact us at:

Alameda Alliance for Health
ATTN: Member Services Department
1240 South Loop Road
Alameda, CA 94502

Phone Number: 1-510-747-4567
Toll-Free: 1-877-932-2738
People with hearing and speaking impairments (CRS/TTY): 711/1-800-735-2929

Types of Information We Keep

The Alliance receives information on you when you choose the Alliance as your health plan. We get your information from the State of California, your doctor/other health care providers on your behalf, and you.

The information the Alliance collects varies by program. We keep the following information: your contact information, such as your address and phone number; your age, ethnicity, gender, and language. We collect and keep your health care information which is called Protected Health Information or PHI. This includes: the doctor you see and their findings about your health; your health care conditions and diagnosis; your health history; your prescriptions; and lab tests. We collect and keep information about the health and wellness classes you went to and whether you were in other health care programs or plans. We also collect and keep the financial records you present when you apply for coverage. This information helps us provide you with the service you need.

Please know that the Alliance will protect your privacy and your information. This information could be oral, written, and electronic. An example of a way that we protect your information is that the Alliance requires staff to be trained on ways to keep your health information private and secure. This also means that Alliance staff are only permitted to access your information at a level necessary to do their job.

How We May Use or Share Your Information

1. **Treatment –** We may use or share your information to help your doctors or hospitals provide health care to you. For example, if you are in the hospital, we may give them your health records sent to us by your doctor. Or we may share this information with a pharmacist who needs it for a prescription for you, or a lab that performs a test for you.
2. **Payment –** We may use or share your information to pay for your health care-related bills. For example, your doctor will give us information we need before we pay them. We may also share information with other health care providers so they can be paid.
3. **Health care operations –** We may use or share your information to operate this health plan.

- For example, we may use or share your information to review and improve the quality of care you receive. It can also be used to review the skills and qualifications of our providers.
- We may use or share this information so we can approve services or referrals.
- We may also use or share this information when we need to for medical reviews or case management. For example, we may refer you to an asthma class if you have asthma.
- We may also use or share this information when we need to for legal services, audits, or business planning and management.
- We may also share your information with our "business associates" that provide certain plan services for us. We will not share your information with these outside groups unless they agree to protect it. Under California law, all parties that receive information may not share it again, except as specifically needed or allowed by law.

4. **Appointment reminders –** We may use or share your information to remind you about doctor or health care visits. If you are not home, we may leave this information on your answering machine or leave a message with the person who answers the phone.
5. **Notification and communication with family –** We may share your information to let a family member, your personal representative or a person responsible for your care know about where you are, your general condition or your death. In case of a disaster, we may share information with a group like the Red Cross so they can contact you. We may also share information with someone who helps you with your care or helps pay for your care. If you are able to decide, we will let you decide before we share the information. But we may share this information in a disaster even if you do not want us to, so we can respond to the emergency. If you are not able to decide because of your health or you cannot be found, our professional staff will use their best judgment in sharing information with your family and others.
6. **Required by law –** As required by law, we will use or share your information, but we will limit our use or sharing to only what we are allowed to use or share by the law.
7. **Provider peer review –** We may use or share your information to review the skills of your provider or the quality of care you receive.

8. **Group health plans –** If you are a member of a group health plan, we may share information with the sponsor of your group health plan. For instance, if your employer provides your health coverage, we may let your employer know if you are still a member of the plan.
9. **Research –** We may share your information without your written consent if the research meets certain rules.
10. **Marketing –** We may contact you to give you information about products or a service. We will not use or share your information for this purpose without your written permission.
11. **Court and administrative proceedings –** We may, and sometimes need to by law, share your information for an administrative or judicial proceeding as we are told to by a court or administrative order, if you were told of the request and you did not object or the court or administrative judge did not agree with your objection.
12. **Health monitoring activities –** We may, and sometimes need to by law, share your information with health monitoring agencies for audits, investigations, inspections and other proceedings, only as allowed by federal and California law.
13. **Public health –** We may, and sometimes need to by law, share your information with public health agencies so they can: prevent or control disease, injury or disability; report child, elder or dependent adult abuse or neglect; report domestic violence; report problems to the Food and Drug Administration (FDA) about products and reactions to medications; and report disease or infection exposure.
14. **Law enforcement –** We may share your information with a law enforcement official. This would be to: identify or locate a suspect, fugitive, material witness or missing person; comply with a court order, warrant, or grand jury subpoena; and other law enforcement purposes.
15. **Public safety –** We may share your information with persons who help prevent or lessen a serious and immediate threat to the health or safety of a person or the public.
16. **Special government functions –** We may share your information for military or national security purposes, to the extent permitted by law. We may also share it with correctional institutions or law enforcement officers that have you in their lawful custody.
17. **Insurers –** We may use or share your information with insurers when we review a health plan application.

18. **Employers –** We may use or share your information with your employer to find out about an illness or injury from work, or for workplace medical surveillance, to the extent that you consent to that use. We may use or share your information with your employer if you consent and/or if permitted by law when there is an employee claim or lawsuit about a medical condition, or if the information is about doing a particular job.
19. Other ways the Alliance may use or share your information:
    - We may, as needed by law, share your information with coroners when they investigate deaths.
    - We may share information with funeral directors, as they need it to carry out duties, to the extent permitted by law.
    - We may share your information with organizations that provide services for organ and tissue transplants.
    - We may use or share your information with the FDA when it is about the quality, safety, or effectiveness of an FDA-related product or activity.
    - We may use or share your information with Conservators/Guardians under certain circumstances.
    - We may share your information as we need to for worker's compensation
    - If the Alliance is sold or merged with another organization, your information / record will be owned by the new owner. But you will be able to change enrollment to another health plan.
    - We may use or share your information in order to protect it when we send it over the internet.
20. **Interoperability Rule –** We may provide certain information to you through a third-party application as allowed by the Interoperability Rules. The Interoperability Rules require health plans like the Alliance to provide certain health information through a third-party application of your choice. For more information about how to select a third-party application, please see "Member Privacy Document" on our website. The Alliance is not responsible for third-party applications and is not responsible for your information once it is transferred to the third-party application at your request.

When we may not use or share your information

Except as described in this Notice of Privacy Practices, we will not use or share your information without your written consent. If you do permit the Alliance to use or share your information for another purpose, you may take back your consent in writing at any time, unless we have already relied on your written consent to use or share your information.

The Alliance may contact you

We may contact you in order to provide you with information, resources like books or DVDs, products or services related to health education, treatment or other health-related benefits and services.

Your privacy rights

1. **Right to request special privacy protections –** You have the right to ask for limits on certain uses and sharing of your information. You can do this by a written request that tells us what information you want to limit and what ways you want to limit our use or sharing of that information. We reserve the right to accept or reject your request, and will let you know of our decision.
2. **Right to request confidential communications –** You have the right to ask that you receive your information in a specific way or at a specific location if the usual way may put you in danger. For example, you may ask that we send information to your work address. Please write us and tell us how you would like to receive your information and why you would be in danger if we did not follow your request. If your request has a cost that you will have to pay for, we will let you know.
3. **Right to see and copy –** You have the right to see and copy your information, with limited exceptions. To see your information, you must send a written request and tell us what information you want to see. Also let us know if you want to see it, copy it, or get a copy of it. California law allows us to charge a fair fee to copy records. We may deny your request under limited circumstances.
4. **Right to request information through a third-party application –** You have the right to request certain information through a third-party application of your choice as allowed by the “Interoperability Rules.”

5. **Right to change or supplement –** You have a right to ask that we change your information that you believe is incorrect or incomplete. You must ask us in writing to change your record. Tell us the reasons you believe the information is not correct. We do not have to change your information, and if we deny your request, we will let you know why. We will also tell you how you can disagree with our denial. We may deny your request of we do not have the information. We may also deny your request if we did not create the information (unless the person that created the information is no longer available to make the amendment). We may also deny your request if you would not be permitted to inspect or copy the information or the information is correct and complete.
6. **Right to an accounting of how we shared your information –** You have a right to receive a list of how we shared certain information during the **six (6) years** prior to your request. Please note that a fee may apply.
7. **Right to receive notice of privacy breach –** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your Protected Health Information.
8. **Right to a paper copy of this Notice of Privacy Practices –** If you would like more information about these rights or if you would like to use these rights, please call the Alliance Member Services Department Monday through Friday, 8 a.m. to 5 p.m. at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Changes to this Notice of Privacy Practices

We have the right to change this Notice of Privacy Practices at any time in the future. Until such change is made, we have to follow this Notice by law. After a change is made, the changed Notice will apply to all protected information that we maintain, regardless of when it was created or received. We will mail the Notice to you within **60 days** of any major change. We will also put the current Notice on our web site at **www.alamedaalliance.org**.

Complaints

Let us know if you have any complaints about this Notice of Privacy Practices or how the Alliance handles your information:

Alameda Alliance for Health
ATTN: Grievance and Appeals Department
1240 South Loop Road
Alameda, CA 94502

You may also let the Secretary of the U.S. Department of Health and Human Services (HHS) know of your complaint. We will never ask you waive your rights to file a complaint. You will not be penalized or retaliated against for filing a complaint.

If you are an Alliance Medi-Cal member, you may also notify the Department of Health Care Services Privacy Office at:

Department of Health Care Services
Office of HIPAA Compliance
P.O. Box 997413, MS 4721
Sacramento, CA 95899-7413

Phone Number: 1-916-255-5259
Toll-Free: 1-866-866-0602
People with hearing and speaking impairments (CRS/TTY):1-877-735-2929

You may also notify the Alliance Privacy Office at:

Alameda Alliance for Health
ATTN: Compliance Department
1240 South Loop Road
Alameda, CA 94502

Phone Number: 1-510-747-4500
Toll-Free: 1-877-932-2738
People with hearing and speaking impairments (CRS/TTY):711/1-800-735-2929

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

Notice about laws

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

Notice about Medi-Cal as a payer of last resort, other health coverage and tort recovery

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

Medi-Cal members may have other health coverage (OHC), also referred to as private health insurance. As a condition of Medi-Cal eligibility, you must apply for and/or retain any available OHC when there is no cost to you.

Federal and state laws require Medi-Cal members to report OHC and any changes to an existing OHC. If you do not report OHC promptly, you may have to repay DHCS for any benefits paid erroneously. Submit your OHC online at http://dhcs.ca.gov/OHC. If you do not have access to the internet, OHC can be reported to your health plan, or by calling 1-800-541-5555 (TTY 1-800-430-7077 or 711; inside California), or 1-916-636-1980 (outside California). DHCS has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. For example, if you are injured in a car accident or at work, auto or workers' compensation insurance may have to pay first or reimburse Medi-Cal.

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

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

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

Notice about estate recovery

The Medi-Cal program must seek repayment from estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes fee-for-service and managed care premiums and capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was a patient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the DHCS estate recovery website at http://dhcs.ca.gov/er or call 1-916-650-0590.

Notice of Action

The Alliance will send you a Notice of Action (NOA) letter any time the Alliance denies, delays, terminates or modifies a request for health care services. If you disagree with the plan's decision, you can always file an appeal with the Alliance. Go to the Appeals section above for important information on filing your appeal. When the Alliance sends you a NOA it will inform you of all rights you have if you disagree with a decision we made.

Contents in Notices

If the Alliance bases denials, delays, terminations, or changes in whole or in part on medical necessity, your NOA must contain the following:

- A statement of the action the Alliance intends to take.
- A clear and concise explanation of the reasons for the Alliance's decision.
- How the Alliance came to their decision. This should include the criteria the Alliance used.
- The medical reasons for the decision. The Alliance must clearly state how the member's condition does not meet the criteria or guidelines.

Translations

The Alliance is required to fully translate and provide written member information in common preferred languages, including all grievance and appeals notices.

The fully translated notice must include the medical reason for the Alliance's decision to reduce, suspend, or stop a request for health care services.

If your preferred language is not available, the Alliance is required to offer verbal assistance in your preferred language so that you can understand the information you receive.

8. Important numbers and words to know

Important phone numbers

Advice Nurse Line
Toll-Free: 1-888-433-1876

Alameda Alliance for Health – Member Services Department
Phone Number: 1-510-747-4567
Toll-Free: 1-877-932-2738
People with hearing and speaking impairments (CRS/TTY): 711/1-800-735-2929

Alameda County Behavioral Health Care Services - ACCESS Program
Toll-Free: 1-800-491-9099

Alameda County Social Services Agency (Medi-Cal Center)
Phone Number: 1-510-777-2300
Toll-Free: 1-800-698-1118

California Children's Services (CCS)
Phone Number: 1-510-208-5970

California Department of Health Care Services (DHCS) – Medi-Cal Managed Care
Phone Number: 1-916-449-5000

California Department of Managed Health Care (DMHC) – HMO Help Center
Toll-Free: 1-888-466-2219
People with hearing and speaking impairments (TDD): 1-877-688-9891

California Home Medical Equipment (CHME)
Toll-Free: 1-800-906-0626

California Relay Service (for the hearing impaired)
Toll-Free: 1-800-735-2929
People with hearing and speaking impairments (CRS): 711

Children First Medical Group (CFMG)
Phone Number: 1-510-428-3154

Community Health Center Network (CHCN)
Phone Number: 1-510-297-0200

Denti-Cal (Medi-Cal Dental)
Toll-Free: 1-800-322-6384
People with hearing and speaking impairments (TTY): 1-800-735-2922

Health Care Options (HCO)
Toll-Free: 1-800-430-4263
People with hearing and speaking impairments (TTY): 1-800-430-7077

MARCH Vision Care
Toll-Free: 1-844-336-2724

Medi-Cal Rx
Toll-Free: 800-977-2273
People with hearing and speaking impairments (TTY/TDD): 800-977-2273 (press 5 or 711)

Regional Center of the East Bay
Phone Number: 1-510-618-6100

Words to know

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

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

American Indian: An individual, defined in Title 25 of the U.S.C. sections 1603(13), 1603(28). 1679(a) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian Health Care Providers (Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

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

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

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

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

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

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

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

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

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

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

Complaint: A member's verbal or written expression of dissatisfaction about a service covered by Medi-Cal, the Alliance, county mental health plan, or a Medi-Cal provider.

Continuity of care: The ability of a plan member to keep getting Medi-Cal services from their existing out-of-network provider for up to 12 months if the provider and the Alliance agree.

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

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

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

Coverage (covered services): Medi-Cal services for which the Alliance is responsible for payment. Covered services are subject to the terms, conditions, limitations and exclusions of the Medi-Cal contract and as listed in this Evidence of Coverage (EOC) and any amendments.

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

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

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

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

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

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

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

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

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

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

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

Excluded services: Services that are not covered by the California Medi-Cal Program.

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

Family planning services: Services to prevent or delay pregnancy.

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

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

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

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

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

Grievance: A member's verbal or written expression of dissatisfaction about the Alliance, a provider, or the services provided. A complaint filed with the Alliance about a network provider is an example of a grievance.

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

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

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

You usually need a referral from your PCP to go to a specialist. Your PCP must get pre-approval from the Alliance before you get care from the specialist.

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

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

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

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

Hospice: Care to reduce physical, emotional, social and spiritual discomforts for a member with a terminal illness. Hospice care is available when the member has a life expectancy of 6 months or less.

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

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

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

Indian Health Care Providers (IHCP): A health care program operated by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. section 1603).

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

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

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

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

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

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

Medical transportation: Transportation when you cannot get to a covered medical appointment and/or pick up prescriptions by car, bus, train or taxi and your provider prescribes it for you. The Alliance pays for the lowest cost transportation for your medical needs when you need a ride to your appointment.

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

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

Member: Any eligible Medi-Cal member enrolled with the Alliance who is entitled to get covered services.

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

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

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

Network provider (or in-network provider): Go to “Participating provider.”

Non-covered service: A service that the Alliance does not cover.

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

Non-participating provider: A provider not in the Alliance network.

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

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

Out-of-area services: Services while a member is anywhere outside of the service area.

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

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

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

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

Palliative care: Care to reduce physical, emotional, social and spiritual discomforts for a member with a serious illness. Palliative care does not require the member to have a life expectancy of 6 months or less.

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

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

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

Plan: Go to “Managed care plan.”

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition. Post-stabilization care services are covered and paid for. Out-of-network hospitals may need pre-approval.

Pre-approval (or prior authorization): Your PCP or other providers must get approval from the Alliance before you get certain services. The Alliance will only approve the services you need. The Alliance will not approve services by non-participating providers if the Alliance believes you can get comparable or more appropriate services through the Alliance providers. A referral is not an approval. You must get approval from the Alliance.

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

Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed.

Primary care: Go to “Routine care.”

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

- You have an emergency
- You need OB/GYN care
- You need sensitive services
- You need family planning services/birth control

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- OB/GYN
- Indian Health Care Provider (IHCP)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (pre-approval): Your PCP or other providers must get approval from the Alliance before you get certain services. The Alliance will only approve the services you need. The Alliance will not approve services by non-participating providers if the Alliance believes you can get comparable or more appropriate services through the Alliance providers. A referral is not an approval. You must get approval from the Alliance.

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

Provider Directory: A list of providers in the Alliance network.

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

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

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

Reconstructive surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors or disease.

Referral: When your PCP says you can get care from another provider. Some covered care services require a referral and pre-approval (prior authorization).

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

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

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

Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care and intimate partner violence.

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

Service area: The geographic area the Alliance serves. This includes Alameda County.

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

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

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

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

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

Tort recovery: When benefits are provided or will be provided to a Medi-Cal member because of an injury for which another party is liable, DHCS recovers the reasonable value of benefits provided to the member for that injury.

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

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