Alameda Alliance for Health

Alliance Group Care Program

Combined Evidence of Coverage and Disclosure Form

You can request this document in other formats (Braille, audio, electronic text file, or large print). Call Alliance Member Services at **510.747.4567** (Toll-Free **1.877.932.2738**; people with hearing and speaking impairments (CRS/TTY) **711/1.800.735.2929**)

Traducción al español: Este documento está disponible en español. Llame al Departamento de Servicios al Miembro de Alliance al **510.747.4567** (Línea gratuita: **1.877.932.2738**; personas con impedimentos auditivos y del habla (CRS/TTY): **711/1.800.735.2929**)

中文譯文：本文件以中文提供。請致電Alliance 成員服務部：**510.747.4567** (免費電話：**1.877.932.2738**; 聽力與語言殘障的人士(CRS/TTY)：**711/1.800.735.2929**)

www.alamedaalliance.org

To find out if you are eligible for Alliance Group Care

Please call the Alameda County Public Authority for IHSS: **510.577.3552**

Or visit their website: **www.ac-pa4ihss.org/hcw-health-benefits.html**

Table of Contents

1. Disclosure, Contacts, and Benefit/Coverage Summary

This booklet gives a summary of the Health Plan benefits.

Disclosure

This booklet is the Alameda Alliance for Health (Alliance) In-Home Supportive Services (IHSS) Alliance Group Care Combined Evidence of Coverage and Disclosure Form (EOC). This EOC booklet includes the terms of coverage. **It is only a summary of the Health Plan coverage.** (*See Benefit and Coverage Matrix in this section for further information*)

The Group Contract (Agreement) between the Alliance and the Public Authority for IHSS Workers in Alameda County (Public Authority) must be consulted to determine the exact terms and conditions of coverage. The Alliance can provide a copy of the Plan Contract upon request. *(See the Contact Information list at the beginning of this EOC*.)

The Benefit Year of this EOC is from October 1 to September 30. You have the right to review this EOC booklet before you enroll. You should read this EOC booklet with care. This way, you will know who or what groups can provide health care services to you. If you have special health care needs, read closely the parts that apply to you.

As well, the Department of Managed Health Care (DMHC) rules require the Alliance to follow the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act's regulations (California Code of Regulations, Title 28). The Alliance must follow all of the rules in the Act or the Act's regulations, even if the EOC booklet does not include them.

Contact Information

Entity	Phone Number	Address	Website
Alameda Alliance for Health	Main Number: **510.747.4500** Toll-Free: **1.877.932.2738** People with hearing and speaking impairments (CRS/TTY):**711/1.800.735.2929**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org**
Alliance Member Services Department	Phone Number: **510.747.4567** Toll-Free: **1.877.932.2738** People with hearing and speaking impairments (CRS/TTY):**711/1.800.735.2929**	Alliance Member Services Department P.O. Box 2818 Alameda, CA 94501-0818	**www.alamedaalliance.org/** contact-**us**
Alliance Grievance and Appeal Department	Phone Number: **510.747.4567** Toll-Free: **1.877.932.2738**	1240 South Loop Road Alameda, CA 94502	To file a Grievance on-line, members must log into the member portal. Go to: **www.alamedaalliance.org** and see log in information.
Alliance Interpreter Scheduling (to schedule face-to-face interpreters)	Phone Number: **510.747.4567** Toll-Free: **1.877.932.2738** People with hearing and speaking impairments (CRS/TTY):**711/1.800.735.2929**		
Alliance Health Programs	Phone Number: **510.747.4577** Toll-Free: **1.877.932.2738**		www.alamedaalliance.org
Alliance Obstetrics Case Management (OBCM) Program	Toll-Free: **1.877.251.9612** Select preferred language, then 4 for the Alliance OBCM Program.		
Beacon Health Strategies (*Also known as College Health IPA*; Subcontracted Behavioral Health Provider for	Toll-Free: **1.855.856.0577** TTY: **1.800.735.2929**	5365 Plaza Drive Cypress, CA 90630	**www.beaconhealthstrategies.com**

Entity	Phone Number	Address	Website
Outpatient Mental Health Services)			
California Children's Services (CCS)	Phone Number: **510.208.5970**	1000 Broadway Suite 500 Oakland, CA 94607	**www.dhcs.ca.gov/services/ccs**
Community Health Center Network (CHCN)	Phone Number: **510.297.0200**	101 Callan Avenue 3rd Floor San Leandro, CA 94577	**www.chcnetwork.org**
Dental Services (Contact the Public Authority)	Public Authority Phone Number: **510.577.3552**	6955 Foothill Blvd. 3rd Floor Oakland, CA 94605	**ac-pa4ihss.org**
Department of Managed Health Care (DMHC)/California HMO Help Center	Toll-Free: **1.888.466.2219** TDD: **1.877.688.9891**	980 Ninth Street Suite 500 Sacramento, CA 95814	**www.dmhc.ca.gov**
Public Authority for In-Home Supportive Services Workers of Alameda County	Phone Number: **510.577.3552**	6955 Foothill Blvd. 3rd Floor Oakland, CA 94605	**ac-pa4ihss.org**
Vision Services Contact the Public Authority	Public Authority Phone Number: **510.577.3552**	6955 Foothill Blvd. 3rd Floor Oakland, CA 94605	**ac-pa4ihss.org**
24-Hour Interpreter Hotline (for interpreters by phone)	Phone Number: **510.809.3986**		
24/7 Health Nurse Line	Toll-Free: **1.855.383.7873** (Use PIN # 690)		

Benefits and Coverage Matrix

This matrix provides a summary of your benefits and can be used to help you compare benefits. *(See Section 8: Schedule of Medical Benefits of this EOC booklet for further information.)*

Annual or Lifetime Maximum

There are no annual or lifetime limits to the cost of benefits.

Benefit	Description/Limitations	Copayment

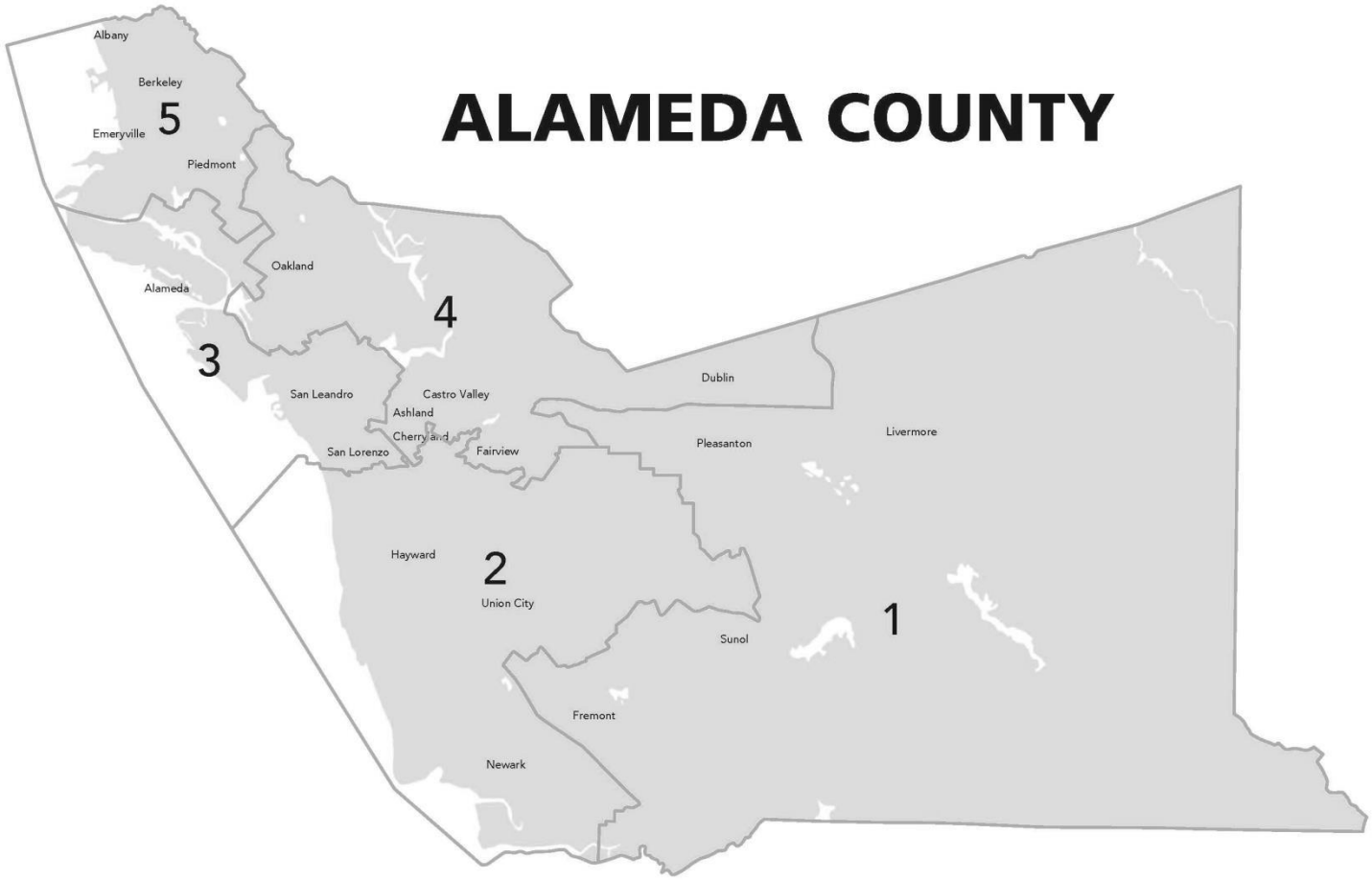
Benefit	Description/Limitations	Copayment
Acupuncture	Self-referral to an Alliance provider for 10 visits each benefit year.	$5 copayment per visit
Cataract Spectacles and Cataract Lenses	Cataract spectacles, cataract contact lenses, intraocular lenses or conventional eyeglasses or contact lenses, as needed, after cataract surgery.	No copayment
Chiropractic Services	Self-referral to an Alliance provider for 20 visits each benefit year.	$10 copayment per visit
Diabetic Management and Treatment	Services, supplies, and equipment for the treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes, as medically necessary.	• $10 copayment for physician office visits. • $10 copayment for generic or $15 for brand name prescription drugs.
Diagnostic and Laboratory Services	Therapeutic and radiological services (such as X-Rays), ECG, EEG, mammography and other diagnostic laboratory and radiology tests, cancer screening tests, and renal dialysis.	No copayment
Durable Medical Equipment	Medical equipment appropriate for use in the home, oxygen and oxygen equipment, insulin pumps, and all related necessary supplies.	No copayment
Emergency Health Coverage	24-hour care for emergency health care services (as defined in *Section 7: Emergent, Urgent and Routine Care* for services both in and out of the Alliance service area). (Copayment is waived if the member is hospitalized.)	$35 copayment per visit
Family Planning Services	Variety of family planning services including counseling, surgical procedures, and prescription contraceptives.	No copayment
Hearing Aid Services	• Hearing aids/services – Audiological exam to measure hearing loss and hearing aid evaluation, monaural or binaural hearing aids, including ear mold(s), hearing aid instrument, initial battery, cords, and other ancillary equipment, and office visits for one (1) year following the provision of covered hearing aid. • Hearing aid replacement is limited to once every three (3) benefit years.	No copayment
Home Health Services	Must be prescribed or directed by the attending physician or other appropriate authority designated by the Alliance.	• $10 per visit for physical, occupational, and speech therapy performed in the home • $10 for physician visit

Benefit	Description/Limitations	Copayment
Hospice Services	Medically necessary nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services, homemaker, volunteer, physical therapy, occupational therapy, and speech therapy.	No copayment
Hospital Services/Inpatient	Inpatient – Semi-private room and board, general nursing care, ancillary services including operating room, intensive care unit, prescribed drugs, laboratory, and radiology, physical, occupational and speech therapy, short-term inpatient hospice care for respite care, pain control, and symptom management.	$100 copayment per admission except for Pregnancy and Maternity Care
Inpatient and Outpatient Alcohol/Substance Use Disorder (SUD)	Inpatient and Outpatient Services are provided through Beacon Health Strategies. Members can call **1.855.856.0577** to access services.	• $100 copayment per inpatient admission • $10 copayment for outpatient SUD office visit benefits • No copayment for outpatient SUD benefits other than office visits
Medical Transportation	Ambulance transportation when medically necessary.	No copayment
Mental Health (MH) Services	Inpatient and Outpatient services are provided through Beacon Health Strategies. Members can call **1.855.856.0577** to access services. • No treatment limitations apply	• $100 copayment per inpatient admission • $10 copayment for outpatient MH office visit benefits • No copayment for outpatient MH benefits other than office visits
Organ Transplants	Medically necessary organ and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a member.	No copayment

Benefit	Description/Limitations	Copayment
Orthotics and Prosthetics	Medically necessary replacement orthotic and prosthetic devices as prescribed by an Alliance provider. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetes.	No copayment
Outpatient Services	Services and supplies for treatment (including radiation and chemotherapy), or surgery in an outpatient hospital setting or ambulatory surgery center.	• $10 copayment for physical, occupational, and speech therapy • $35 copayment for emergency health care services
Phenylketonuria (PKU)	• Testing and treatment of PKU. • Formulas and special food products for treatment of PKU.	No copayment
Physician Office Visits	Office visits	$10 copayment except for Preventive Health Services
Physical, Occupational, and Speech Therapy	• Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. • Limited to short-term therapy for a period not exceeding 60 consecutive calendar days per condition (may be extended beyond 60 days if medically necessary and if condition will improve significantly) • 60-day limitation does not apply to therapy for Pervasive Developmental Disorder (PDD) or Autism. However, such therapy is subject to review every six (6) months and modification when appropriate.	$10 copayment for physical, occupational, and speech therapy
Pregnancy and Maternity Care	• Professional and inpatient hospital services including prenatal and postnatal care, newborn, and nursery care for the member's newborn. • Newborn coverage limited to first 30 days of life.	No copayment
Prescription Drug Coverage	• 30-day supply • One (1) cycle of tobacco cessation drugs per benefit year. Inpatient drugs – No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the provider's office or in an outpatient facility setting.	• $10 copayment for generic • $15 for brand name prescription drugs

Benefit	Description/Limitations	Copayment
Preventive Health Services	• Periodic health examinations • Immunizations • Vision and hearing testing • Venereal disease testing • Confidential HIV counseling and testing • Annual cervical cancer screening tests including PAP smear exams • Mammograms	No copayment
Reconstructive Surgery	Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) To improve function; (B) To create a normal appearance, to the extent possible	No copayment
Skilled Nursing Care	Medically necessary skilled nursing care including room and board, x-ray and laboratory services, and other ancillary services, medications, and supplies up to 100 days per benefit year.	No copayment
Abortion Services	These services are available without a referral or authorization. However, these services are not covered if performed by an out-of-plan provider. For information, please call the Alliance Member Services Department (See the Contact Information List for further information.)	$10 copayment per visit
Urgent Care Services	Services received at an urgent care center. (Copayment is waived if the member is hospitalized.)	$10 copayment per visit

Service Area



2. Introduction

Welcome to Alameda Alliance for Health (Alliance)!

The Alliance is a licensed, local Health Plan. It is not a medical provider. Independent physicians, clinics, hospitals, and other professional health care providers have contracts with the Alliance to provide all health care services. Alliance health care providers are not employees of the Alliance.

This Booklet

This booklet is called the Combined Evidence of Coverage (EOC) and Disclosure Form and it contains detailed information about the Alliance Group Care Program. It provides details about the providers, benefits, terms and conditions of coverage. You will also find the rules of the health plan, and your rights and responsibilities as a member. In this EOC booklet, "you," "your," and "member" refers to the person covered under the Alliance Group Care Program. "We," "us," "Health Plan," and "our" refers to the Alliance. "Provider," "plan provider," or "participating provider" refers to a physician, hospital, medical group, pharmacy, or other health care provider who provides medical services to you.

If you have any questions about your coverage or any of the plan benefits, you may call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

Member Services

Member Services/Customer Service Representatives can assist you with information about Alliance benefits and services.

- We can answer questions about the Health Plan
- We can help you choose a Primary Care Provider (PCP)
- We can tell you where to get the services you need
- We can provide you with translation services if English is not your preferred language
- We can help you schedule an interpreter for your medical appointment
- We can help you with questions about approval for services (the authorizations and the utilization management (UM) process)
- Members with hearing and speaking impairments may use the California Relay Service (CRS) or Teletype (TTY)
- We can provide benefits information and plan letters in your language or a format such as braille, large size print or audio tape

- Language Services are available for members who do not speak English

Please call the Alliance Member Services Department to ask for help Monday through Friday, 8 am to 5 pm. *(See the Contact Information List for further information*.)

Language Services

If you or your representative prefers to speak in a language other than English, including American Sign Language, please call the Alliance Member Services Department. *(See Contact Information List for phone number)*. Our staff can help you find a health care provider who speaks your language. If you cannot find a health care provider who meets your language needs, you can ask to have an interpreter for medical visits **at no cost to you** or your provider. We urge you not to use family members, children, or friends as interpreters.

Interpreter services are available 24 hours a day, 7 days a week. Alliance providers and hospitals are also required to offer a qualified interpreter for you, either face-to-face or over the phone.

To schedule face-to-face interpreter services, translations or alternate formats of benefits materials:
Please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm. Please call 72 hours in advance to schedule face-to-face interpreter services. (*See the Contact Information List for further information.*)

To get after hours telephonic interpreter services:
Call our 24-hour Interpreter Hotline. (*See Contact Information List for further information*.)

This booklet, as well as other informational material, is offered in Spanish and Chinese, and other formats as requested. If your linguistic needs are not met, you can file a grievance (*See Section 14: Alliance Grievance and Appeal Procedures for further information*).

Member Identification Card

All members are given a Member Identification (ID) Card. This card contains important information about your medical benefits. If you have not received, or if you have lost your Alliance Member ID Card, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*) We will send you a new card.

Please show your Alliance Member ID Card to your provider when you receive medical care or pick up a prescription at the pharmacy.

Only the member may receive medical services using his or her Alliance Member ID Card. If a card is used by or for someone other than the member, that person will be billed for services he or she receives. If you let someone else use your Member ID Card, the Alliance may terminate or end your coverage.

Member Rights and Responsibilities

As an Alliance member, you have the right to:

1. Receive information about your rights and responsibilities.
2. Get information about the Alliance, its programs, and its doctors and the health care network.
3. Be treated with respect at all times. The Alliance values your dignity and right to privacy.
4. Keep your health information private.
5. Help make choices about your health care with your doctor. This includes the right to refuse treatment.
6. Talk freely with your doctors about treatment options for your health problem, in spite of cost or benefit coverage.
7. Voice complaints or appeals, either in words or in writing, about the Alliance, its doctors, or the care we provide.
8. Advise on the Alliance's member rights and responsibilities policy.
9. Choose a doctor within the Alliance's network.
10. Get oral interpretation in the language that you speak at no cost to you. This includes interpretation when you receive care outside of business hours.
11. Have access to:
    a. Treatment for sexually transmitted disease
    b. Emergency care outside the Alliance's network as detailed in Federal law
12. Get information about and create an advance directive.
13. Review, request changes to, and receive a copy of your health records.
14. Leave the Alliance upon request at any time, subject to any restricted disenrollment period.
15. Get member information in other formats. This includes braille, large size print, and audio.
16. Be free from any form of control or limits used as a means of pressure, reproof, revenge or ease of the workload on the Alliance or your doctor.
17. Get information about your health condition and treatment plan options in a way that is easy for you to understand.
18. Use these rights freely without changing how you are treated by the Alliance, doctors and the health care network, or the State.
19. You have the freedom to use these rights without fear of being harmed in return.

If you would like more information about your right to make decisions about medical treatment or advance directives, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

As an Alliance Member, your responsibilities are to:

1. Tell the Alliance and your doctors what we need to know (to the degree possible) so we can provide care.
2. Follow care plans and advice for care that you have agreed to with your doctors.
3. Learn about your health problems and help to set treatment goals.
4. Work with your doctor.
5. Always present your Alliance Member ID Card when getting services.
6. Ask questions about any medical issues and make certain you understand your doctor and the plan for your care.
7. Give your doctors and the Alliance correct information.
8. Help the Alliance maintain accurate and current records. Contact us as soon as you have changes in address, family status, and other health care coverage.
9. Make and keep medical appointments. Inform your doctor at least 24 hours in advance when you must cancel an appointment.
10. Treat all the Alliance staff and health care staff with respect and courtesy.
11. Use the emergency room only in an emergency or when your doctor directs you to the emergency room.

3. Eligibility, Enrollment, Effective Date of Coverage, and Member Financial Responsibility

Eligibility Requirements

You will be enrolled in the Alliance Group Care program in accordance with the rules and regulations set forth by the Public Authority. (*See the Contact Information List for further information*.)

Dependents

Dependents are not eligible for benefits under the Alliance Group Care Program.

Other Rules of Eligibility

The Public Authority shall not be entitled to receive benefits for its employees until the required enrollment data and forms have been received and accepted by the Alliance and the applicable periodic prepayment fees have been collected.

Subject to COBRA and applicable law, a member will no longer be eligible for benefits under Alliance Group Care Program when the member is no longer an employee meeting all of the criteria set forth by the Public Authority. (*See Section 13: Individual Continuation of Benefits for further information.*)

Notification of Eligibility Changes

It is the member's responsibility to notify the Alliance within 31 days of all changes in eligibility affecting the member's enrollment in the Alliance Group Care Program.

Effective Date of Coverage

The Public Authority will provide the member's information to the Alliance monthly to determine effective date of coverage and date of coverage termination. The effective date of coverage for a member who is an IHSS worker for the Public Authority shall be the first day of the month following the receipt of the member's information by the Alliance. Coverage will terminate on the last day of the month following receipt of the member's termination by the Alliance.

Replacement Coverage

There shall be no delay in the effective date of enrollment for coverage, to the extent that the Alliance provides replacement coverage under Section 1399.63 of the Knox-Keene Act, within 60 days of the date of discontinuance of the Public Authority's previous group health plan for members who were validly covered under such prior Public Authority health plan on the date of discontinuance. However, with respect to members who are totally disabled on the date of discontinuance of the prior Public Authority health plan and are entitled to extension of benefits under Section 1399.62 of the Act, the Alliance is not required to provide benefits for services or expenses directly related to any conditions which caused the total disability. Any delayed effective date of enrollment shall be of no force or effect to the extent a delay would be prohibited under Applicable Law.

Financial Responsibilities

Periodic Prepayment Fees

Public Authority shall remit payment, on or prior to the effective date of the Agreement, the applicable periodic prepayment fees/premium, including the member share, for each member entitled to receive benefits as of that date as reflected in the eligibility report. Thereafter, the applicable periodic prepayment fees/premium shall be remitted to the Alliance on or before the 15th day of each month during the term of the Agreement. The periodic prepayment fee/premium shall remain in effect for the term of the Agreement unless modified in the Agreement by the Alliance and the Public Authority. Any contributions required of members shall be arranged for members solely by the Public Authority.

Copayments, Deductibles, and Other Charges

There are no deductibles or annual or lifetime financial benefit maximums. Though, some benefits have annual maximums based on frequency of services. Members are financially responsible for the specific copayments listed in the Benefits and Coverage Matrix and in the Medical Benefits, and Mental Health portions of this document.

If you have any questions with regards to copayments, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.)

When a member fails to appear for a scheduled appointment and does not cancel such an appointment at least 24 hours in advance, the member may be responsible for any missed appointment charges.

4. Choice of Physicians, Providers, and Facilities

Please read the following information so you will know from whom or what group of providers health care may be obtained.

Provider and Facilities Locations

You received a provider directory in your enrollment packet. To request another copy, please call the Alliance Member Services Department. (*See the Contact Information List for further information*). You can also view the provider directory online at **www.alamedaalliance.org**. The provider directory lists all of the providers contracted with the plan who provide services to Alliance Group Care members. The names and locations of PCPs, specialist physicians, non-physician health care practitioners, clinics, skilled nursing facilities, and hospitals are included in the directory. Before selecting a PCP, you should verify if the PCP is accepting new patients by calling the PCP's office.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments or abortion. You should obtain more information before you enroll. Please call your prospective doctor, medical group, independent practice association, or clinic, or call the Alliance Member Services Department at 510.747.4567 or toll-free at 1.877.932.2738 to ensure that you obtain the health care services that you need.

Liability of Member for Payment

Members are not financially responsible for covered services, other than for applicable copayments, if referred and authorized, as medically necessary. If the member receives services and fails to consult their PCP for the necessary approval, or fails to adhere to the Alliance's referral and/or authorization procedures, the member will not be covered for such services and will be liable for the entire payment for those services, except in emergencies. If you are outside the service area and need non-emergency or non-urgent medical services, contact your PCP to get authorization before you receive these services. Non-emergency or non-urgent services received outside of the Alliance's service area or outside of the network without an authorization from the Alliance before receiving such services are not covered. However, members will not be liable for payment for emergency services. In the event the plan fails to pay a non-contracting provider for services rendered, the member may be liable to the non-contracting provider for the cost of the services.

The Alliance is regulated by DMHC. In the event the Alliance fails to pay a plan provider, the member will not be liable to the plan provider for any money owed by the Alliance. To obtain services not provided by plan providers, within the service area, members must first consult with their PCP. The PCP or the Alliance will in turn need to authorize the service in advance, unless the situation is urgent or emergent, in which case an authorization is not necessary. (*See Section 6: How to Use Your Health Plan and Section 8: Emergent, Urgent, and Routine Care for further information*.)

How to Choose and Access a PCP

You are required to have a PCP and should select a PCP within 30 days of the effective date of coverage. Choose a PCP from the provider directory. You may request a paper copy of the provider directory by calling the Alliance Member Services Department or visit our website for our online provider directory at **www.alamedaalliance.org**. (*See the Contact Information List for further information.*) Your PCP should be within the Alliance Provider Network and close to where you work or live. In the event that the PCP you choose is not accepting new patients, you will be asked to choose another PCP.

If you do not choose your PCP within 30 days of when you become a member, we will let you know that we have not received your choice and we will choose a PCP for you. We will make every reasonable effort to match you with a PCP based on your needs. If you are not happy with the choice we make, you can call the Alliance Member Services Department to choose a PCP yourself. (*See the Contact Information List for further information.*)

Your PCP manages and directs all of your medical care needs, including check-ups and immunizations. The PCP will also arrange for referrals to most specialist physicians and other providers, make arrangements for hospital care, and obtain any required prior authorizations for certain health care services. You do not need a referral or authorization from your PCP for OB/GYN visits, emergent care, or urgent care. Your PCP will also order lab tests, x-rays, and other covered services as required.

We work with qualified PCPs and specialist doctors. To find out about the background of one of our doctors in our network, such as their specialty or whether they are Board certified, visit our website for our online provider directory at **www.alamedaalliance.org** or call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

If you need help in choosing a PCP, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

Making an Appointment

Please call your PCP's office to make an appointment for routine check-ups or sick visits. When you call, please tell them you are an Alliance Group Care member. The name and phone number of your PCP are on the front of your Alliance Member ID Card.

When you call to schedule an appointment, you may not be able to see the provider right away. Alliance providers are required to meet at least the following standards for scheduling an appointment.

The wait times listed below apply to Alliance provider types that are: PCPs, Ancillary, Specialty, and Mental Health.

Appointment Type	Conditions	Timeframe within request for appointment
Urgent Care	Services that do not require a Prior Authorization	Within 48 hours
	Services that require a Prior Authorization	Within 96 hours
Non-urgent Care	For the diagnosis or treatment of injury, illness, or other health problem	Within 10 business days
Non-urgent Specialist Care	Non-urgent appointments with specialist physicians	Within 15 business days*
Non-urgent Mental Health Care	Non-urgent appointments with a non-physician mental health care provider	Within 10 business days*
Non-urgent Ancillary Care	For the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days*

***Exceptions:** The applicable waiting time for a particular appointment may be extended if the referring or treating health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

Preventive and Follow-Up Care - The following preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating health care provider acting within the scope of his or her practice:

- Standing referrals for chronic problems
- Pregnancy
- Cardiac conditions
- Mental health conditions
- Lab and radiology services
- Other follow ups as ordered by your provider

Telephone Triage or Screening - Triage or screening is offered by calling your PCP 24 hours a day, 7 days a week. Wait time does not exceed 30 minutes.

"Triage" or "screening" means the assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

Preventive care services and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating health care provider acting within the scope of his or her practice.

When you have an appointment, please be on time. To make the most of your time with the PCP:

- Ask questions if you do not understand what you need to know
- Bring a list of health problems and questions
- Bring the medicines you are using
- Remember to bring your Alliance Member ID Card
- Tell your PCP what you have already done to treat any conditions you have and any ideas you have for treatment
- Tell your PCP what you think the problem is, even if you do not think it is important. This may help the PCP

Your Initial Health Exam

All new members should see their PCP for an initial health exam within four (4) months of becoming an Alliance member. This first meeting with your new PCP is important. It's a time to get to know each other and review your health. Your PCP will help you understand your medical needs and advise you about staying healthy. Call your PCP's office for an appointment today!

Change an Appointment

Call your PCP's office as soon as possible if:

- You are going to be late for your appointment; or
- You won't be able to go to your appointment.

This will help your PCP reduce the time everyone waits in the waiting room. You can also reschedule your appointment to another day if needed.

Please note that if you miss an appointment and do not cancel the appointment in a way that follows the PCP's policies, the PCP may charge you a fee that you will have to pay.

If you miss several appointments without calling to cancel them in advance, your PCP can decide not to see you as a patient any more. In that situation, we would contact you so that you could choose another PCP.

Changing Your PCP

It is best to stay with the same PCP so she or he can get to know your needs. However, you may change you PCP for any reason. If you need to change your PCP, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

If you request a change on or before the 5th day of the month, the change will be effective on the 1st day of the same month. If you request a change after the 5th day of the month, the change will be effective on the 1st day of the following month.

When you change PCPs, we will send you a new Alliance ID card in the mail. Your new card will have the name and phone number of your new PCP on it. It will also have the date that your PCP change is effective.

We may require you to change your PCP if you:

- Behave in a rude or abusive way, or disrupt the provider's office in other ways;
- Continually refuse recommended procedures and treatments that prevent our provider from providing proper medical care;
- Keep making appointments and not showing up for them.

We will notify you in writing when you must change your PCP.

How to Get Care When Your Primary Care Provider's Office is Closed

If you need care when your PCP's office is closed (such as after normal business hours, on the weekends or holidays), call your PCP's office. Your PCP's office will have a message or a service to tell you how to get care after normal office hours.

You can also call Alliance Free Nurse Advice line. (*See the Contact Information List for further information*.)

Continuing Care

For New Members

Under some circumstances, the Alliance will provide Continuity of Care for new members who are receiving medical services from a non-participating provider, such as a physician or hospital, when the Alliance determines that continuing treatment with a non-participating provider is medically appropriate. If you are a new member, you may request permission to continue receiving medical services from a non-participating provider if you were receiving this care before enrolling in the Alliance and if you have one of the following conditions:

- ***Acute condition*** **-** Completion of covered services shall be provided for the duration of the acute condition.
- ***Pregnancy (including care after the birth)*** **-** Completion of covered services shall be provided for the duration of the pregnancy when (1) the pregnancy is high-risk, or (2) the member is in her second or third trimester.
- ***Serious chronic condition*** **-** Completion of covered services shall be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the member and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the time you enroll with the Alliance.
- ***Surgeries and/or Procedures*** **-** Performance of surgeries and/or other procedures that the member's previous plan authorized as part of a documented course of treatment, and that had been recommended and documented by the non-participating provider to occur within 180 days of the time the member enrolled with the Alliance.
- ***Terminal illness*** **-** Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed 12 months from the time you enroll with the Alliance.

To obtain a copy of our Continuity of Care policy, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.) Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable copayments under this plan.

We will request that the non-participating provider agrees to the same contractual terms and conditions that are imposed upon participating providers providing similar services, including payment terms. If the non-participating provider does not accept the terms and conditions, the Alliance is not required to continue that provider's services. The Alliance is not required to provide Continuity of Care as described in this section to a newly covered member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Alliance coverage. Continuity of Care does not provide coverage for benefits not otherwise covered.

The Alliance will review your request and issue a decision within five (5) business days after receiving all of the information necessary to complete the review. Urgent cases will be reviewed and a decision issued within 72 hours of receipt of the information. If your request is approved, the Alliance will issue an authorization for the requested services. You will be notified in writing if your request is not approved. If we determine that you do not meet the criteria for Continuity of Care and you disagree with our determination, you can file a grievance. (*See Section 14: Alliance Grievance and Appeal Procedures for further information.*)

If you have further questions about Continuity of Care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, toll-free at **1.888.466.2219**; people with hearing and speaking impairments (CRS/TTY) **1.877.688.9891**; or online at **www.dmhc.ca.gov**.

Terminated Providers

If your PCP or other health care provider stops working with the Alliance, we will let you know by mail 30 days before the contract termination date.

The Alliance will provide Continuity of Care for covered services rendered to you by a provider whose participation has terminated, if you were receiving this care from this provider prior to termination and you have one of the following conditions:

- ***Acute condition*** **-** Completion of covered services shall be provided for the duration of the acute condition.

- ***Pregnancy (including care after the birth)*** **-** Completion of covered services shall be provided for the duration of the pregnancy when (1) the pregnancy is high-risk, or (2) the member is in her second or third trimester.
- ***Serious chronic condition*** **-** Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the member and the terminated provider, and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the provider's contract termination date.
- ***Surgeries and/or Procedures*** **-** Performance of surgeries or other procedures that the Alliance had authorized as part of a documented course of treatment, and that had been recommended, and documented by the provider to occur within 180 days of the provider's contract termination date.
- ***Terminal illness*** **-** Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed 12 months from the time the provider stops contracting with the Alliance.

Continuity of Care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with the Alliance prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, we are not required to continue the provider's services beyond the contract termination date.

To obtain a copy of our Continuity of Care policy, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*) Normally, eligibility to receive Continuity of Care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of Care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable co-payments under this plan.

The Alliance will review your request and issue a decision within five (5) business days after receiving all of the information necessary to complete the review. Urgent cases will be reviewed and a decision issued within 72 hours of receipt of the information. If your request is approved, the Alliance will issue an authorization for the requested services. You will be notified in writing if your request is not approved. If we determine that you do not meet the criteria for Continuity of Care and you disagree with our determination, you can file a grievance (*See Section 14: Alliance Grievance and Appeal Procedures for further information*).

If you have further questions about Continuity of Care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, toll-free at **1.888.466.2219**; people with hearing and speaking impairments (CRS/TTY) **1.877.688.9891**; or online at **www.dmhc.ca.gov**.

5. Timely Access To Care

Please refer to the table on page 17 for expected wait times for different types of appointments.

6. How to Use Your Health Plan

Referrals and Authorizations for Services

Referrals to Specialists

Your PCP will refer you to a specialist physician for all medically necessary covered services that he or she cannot provide. You will be referred to an Alliance specialist.

If your PCP is a provider with the Community Health Center Network (CHCN), this information will be on your Alliance Member ID Card. If you see this information on your Alliance Member ID Card, it means that you will need to see specialists within their network. If you have any questions, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.)

Services that generally require a referral include, but are not limited to:

- Alliance Specialists' Physician Office Visits
- Diagnostic X-rays, including Mammograms
- Laboratory Services

Mental Health Services

Mental Health services are obtained through Beacon Health Strategies. Members can call **1.855.856.0577** to access services.

Standing Referrals

If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing referral to a specialist in order to receive continuing specialized care. If you receive a standing referral to a specialist, you will not need to get a referral every time you see that specialist. Additionally, if your condition or disease is life threatening, degenerative, or disabling, you may need to receive a standing referral to a specialist or specialty care center that has expertise in treating your condition or disease, and for the purpose of having the specialist coordinate your health care.

To get a standing referral, please call your PCP.

Services that Do Not Require a Referral - Alliance Providers

The following services do not require a referral from your PCP or the Alliance, if you use Alliance providers:

- Diagnosis and treatment of sexually transmitted infection
- Family Planning
- OB/GYN Services
- Prenatal Care
- Services provided by your PCP
- Abortion Services
- Urgent and Emergent Services (*see Section 8: Emergent, Urgent, and Routine Care for further information*)
- Diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault

Authorizations

The Alliance must approve some medical services, medical equipment, and/or medications before you get them. This process is called Utilization Management or UM. Your provider knows which services require an authorization. Prior approval is done by having your provider submit an authorization request to the Alliance. The authorization is reviewed to ensure that you are receiving services that are medically necessary and are covered by your health plan.

As an Alliance member, you should know how we make decisions:

1. We check if a service is medically needed and covered by the Alliance before making a UM decision. When the Alliance gets an Authorization Request from a provider, our medical staff (doctors, nurses, and pharmacists) review it. They review each case to make sure you are getting quality and most appropriate treatment for your medical condition according to clinical guidelines.
2. We do not reward anyone who makes a UM decision, which includes doctors, when they deny coverage for a service to a member.
3. We do not give anyone extra money to keep you from getting the care you need or for getting less care.

We will decide whether to authorize the services after getting all the facts (including exams and test results) within five (5) business days if the service is not urgent. We will decide no later than 72 hours for an urgent service. If the Alliance cannot meet these timeframes, we will let you and your provider know that more time is needed.

If an authorization request has been approved, the provider can give you the service(s), medical equipment, or medication(s). In the event an authorization request is denied, the provider will be notified initially by telephone or facsimile. Additionally, you and the provider will get a letter from us within 1-2 business days. The letter will let you and the provider know that the authorization request was denied and why. It will also tell you and the provider about your right to appeal the denial, and give you information on how to do that.

If you receive specialty services before you receive the required authorization, you will be responsible for the payment of the cost of the treatment. This does not apply to emergent or urgent situations. (*See Section 8: Emergent, Urgent and Routine Care for further information.*)

Services that require an authorization include, but are not limited to:

- Durable medical equipment, orthotics, and prosthetics
- Electroconvulsive Therapy (ECT)
- Home Health Care
- Hospice Care
- Inpatient Drug and Alcohol Abuse Services
- Inpatient Hospital Services
- Inpatient Mental Health Services
- Outpatient Physical, Occupational, or Speech Therapy
- Outpatient Transcranial Magnetic Stimulation (TMS)
- Psychological and Neuropsychological Testing
- Services from non-Alliance Providers
- Skilled Nursing Facility Care
- Some Prescriptions

Second Opinions

If you have questions about a treatment or surgery that your provider says you need, you may want a second opinion. Reasons you may ask for a second opinion include:

- You question the reasonableness or necessity of a recommended surgical procedure
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial impairment
- Your provider is unable to diagnose your condition or your diagnosis is in doubt due to conflicting test results
- You have attempted to follow your treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan, but your health is not improving

You should speak to your PCP if you want a second opinion. A prior authorization from the Alliance is required to receive a second opinion.

If your medical condition poses an imminent and serious threat to your health, including, but not limited to, the potential loss of life, loss of limb, loss of bodily function, or substantial impairment, or if a delay would be detrimental to your ability to regain maximum function, your request for a second opinion will be processed within 72 hours after the Alliance receives your request.

You will be responsible for paying all copayments for the second opinion you receive.

If your request to obtain a second opinion is denied and you would like to contest the denial, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

New Technology

The Alliance wants to provide our members with quality care. We have a process for reviewing new technology such as medical or behavioral procedures, drugs, and devices. We review reports from medical experts to decide if we should cover the new technology as a benefit for our member.

7. Available Services

Alliance Health Education Services

You are the most important person involved in your health. The day-to-day choices you make can help you live a healthier life. You will benefit from knowing about and taking care of your body. Your health care is a team effort between you, your PCP, and the Alliance. We want you to be as healthy as possible. This might mean quitting smoking, eating healthier, being more physically active, or learning how to reduce stress. If you have a question about health education, please ask your PCP or call Alliance Health Programs or the Alliance Member Services Department to find out ways we can help you stay healthy. (*See the Contact sheet for phone number.*)

As an Alliance member, you will get a newsletter called "Alliance Member Connect." The newsletters will tell you about health education programs available your community, and will have articles on health topics that will benefit you and your family.

Asthma Services

Asthma affects both children and adults. It can be very hard to breathe during an asthma episode (attack). The good thing is that most people can learn to control their asthma and stay healthy. Work with your PCP to create an asthma action plan. Your PCP and Alliance Health Programs can help you learn how to avoid things that trigger asthma and to use medicine the best way. With good management, you can help prevent attacks. For more information on asthma, please contact Alliance Health Programs. (*See the Contact Information List for further information.)*

Breastfeeding Services

Breastfeeding has great benefits for the mom and baby. Breastmilk has all the nutrition needed to help your baby stay healthy, and it costs a lot less than formula. The Alliance offers breastfeeding resources such as free education referrals, and free breastfeeding support and breast pump referrals. Call Alliance Health Programs or Alliance Obstetrics Case Management (OBCM) Program to learn about available services. (*See the Contact Information List for further information.)*

California Children's Services (CCS)

As part of the services provided, Alliance members under the age of 21 requiring specialized medical care may be eligible for CCS.

CCS is a California medical program that treats children with certain physically debilitating conditions and who need specialized medical care. This program is offered to all children in California whose families meet certain health, income, and housing guidelines. All services provided through the CCS Program are coordinated by the Alameda County CCS Office.

If a member's PCP suspects or finds a possible CCS-eligible condition, he/she must refer the member to the local CCS Program. The CCS Program (local or regional office) will decide if the member's condition covered for CCS services.

If a member is chosen for CCS services, the member will stay enrolled in the Alliance Group Care Program. The member will be referred and must receive treatment for the CCS-eligible condition through the specialized network of CCS providers and/or CCS-approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS-eligible conditions.

The Alliance will continue to provide primary care and preventative services that are not related to the CCS-eligible condition, as described in this document, and will also work with the CCS Program to coordinate care provided by both the CCS Program and the Alliance.

Confidential HIV Counseling and Testing Services

You may obtain testing from your PCP or clinics listed in the "Confidential HIV Testing Sites" section of the provider directory. You can also view the provider directory online at **www.alamedaalliance.org**. You do not need your PCP's approval for these services.

Diabetes Management Services

Diabetes is a serious disease that affects the way the body uses food as energy. If it is not managed, diabetes can cause harmful health problems. The good news is that anyone can learn how to live a healthy life, even with diabetes!

Members under the age of 21 with diabetes may be eligible for CCS. Children who are eligible for CCS must receive these services through the CCS Program.

If you have diabetes, you must take an active part in caring for yourself each day. Through a team effort between you, your PCP, and the Alliance, we can better manage your diabetes. You should have regular check-ups with your PCP to check your feet, blood pressure, and blood glucose. You should also have a diabetic eye exam each year with an eye care doctor. Your PCP can also refer you to a diabetes education program. There you will learn about diabetes self-care, such as taking medicines, testing your blood, meal planning, exercise tips, and how to

lower stress. For more information on diabetes education programs, please contact Alliance Health Programs. (*See the Contact Information List for further information*.)

Drug and Alcohol Treatment Services

Drug and alcohol treatment services (detoxification) are covered benefits through the Alliance's contracted behavioral health plan, Beacon Health Strategies. To access services, members can call Beacon Health Strategies at **1.855.856.0577**.

Family Planning Services

Please see your PCP for family planning services. You may also go to an obstetrical or gynecological specialist provider (OB/GYN), certified nurse midwife, certified nurse practitioner, or clinic in our plan. You do not need your PCP's approval to go to another provider or clinic. Please see the provider directory for family planning service sites. You can also view the provider directory online at **www.alamedaalliance.org**.

Genetic Testing and Counseling Services

If you are planning to get pregnant or are pregnant and want information about genetic testing and counseling, please see your PCP.

Gynecological Services

You do not need a referral from your PCP for OB/GYN services. You can to go any OB/GYN, certified nurse midwife, certified nurse practitioner, or clinic in our plan without your PCP's approval. Please see the provider directory for the providers in our network. You can also view the provider directory online at **www.alamedaalliance.org**.

Women should get an annual (yearly) check-up, including a gynecological exam from their PCP or an OB/GYN. A good way to remember these visits is to schedule an appointment around your birthday each year. These check-ups help you stay healthy. If you want more information about these exams, please contact Alliance Health Programs. (*See the Contact Information for further information*.)

New Baby Services

Your newborn baby is automatically covered by the Alliance from the date of birth through the first 30 days of life only. Dependents are not eligible to enroll in the Alliance Group Care Program.

Mental Health Services

Mental Health services are covered benefits through the Alliance's contracted behavioral health plan, Beacon Health Strategies. Members can call Beacon Health Strategies at **1.855.856.0577** to access services.

Outpatient Pharmacy Services

A doctor from the Alliance Provider Network must write your prescriptions except when you receive emergency or urgent care services. You must get the drugs from a pharmacy in the Alliance Pharmacy Network, except for emergency or urgent care situations. Be sure to bring your Alliance Member ID Card with you to the pharmacy.

We cover medically necessary drugs and items when prescribed by an Alliance provider and dispensed at an Alliance pharmacy.

Formulary and Non-Formulary Drugs

Our drug formulary is a list of drugs that have been approved by our Pharmacy and Therapeutics (P&T) Committee for our members. A committee of Alliance doctors and pharmacists reviews drugs to add or remove from the formulary every three (3) months. They choose drugs for the list using factors like how safe the drug is and how well it works.

Drugs prescribed for you that are on the Alliance formulary generally do not require an authorization. There are some formulary drugs that may have certain limits or require Step Therapy (see subsequent topics below). A drug that is not on the list (a non-formulary drug) may be approved if your doctor requests an authorization and gives the Alliance a reason for why you need the non-formulary drug.

To find out if a drug is on the formulary, or to obtain a copy of the formulary, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.) The formulary is also available on our website at **www.alamedaalliance.org**. A drug that is on the formulary list does not guarantee that your doctor will prescribe that drug.

Your doctor may also prescribe a drug for a use that is different from the use for which that drug has been approved if it is medically necessary and all conditions for authorization are met.

If the Alliance denies your request for a drug if it is determined the drug is not medically necessary, experimental, or investigational, you may request an Independent Medical Review (IMR). *(See Section 14: Grievance and Appeal Procedures for further information.)*

Brand-Name and Generic Drugs

A generic drug has the same active ingredient as the brand name version of the drug both are approved by the Food and Drug Administration (FDA). Generic drugs usually cost less than brand name drugs.

The Alliance has a mandatory generic program. This program promotes the use of generic options over brand when medically appropriate. When your doctor writes you a prescription for a brand name drug and not a generic due to medical need, your doctor must request an authorization and give the Alliance a reason for why you need the brand drug.

Quantity Limits/Day Supply Limit

We cover medically necessary drugs prescribed by your doctor for a 30-day supply in a 30-day period. If you require a drug that goes beyond the limit, your doctor can submit a Prior Authorization Form to us. In some cases, your doctor may be able to write a prescription for a 90-day supply of maintenance drugs. Maintenance drugs are drugs that you need to take for a long time, such as pills for high blood pressure or diabetes.

Step Therapy

In some cases, the Alliance requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. Your doctor can request an authorization by submitting a Prior Authorization Form to us.

Pregnancy Services

If you are an Alliance member and you are pregnant, or think you are pregnant, it is important to go to your provider to get prenatal care as soon as possible – this way both you and your baby can be as healthy as possible. You do not need a referral from your PCP to see Alliance OB/GYNs, certified nurse midwives, certified nurse practitioners, or clinics in our plan.

If you would like information on having a healthy pregnancy, call Alliance Health Programs. We can also help you find support services, such as how to quit smoking, breastfeeding, and dealing with family stress.

After you have your baby, you will need to see your provider six (6) weeks later. This is an important time to let your provider see how your body is changing after delivery and make sure that you are doing well. A few days after you give birth, call your provider's office to schedule a postpartum appointment.

Sexually Transmitted Disease Care

You may get confidential testing and treatment for sexually transmitted diseases (STDs), like syphilis, gonorrhea, and chlamydia.

We have the following types of providers in our plan that may provide treatment:

- Family Planning Sites
- Certified Midwives and Certified Nurse Practitioners
- Primary Care Providers
- STD Testing and Treatment Sites
- Women's Specialists (OB/GYNs)

Your PCP does not have to approve this care. Please look at the "STD Testing and Treatment Sites," "Obstetricians/Gynecologists," and "PCPs – Your Regular Doctor" sections in the provider directory for these services.

Abortion Services

Abortion services are covered only if provided by an Alliance provider. Members do not need approval from their PCP for this service.

8. Emergent, Urgent, and Routine Care

What to do in an Emergency

An emergency is the sudden start/onset of a medical condition or illness that is an immediate threat to the wellbeing of the patient (including severe pain), that if you did not get immediate medical attention you could reasonably expect that:

- Your health would be put in serious jeopardy;
- You would have serious problems with your bodily functions; or
- You would have serious damage to any part or organ of your body

The Alliance covers 24-hour care for emergencies, both in and outside of Alameda County. You do not need prior authorization for emergency care. Emergency care includes screening, examination, and evaluation of a medical and/or psychiatric emergency condition, and care and treatment is necessary to eliminate the medical and/or psychiatric emergency condition within the capabilities of the facility. Active labor associated with pregnancy is an emergency condition.

When you need emergency care, go to the nearest emergency room or call 911. Show the emergency room staff your Alliance Member ID Card. If you receive emergency services inside or outside of the plan service area and receive a bill, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.)

Post Stabilization and Follow-Up Care

After receiving emergency services, you will need to call your PCP for any additional care that you will need.

Once your emergency medical condition has been treated at a hospital and an emergency no longer exists because your condition has become stable, the doctor who is treating you may want you to stay in the hospital for a while longer before you can safely leave the hospital. The services you receive after an emergency condition is stabilized are called “post-stabilization services.”

If the hospital where you received emergency services is not part of the Alliance’s contracted network (non-contracted hospital), the non-contracted hospital will contact the Alliance to get approval for you to stay in the non-contracted hospital.

If the Alliance approves your continued stay in the non-contracted hospital, you will not have to pay for services except for any copayments normally required by the Alliance.

If the Alliance has notified the non-contracting hospital that you can safely be moved to one of the plan's contracted hospitals, the Alliance will arrange and pay for you to be moved from the non-contracted hospital to a contracted hospital.

If the Alliance determines that you can be safely transferred to a contracted hospital, and you or your parent(s) or legal guardian do not agree to you being transferred, you will have to pay for all of the cost for post-stabilization services provided to you at the non-contracted hospital after your emergency condition is stabilized.

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get contact information at the plan to ask for approval to provide services once you are stable.

Getting Urgent Care Services

An urgent medical condition is not an emergency, but may require prompt medical attention.

Urgent care services are those services:

- Necessary to prevent serious deterioration of health
- Resulting from an unforeseen illness, injury or complication from an existing condition, including pregnancy, for which treatment cannot be delayed until you return to the plan's service area

The Alliance covers urgent care, both in and outside of Alameda County, but the way to get urgent care services is different.

In Alameda County

If you need urgent care services while you are within Alameda County, you can call your PCP. Your PCP's phone number is on the front of your Alliance ID card. You can call your PCP anytime of the day or night.

In the event that you are unable to see your PCP, you may go to any in-network urgent care facility in Alameda County. For a list of contracted Urgent Care Center, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.)

Outside of Alameda County

If you need urgent care services while you are outside of Alameda County, you are encouraged to call your PCP. You can obtain urgent care services without authorization and without calling your PCP. If you get urgent care treatment while outside of the Alliance service area and you get a bill, please call Alliance Member Services. (*See the Contact Information List for further information*.) (*See Section 11: Coordination of Benefits and Third-Party Liability.*)

Non-Emergent/Urgent Services

Medical services that are provided in an emergency care or urgent care setting for conditions that are not an emergency or urgent are not covered under this plan. Members will be responsible for the charges related to these services. The plan will review these services based on the reasonable belief of the member at the time the services were accessed that their situation was either an emergency or urgent.

How to Get Routine Care

Routine Care is important medical care to keep you healthy. Routine care can be check-ups and services to keep you from getting sick.

Your PCP will most likely be your provider of routine care. You should make regular appointments for check-ups.

9. Schedule of Medical Benefits

Subject to referral by your PCP, authorization, and applicable co-payments, and all other terms, conditions, limitations, and exclusions of this EOC, including those listed in the *General Exclusions and Limitations* section. The following services are covered by the Alliance when medically necessary or determined to be preventive care services:

Acupuncture

Acupuncture services are provided as a self-referral benefit. Services must be obtained from an Alliance participating provider.

Cost to Member

- $5 copayment

Exclusions/Limitations

- Benefits are limited to 10 visits per benefit year

Cancer Clinical Trial

Cancer clinical trials are studies of new drugs or other cancer treatments.

Coverage for a member's participation in a cancer clinical trial, phases I through IV, is covered when the member's physician has recommended participation in the trial, and the member meets the following requirements:

- Member must be diagnosed with cancer;
- Member must be accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer;
- Member's treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful impact to the member; and
- The trial must meet the following requirements:
    - Trials must have a therapeutic intent with documentation provided by the treating physician; and
    - Treatment provided must be approved by one of the following:
        - The National Institute of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or
        - Involve a drug that is exempt under the Federal regulations from a new drug application

Benefits include the payment of costs associated with the provision of routine patient care that would otherwise be covered if they were not provided in connection with an approved clinical trial program.

Routine patient costs for cancer clinical trials include:

- Health care services required for the provision of the investigational drug, item, device, or service
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications

Cost to Member

- $10 copayment for office visits
- $10 copayment for generic
- $15 for brand name prescription drugs

Exclusions/Limitations

- Any item or service that is provided only to fulfill data collection and analysis needs and that is not used in the clinical management of the patient.
- Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California.
- Health care services that are customarily provided by the research sponsors free of charge for anyone enrolled in the trial.
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental).
- Outpatient self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications as prescribed by the member's Alliance provider.
- Podiatric devices to prevent or treat diabetes complications.
- Provision of non-FDA-approved drugs or devices that are the subject of the trial.
- Services other than health care services, such as travel, housing, and other non-clinical costs that a member may be charged due to participation in the trial.

Cataracts Spectacles and Cataract Lenses

One (1) pair of conventional eyeglasses or conventional contact lenses is covered if necessary after cataract surgery with insertion of an intraocular lens.

Cost to Member

- No copayment

Chiropractic Services

Chiropractic services are provided as a self-referral benefit. Services must be obtained from an Alliance participating provider.

Cost to Member

- $10 copayment

Exclusions/Limitations

- Benefits are limited to 20 visits per benefit year

Dental Care

Contact the Public Authority for information about dental services. (*See the Contact Sheet for phone number.*)

Diabetic Management and Treatment

The following services, supplies, and equipment for the treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes, are covered by the Alliance when medically necessary or determined to be preventive care services, even if the items are available without a prescription:

- Blood glucose monitors and blood glucose testing strips, including blood glucose monitors designed to assist the visually impaired
- Glucagon
- Insulin
- Insulin pumps and all related necessary supplies
- Insulin syringes
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Outpatient self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications as prescribed by the member's Alliance provider

- Pen delivery system for the administration of insulin
- Podiatric devices to prevent or treat diabetes complications
- Prescriptive medications for the treatment of diabetes
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

Cost to Member

- $10 for physician office visits
- $10 copayment for generic or $15 for brand name prescription drugs

Diagnostic and Laboratory Services

Medically necessary laboratory and major diagnostic services to appropriately evaluate, diagnose, treat, and follow-up on the care of members, include, but are not limited to:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Tests for management of diabetes, cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (glycohemoglobin)
- Generally accepted cancer screening tests to include mammography, prostate cancer screening, cytology exams on a periodic basis, including PAP tests, and the option of any other cervical cancer screening test approved by the FDA upon referral by the member's health care provider and consistent with generally-accepted medical practice and scientific evidence

Cost to Member

- No copayment

Durable Medical Equipment (DME)

Medical equipment appropriate for use in the home that:

- Is intended for repeated use
- Is generally not useful to a person in the absence of illness or injury
- Primarily serves a medical purpose

Repair or replacement is covered unless needed because of misuse or loss. The Alliance may determine whether to rent or purchase standard equipment.

Examples include:

- Oxygen and oxygen equipment
- Pulmoaides and related supplies

- Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
- Ostomy bags and urinary catheters and supplies.
- Wheelchairs

Cost to Member

- No copayment

Exclusions/Limitations

- Comfort or convenience items
- Disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment; experimental or research equipment
- Devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one (1) piece of equipment that serves the same function

Emergency Services

24-hour care is covered for an emergency medical condition.

An emergency is the sudden start/onset of a medical or psychiatric condition or illness that is an immediate threat to the wellbeing of the patient (including severe pain), that if you did not get immediate medical attention you could reasonably expect that:

- Your health would be put in serious jeopardy;
- You would have serious problems with your bodily functions; or
- You would have serious damage to any part or organ of your body.

Cost to Member

- $35 copayment (copayment will be waived if the member is admitted to the hospital)

Family Planning

Please see your PCP for family planning services. The following family planning services are covered by the Alliance when medically necessary or determined to be preventive care services:

- Office visits for family planning examinations

- Prescription contraceptives and devices: All FDA approved injectable, contraceptive drugs and prescription devices are covered including internally implanted time-release contraceptives such as Norplant. A 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time.
- Family planning counseling
- Professional services for sterilization as permitted by State and Federal Law
- Diagnosis and treatment of sexually transmitted infections
- Pregnancy tests and family planning related lab and x-rays

Cost to Member

- No copayment

Exclusions/Limitations

- Over-the-counter drugs, supplies, and devices, including non-prescription contraceptive jellies, ointments, foam, condoms, etc. (See the *Exclusions/Limitations* under the *Prescription Drug* benefit in this section)
- In-vitro fertilization

Hearing Test and Aids Services

The following hearing test and aids services are covered by the Alliance when medically necessary:

- Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid needed
- Monaural or binaural hearing aids including ear molds(s), the hearing aid instrument, the initial battery, cords, and other equipment
- Visits for fitting, counseling, adjustments, and repairs, etc. are covered under warranty at no charge for one (1) year

Cost to Member

- No co-payment

Exclusions/Limitations

- Purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of hearing loss
- Replacement parts for hearing aids, repair of a hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once (1) in a 36-month period

- Surgically implanted hearing devices

Home Health Care Services

Home health care services are the delivery of skilled medical services such as short-term physical therapy, occupational therapy, speech therapy, and respiratory therapy when prescribed by a Plan practitioner (subject to visit limitations under the Physical/Occupational/ Speech Therapy benefit.) These services are provided by Alliance-contracted providers to a homebound member and include visits by RNs, LVNs, and home health aides.

These services are designed to transition the member from inpatient care or to prevent hospitalization. (A homebound member is a person who is unable to leave his or her home due to a medical condition except with considerable effort and assistance.)

Home health care services are provided under the direction of a home health treatment plan and only when medically necessary and authorized. Home health care services must be provided under the direct care and supervision of the member's Alliance provider or other appropriate authority designated by the Alliance and within the service area. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the Alliance to choose the setting for providing the care.

The Health Plan exercises prudent medical case management to ensure that appropriate care is rendered in the appropriate setting.

Medical case management may include considerations of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or setting.

<u>Cost to Member</u>

- $10 per visit for physical, occupational, and speech therapy performed in the home
- $10 for physician visit

<u>Exclusions/Limitations</u>

- Services that are non-skilled, custodial, or domiciliary care, as defined by the Alliance

Hospice Care

The Alliance provides hospice care for its members who are terminally ill. Members have the option to choose this home-based treatment instead of the other benefits for terminal illness that are covered by the Alliance. Terminal illness is defined as a medical condition resulting in a prognosis of life expectancy of one (1) year or less, if the disease follows its natural course.

Hospice care is a specialized form of interdisciplinary health care that is designed to provide medical treatment for pain and other symptoms associated with a terminal illness, but does not provide for efforts to cure the disease. Hospice care must be provided by a hospice provider contracted with the Alliance. (The member may change the decision to receive hospice care at any time and request other services offered by the Alliance instead.)

When ordered by an Alliance physician and authorized by the Alliance, the hospice benefits include:

- Counseling and bereavement services
- Drugs
- Home health aide services
- Homemaker services and short-term respite care
- Medical social services
- Medical supplies and appliances
- Nursing care
- Physical/occupational/speech therapy; short-term inpatient care for pain control and symptom management
- Physician services

Cost to Member

- No co-payment

Exclusions/Limitations

- Hospice care is limited to those individuals who are diagnosed with a terminal illness and who elect hospice care for such illness instead of the restorative services covered by the Plan

Hospital Services/Inpatient

Hospital inpatient care is service you get when you are admitted to an Alliance hospital. To get treatment at a hospital, your PCP must get an approval from the Alliance.

Emergent care and urgent care services do not need to be authorized or referred. Hospital benefits are not covered if the member refuses to be under the direct care and treatment of Alliance providers, or if services are received through a provider whose services have not been authorized.

The following hospital services are covered benefits when provided at a participating Alliance hospital as referred by your Alliance Provider and authorized in accordance with Alliance rules:

- Treatment while in hospital
- Administration of blood and blood products
- Drugs, medications, anesthesia, IV fluids, biologicals, and oxygen administered in the hospital
- Inpatient hospital services, including semi-private room, meals (including special diets when medically necessary), and general nursing care
- Inpatient physical, occupational, and speech therapy services are covered as medically necessary
- Intensive care services
- Medically necessary ancillary services such as diagnostic laboratory and x-ray services
- Operating room, special treatment rooms, delivery room, newborn nursery room, and related facilities
- Radiation therapy, chemotherapy, and renal dialysis
- Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses (not including surgically implanted hearing aids), other medical supplies, medical appliances and equipment administered in the hospital, and prosthetic devices for a member having a mastectomy (to restore and achieve symmetry for the member), or a member having a laryngectomy (to restore speech)
- Other diagnostic, therapeutic, habilitative, and rehabilitative services as appropriate
- Coordinated discharge planning, including the planning of such continuing care as may be necessary

<u>Cost to Member</u>

- $100 per admission except for Pregnancy and Maternity Care

<u>Exclusions/Limitations</u>

- Convenience items such as telephones, televisions, guest trays, and personal hygiene items
- Private rooms
- Services of the dentist or oral surgeon for dental procedures.

Medical Transportation Services

- *Emergency Ambulance Services*: Ambulance transportation to the nearest hospital is covered if the member had reason to believe that the medical condition was an emergency, and that the condition required emergency transportation. This includes ambulance transportation services provided through the "911" emergency response system
- *Authorized Ambulance Services*: Ambulance services to transfer a member to or from a participating hospital or skilled nursing facility in connection with an authorized confinement/admission will be authorized only when transportation by other means would adversely affect the member's medical condition, whether or not such other means of transportation are available

Cost to Member

- No copayment

Exclusions/Limitations

- Coverage for transportation, including transportation by airplane, passenger car, taxi, or other form of public conveyance
- Ambulance transportation to the home unless medically necessary and authorized by the Alliance

Mental Health and Substance Use Disorder Care

Mental health (MH) services are provided by the Plan's contracted behavioral health provider, Beacon Health Strategies. Members can call **1.855.856.0577** to access MH services. All MH conditions identified as a mental disorder in the Diagnostic and Statistical Manual (DSM), Fourth Edition, are covered, including severe mental illnesses (SMI). The Alliance also covers all substance use disorder (SUD) services.

Inpatient MH and SUD Services

These are services ordered and performed by a Plan MH Provider for the treatment of an acute phase of a MH and/or SUD condition during a certified confinement in a Plan hospital.

Inpatient MH and SUD benefits include:

- MH Psychiatric Hospitalization
- MH Crisis Residential Program
- SUD Inpatient Detoxification, as medically appropriate to remove toxic substances from the system
- SUD Inpatient Services

Outpatient MH and SUD Services

These are services used to provide crisis intervention and treatment of alcoholism, drug abuse, or mental health on an outpatient basis as medical appropriate.

Outpatient MH and SUD benefits that are office visits:

- MH individual and group evaluation and treatment
- Psychological testing
- Psychiatric testing/observation
- Outpatient monitoring of drug therapy
- SUD individual and group evaluation and treatment
- SUD individual and group chemical dependency counseling

Outpatient MH and SUD benefits other than office visits:

- MH multidisciplinary treatment (intensive outpatient psychiatric treatment program)
- SUD intensive outpatient program
- SUD medication treatment for withdrawal
- Behavioral Health treatment for PDD/Autism
- Opioid replacement therapy

Cost to Member

- $100 per admission
- $10 copayment for outpatient MH and SUD office visit benefits
- No copayment for outpatient MH and SUD benefits other than office visits

Nurse Line

The Alliance Nurse Line is offered 24/7 to all members to help answer your health questions in regards to common illnesses and conditions, healthy lifestyle tips, health screenings and shots. The free Nurse Line links you to a Registered Nurse who will discuss your health and wellbeing. The Registered Nurse will also help you decide what kind of care to seek, including: if your health problem can be treated at home, if you should see a doctor, or if you might need to get urgent or immediate care.

Members can call **1.855.383.7873** (PIN# 690) to access the Nurse Line services 24/7.

Organ Transplant Benefits

Benefits include coverage for medically necessary organ and bone marrow transplants that are not experimental or investigational.

The benefit includes payment for:

- Medically necessary and reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor, if these expenses are directly related to the transplant for a member
- Testing member's relatives for matching bone marrow transplants.
- Searching for and testing unrelated bone marrow donors through a recognized donor registry
- Charges associated with procuring donor organs through a recognized donor transplant bank are covered if the expenses are directly related to the anticipated transplant for the member

If the Alliance denies your organ transplant request based on a determination that the service is not medically necessary, experimental or investigational, you may request an Independent Medical Review (IMR). (*See Section 14: Grievance and Appeal Procedures for further information.*)

Cost to Member

- No copayment

Exclusions/Limitations

- Organ transplant services will be covered and paid for by CCS if the member is to be found CCS-eligible. The Alliance will coordinate these services with CCS for the member (*See Section 7: Available Services for further information.*)

Orthotics and Prosthetics

The Alliance covers medically necessary prosthetic and orthotic devices (and replacement) as prescribed by a practitioner.
The benefit includes payment for:

- Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic devices to restore and achieve symmetry incident to a mastectomy
- Covered items must be physician-prescribed, custom-fitted, standard orthotic or prosthetic devices, authorized by the Alliance and dispensed by a Plan provider
- Repair is provided unless necessitated by misuse or loss. The Alliance, at its option, may replace or repair an item

Cost to Member

- No copayment

Exclusions/Limitations

- Corrective shoes, shoe inserts, and arch supports, except for therapeutic footwear for diabetes
- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts
- Dental appliances
- Electronic voice producing machines
- More than one (1) device for the same part of the body
- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery)
- Over the counter items

Outpatient Services

Outpatient services include:

- Diagnostic, surgical, and therapeutic services (including radiation and chemotherapy) in an outpatient setting or ambulatory surgery center
- Physical, occupational, and speech therapy as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis
- Related services and supplies in connection with outpatient care, including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the member's stay at the facility
- Hospital services which can reasonably be provided on an ambulatory basis

Cost to Member

- $10 copayment per visit for Physical Therapy, Speech Therapy, and Occupational Therapy performed on an outpatient basis
- $35 copayment for emergency health care services (waived if admitted to the hospital)

Exclusions/Limitations

- Services of the dentist or oral surgeon for dental procedures.

Phenylketonuria (PKU)

The testing and treatment of PKU are covered, including formulas and special food products that are part of a diet prescribed by a physician or registered dietitian in consultation with a physician who specializes in the treatment of metabolic diseases, and who participates in or is authorized by the Plan.

"Special food product" is defined as a food product that is:

- Specially formulated to have less than one (1) gram of protein per serving, but does not include food that is naturally low in protein; and
- Used in place of normal food products. Normal food products are those foods found in retail food stores and used by the general population.

Cost to Member

- No copayment

Physician Office Visits

Physician office visits are medically necessary professional services and consultations by a physician or other health care provider. They include examination, diagnosis, and treatment of a medical condition, disease or injury, including referred specialist office visits.

Cost to Member

- $10 copayment for office visits and home visits
- No copayment for preventative care. (*See the Preventative Health Services for further information*.)

Physical, Occupational, and Speech Therapy

Habilitative therapy is therapy to help make a part of your body work as normally as possible. Rehabilitative therapy is therapy to help restore a part of your body to its pre-injury condition. Physical, occupational, and speech therapy are types of habilitative and rehabilitative therapy. The Alliance covers such therapy if it is medically necessary. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home.

Cost to Member

- $10 copayment per visit provided on an outpatient basis
- No copayment for inpatient therapy

Exclusions/Limitations

- Limited to short-term therapy for a period not exceeding 60 consecutive calendar days per condition following the date of the first therapy session
- The Alliance provides additional therapy beyond the 60 days if medically necessary and if the condition will improve significantly
- The 60 days limitation does not apply to approved treatment plans for Pervasive Developmental Disorder (PDD) or autism. However, treatment plans prescribed by a

qualified autism service provider will be reviewed every six (6) months and modified when appropriate

Pregnancy and Maternity Care

Prenatal and Postnatal Physician Office Visits and Delivery

This benefit includes medically necessary professional and hospital services, including prenatal and postnatal care, care for complications of pregnancy, diagnostic and genetic testing, examinations of the member's newborn, and nursery care while the mother is hospitalized within the first 30 days after birth.

Also included is counseling for nutrition, health education and social support needs and coverage for participation in the statewide prenatal testing program administered by the California Department of Health Care Services.

Inpatient Hospital Services*:*

Hospital services for the purposes of a normal delivery, cesarean section delivery, complications, or medical conditions arising from pregnancy or resulting childbirth. The length of inpatient hospital stay is based upon the unique characteristics of each member and her newborn child, taking into consideration the health of the member, the health and stability of the member's newborn, the ability and confidence of the parent(s) to care for the member's newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up care.

The Alliance will not restrict its inpatient hospital care to less than 48 hours following a normal vaginal delivery and not less than 96 hours following a cesarean section delivery. However, coverage of inpatient hospital care may be for a time period less than 48 to 96 hours if the following two (2) conditions are met:

1. The discharge decision is made by the treating physician in consultation with the mother; and
2. The treating physician schedules a follow-up visit for the member and her newborn within 48 hours of discharge.

In addition to OB/GYN services, certified nurse midwife and nurse practitioner services are available to members seeking obstetrical care. The chosen nurse midwife or nurse practitioner must be associated with a practicing physician contracted with the Alliance. These participating providers are listed in the provider directory.

Cost to Member

- No copayment

Prescription Drugs

The Alliance covers medically necessary drugs when prescribed by a practitioner. Generic equivalent prescription drugs must be dispensed, as available, provided that no medical contraindications exist. If there is no generic-equivalent drug available, or if the prescribing physician has indicated that no substitution should be made and the request has been authorized, a brand-name drug may be dispensed.

The benefit includes payment for:

- Contraceptive drugs and devices, including oral and injectable medications that are FDA-approved. This includes internally time-released contraceptives such as Norplant (no refund if medication is removed). A 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time.
- Emergency contraceptive prescription drugs are covered without prior authorization. You should contact your PCP within 72 hours after the need for emergency contraception to obtain a prescription. Some pharmacists are trained to dispense emergency contraceptives without a prescription, but in most cases, you will need a prescription. If you use a contracted pharmacy, you will be required to pay your prescription co-payment. You may obtain the medication at a non-contracted pharmacy, but you may be required to pay for the medication, and submit your receipt to the Alliance for reimbursement, less your copayment
- Injectable medications (including insulin), needles and syringes necessary for the administration of covered injectable medication
- Blood glucose testing strips in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
- Ketone urine testing strips for type I diabetes and lancets
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
- Medically necessary drugs administered while a member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when provided through a Plan pharmacy
- Oral contraceptives pursuant to Plan's formulary
- Tobacco cessation drugs are covered for one (1) cycle or course of treatment per benefit year. It is recommended that the member for whom the treatment is prescribed attend a tobacco cessation program. To obtain a current listing of tobacco cessation

programs/classes, please call the Alliance Member Services Department. *(See the Contact Information List for further information*.)

If a member needs a non-formulary drug after hours, including weekends and holidays, an emergency supply of the drug may immediately be given to the member without prior authorization, subject to medical necessity and retrospective review.

To find out if a drug is on the formulary, or to obtain a copy of the formulary, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.) The formulary is also available on our website at **www.alamedaalliance.org**. A drug that is on the formulary list does not guarantee that your doctor will prescribe that drug. The presence of a drug on the Alliance formulary does not guarantee that a member will be prescribed that drug by his or her prescribing physician for a particular medical condition. For some drugs on the Alliance's formulary, limitations may apply.

Cost to Member

- $10 copayment per prescription for generic drugs or $15 per prescription for brand name drugs for up to a 30-day supply. Higher copayment amount will apply for 90-day supply of maintenance drugs
- No copayment for prescription drugs provided in an inpatient setting during the member's stay
- No copayment for drugs administered in the provider's office during the member's visit
- No copayment for drugs administered or in an outpatient facility setting during the members visit
- No copayment for FDA-approved contraceptive drugs and devices

Exclusions/Limitations

- Dietary supplements, appetite suppressants, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity
- Drugs for solely cosmetic purposes
- Experimental or investigational drugs
- Drugs not requiring a written prescription order (except insulin)
- Patent or over-the-counter drugs, supplies and devices including non-prescription contraceptives, jellies, ointments, foams, condoms etc.
- Drugs to treat erectile dysfunction.

If the Alliance denies your request for prescription drugs based on a determination that the drug is not medically necessary, experimental, or investigational, you may request an IMR. (*See Section 14: Grievance and Appeal Procedures for further information*.)

Preventive Health Services

The following services are covered by the Alliance when medically necessary or determined to be preventive care services:

- Vision and hearing tests
- Services for the detection of asymptomatic diseases, including Periodic health examinations, a variety of voluntary family planning services and prenatal care
- Cytology examinations on a reasonable periodic basis (including annual Pap smear exam)
- Immunizations consistent with the most current recommendations by the U.S. Public Health Services
- Periodic health exams, including all routine diagnostic testing and laboratory services suitable for such examinations
- Testing for sexually transmitted infection, including confidential HIV/AIDS counseling and testing
- Effective health education services including information regarding personal health behavior and health care, and recommendations, regarding the optimal use of health care services provided by the Plan.

Cost to Member

- No copayment

Exclusions/Limitations

Examinations for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance, by order of a court, or for travel, are not covered unless the examination corresponds to the schedule of routine physical examinations and immunizations.

Reconstructive Surgery

The following services are covered by the Alliance when medically necessary:

- Reconstructive surgical services performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) To improve function; (B) To create a normal appearance, to the extent possible
- Breast prostheses and reconstructive surgery to restore and achieve symmetry and any complications following a mastectomy are covered. For reconstructive surgical services following a mastectomy or lymph node dissection:

  - The hospital stay associated with a mastectomy or lymph node dissection is determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes.
- All complications of the mastectomy and reconstructive surgery, prosthesis for and reconstruction of the affected breast, and reconstructive surgery on the other breast needed to produce a symmetric appearance, are covered

Cost to Member

- No copayment

Skilled Nursing Facility Services

A skilled nursing facility is a facility which contracts with the Alliance and provides continuous skilled nursing services. A skilled nursing facility may be a distinct part of a hospital, and the use of such a distinct part shall be counted towards the maximum number of days allowed under this benefit: member benefits are limited to 100 days during any benefit year.

Subject to this limitation, the following skilled nursing facility benefits are provided when medically necessary and authorized, and not for custodial, convalescent, or domiciliary care:

- Durable equipment utilized by the member during an authorized stay in the skilled nursing facility
- General nursing care and special duty nursing when authorized
- Physical, occupational, and speech therapy, and other habilitative/rehabilitative services as medically necessary
- Respiratory therapy administered in the skilled nursing facility
- Semi-private room and board, unless a private room is medically necessary and authorized. If a private room is used without authorization, the member will be responsible for the difference between the skilled nursing facility's customary charge for a two (2) bedroom and the private room
- Special diets, when authorized

Cost to Member

- No copayment

Exclusions/Limitations

- Services that are non-skilled, custodial, or domiciliary care, as defined by the Alliance
- 100 Skilled Nursing days per benefit year

Abortion

Abortion services are covered only if provided by an Alliance provider. Members do not need approval from their PCP for this service.

Cost to Member

- $10 copayment per visit

Urgent Care

For urgent services within the Alliance service area, members must call their PCP. Your PCP's phone number is on the front of your Alliance Member ID card. You can call your PCP anytime of the day or night.

In the event that you are unable to see your PCP, you may go to any in-network urgent care facility in Alameda County. For a list of contracted Urgent Care Center, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.)

If you are outside of the service area and require urgent services, you may receive such services from a non-contracted provider. (*See Section 8: Emergent, Urgent, and Routine Care for further information.)* If you get urgent care treatment while outside of the Alliance service area and you get a bill, please call the Alliance Member Services Department. (*See the Contact Information List for further information*.)

Cost to Member

- $10 copayment per visit (Waived if admitted to the hospital)

Vision Care

Contact the Public Authority for information about vision services. (*See the Contact Sheet for phone number.*)

10. Exclusions and Limitations

Only those services that are specifically described as benefits in this EOC (and in any riders, inserts, or attachments to this document) are covered benefits of the Alliance Group Care Program. Services are covered benefits only if obtained in accordance with the procedures described in this document, including all authorization requirements and referral and coordinated by the member's PCP.

Members may request an IMR of disputed health care services from the Department of Managed Health Care for situations described in *Section 14. Grievance and Appeal Procedures.*

Exclusions/Limitations

1. All medical and hospital costs when the member is admitted to a hospital by a non-Plan physician without preauthorization by the Alliance, except in emergencies as described herein, are not covered benefits.
2. All services that would otherwise be covered by CCS are not covered benefits.
3. Amniocentesis, except when medically necessary, is not a covered benefit.
4. Any benefits in excess of limits specified within this EOC.
5. Any services and benefits rendered when the person is not eligible, i.e., prior to the person's effective date of coverage or after the person's coverage is terminated, are not covered benefits.
6. Any services or items specified as excluded within this EOC.
7. Appliance therapy for treatment of temporomandibular joint dysfunction (TMJ) is not a covered benefit.
8. Biofeedback therapy is not a covered benefit, except if part of a treatment plan for Pervasive Developmental Disorder (PDD) or Autism.
9. Conventional or surgical orthodontics or orthognathics are not covered benefits.
10. Custodial and domiciliary care incident to services rendered in the home; hospital (except as provided as part of hospice care); or confinement in a health facility primarily for custodial, maintenance, or domiciliary care, are not a covered benefit. This exclusion does not refer to home-based behavioral health therapy (BHT) for PDD or autism.
11. Cytotoxic food testing, chelation therapy (except for heavy metal poisoning), and radial keratotomy, unless pre-authorized the Alliance, are not covered benefits.
12. Examinations and reports for the purpose of obtaining or maintaining employment, insurance, governmental licensure, for camp or school admissions, for employer-requested annual physical exams, or for premarital purposes, are not covered benefits.
13. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under Cataract Spectacles and Cataract Lenses.

14. Hair analysis, unless used as a diagnostic tool for heavy metal poisoning, is not a covered benefit.
15. Home and vehicle improvements, including any modifications or attachments made to dwellings, property, or motor vehicles, including ramps, elevators, stair lifts, swimming pools, air filtering systems, environmental control equipment, spas, hot tubs, or automobile hand controls, are not covered benefits.
16. Learning and self-improvement programs, including the treatment of hyperkinetic syndrome, learning disabilities, or behavioral problems; or incident to reading, vocational, educational, recreational, art, dance or music therapy; weight control or exercise programs; are not covered benefits, except if part of treatment plan for PDD or Autism.
17. Long-term care benefits including long-term skilled nursing care in a facility and respite care are excluded, except as the Alliance will determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Skilled Nursing Care and Hospice benefits.
18. Medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are:
    a. Experimental or investigational; or
    b. Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, are not covered benefits. (*See Section 14: Grievance and Appeal Procedures for further information*.)
19. Medical services that are received in an emergency care setting for conditions that are not emergencies, if you reasonably should have known that an emergency care situation did not exist, are not covered benefits.
20. Non-skilled care is care that can be performed safely and effectively by family members or persons without a certification or the presence of a supervising nurse, except for authorized homemaker services for hospice care. This exclusion does not apply to non-licensed qualified autism service professional and paraprofessional who provide care to enrollees with PDD or autism.
21. Private duty nursing of any sort is not a covered benefit unless determined medically necessary by the Alliance.
22. Programs for weight control, or weight loss treatments or supplies, nutritional and/or dietary supplements, except for total parenteral nutrition (TPN), and for the treatment of PKU, are not covered benefits unless determined medically necessary by the Alliance.
23. Reversal of voluntary sterilization is not a covered benefit unless determined medically necessary by the Alliance.

24. Services obtained from non-Alliance hospitals, skilled nursing facilities, physicians, or other providers, unless provided in an emergency, or as otherwise described herein, are not covered benefits.
25. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan are not covered benefits.
26. Services, supplies, items, procedures, or equipment that is not medically necessary, unless otherwise specified, are not covered benefits.
27. Surgery for morbid obesity, including gastric bypass, gastric stapling, prescription medications, and other procedures for the treatment of obesity are not covered benefits, unless medically necessary in accordance with professionally recognized standards of practice.
28. The following forms of therapy are not covered benefits – manipulative therapy (except as part of treatment plan for PDD or autism), hypnotherapy and sex therapy.
29. Medical and hospital services of a member donor, or prospective donor when the recipient of an organ transplant is not a member.
30. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain, for which benefits are provided or payable under any worker's compensation benefit plan, are not covered benefits.
31. Treatment of infertility is excluded, including but not limited to in-vitro fertilization, GIFT (Gamete Interfallopian Transfer), ZIFT and ovum transplants, or any other form of induced fertilization or artificial insemination.
32. Trimming of corns, calluses, and nails for circulatory conditions are not covered benefits, unless determined medically necessary by the Alliance.
33. Vocational rehabilitation is not a covered benefit.
34. Marriage or relationship counseling.
35. Vision and Dental Care services.

Additional services exclusions and limits are noted in the previous benefits description sections.

11. Coordination of Benefits and Third-Party Liability

Coordination of Benefits

If an Alliance member is also entitled to benefits under any of the conditions listed below, the Alliance's liability for benefits shall be reduced by the amount of benefits paid by the other responsible party, or the reasonable value of the services provided without any cost to the member, when he or she is entitled to these other benefits. This applies when the member is entitled to:

- Benefits provided as a result of a Worker's Compensation claim
- Benefits provided free of charge or without expectation of payment

Third-Party Liability

If a member is injured through the act or omission of another person (a "third party"), the Alliance shall, with respect to services required as a result of that injury, require that the member to cooperate with the Alliance in the following manner:

- Agree to reimburse the Alliance the reasonable costs actually paid by the Alliance immediately upon collection of damages by the member, whether by action of a law, settlement, or otherwise; and
- Fully cooperate, effect, and protect the Alliance's lien rights, not to exceed the sum of the reasonable costs actually paid by the Alliance. The lien may be filed with the third party, the third party's agent, or the court.

All liens filed by the Alliance for the recovery of payments made by the Alliance for the provision of medical services to the member shall be in accordance with Civil Code Section 3040.

Third-Party Liability Member Responsibilities

Each member will:

1. Complete any paperwork that the Alliance or the medical providers may reasonably require to assist in enforcing the lien.
2. Give prompt notification to the Alliance of the name and location of the third party, if known, the name and address of the member's lawyer, if using one, and a description of how the injuries were caused.
3. Hold any money that member or the member's lawyer receives from the third parties or their insurance companies in trust, and reimburse the Alliance for the amount of the lien as soon as the member is paid by the third party.

4. Notify the Alliance immediately upon receiving any money or the member's lawyer receiving any money from the third parties or their insurance companies.
5. Promptly respond to inquiries about the status of the third-party case and any settlement discussions.

12. Disenrollment

Term and Termination - Group Agreement

Termination and Renewal Provisions

The initial term of the agreement between the Alliance and IHSS shall commence and continue through the effective period set forth in the cover sheet, unless terminated earlier as described elsewhere in the agreement. Thereafter, the agreement shall be automatically renewed for subsequent terms of 12 months, each subject to the termination provisions contained herein.

The Public Authority may terminate the Agreement, or any renewals thereafter of the agreement, by giving Alliance 90 days prior written notice of its intent to terminate.

Effective Date of Termination

Any termination of the Agreement for any reason specified below shall be effective on the last day of the calendar month in which the termination date occurs, notwithstanding any specified notice period.

Termination for Good Cause

The agreement may be terminated by either party with good cause upon 30 days prior by written notice to the other party due to any material breach by the other party, other than nonpayment by the Public Authority, if such breach has not been cured by the expiration of such 30-day notice period, or due to failure of the parties to reach an agreement, by the applicable renewal date of the agreement, upon the Periodic Prepayment Fees to be paid under the Agreement commencing as of that date.

Termination for Failure to Pay

If the Public Authority fails to pay any amount due to the Alliance within 15 days after the Alliance's notice to the Public Authority of the amount due, and the Alliance bills the Public Authority for the amount due, then the Alliance may terminate the rights of the members involved, effective upon the Alliance's issuance of a written notification of cancellation to the Public Authority. Such rights may be reinstated only by payment of the amounts due and in accordance with Reinstatement sub-section in this EOC. The Alliance shall continue to provide benefits to members, including those members who are hospitalized or undergoing treatment, until expiration of the applicable reinstatement period. Thereafter, the Alliance shall not be liable for benefits to members, including those members who are hospitalized or undergoing treatment.

Reinstatement

Receipt by the Alliance of the proper Periodic Prepayment Fees within 15 days of the Alliance issuance of the notice of cancellation to the Public Authority for non-payment of Periodic Prepayment Fees shall reinstate the members as though there never was a cancellation. If such payment is received after said 15-day period, the Alliance, at its option, may either refund the Public Authority the amounts paid and consider the agreement terminated, or issue to the Public Authority, within 20 days of the receipt of such payment, a new agreement accompanied by written notice stating clearly those respects in which the new agreement differs from the agreement in benefits or other terms.

Refunds

If the rights of a member hereunder are terminated, Periodic Prepayment Fees received from the Public Authority on account of the terminated member applicable to periods after the effective date of termination, plus amounts due on claims, if any, less any amounts due to the Alliance or plan providers, shall be refunded to the Public Authority within 30 days, and neither the Alliance nor plan providers shall have any further liability or responsibility under the agreement.

Changes in Law

In the event there is any amendment of the Knox-Keene Act or change in the interpretation of the Act by DMHC, which expands the basis upon which a health care service plan may terminate, cancel, or decline to renew the Public Authority Member Agreements, the Alliance may amend the agreement unilaterally, effective immediately, and then provide the Public Authority with written notice of the amendment within 15 days.

Election to Not Renew

The Alliance may elect not to renew the Agreement with 180 days prior written notice in the event that the Alliance elects to cease to provide new or existing group health benefit plans in California. The Alliance may also elect not to renew the Agreement with 90 days prior written notice if it withdraws the plan benefits applicable to the agreement from the market.

Failure to Agree on Renewal Premium

The Alliance may terminate the agreement automatically, in the event the Public Authority and the Alliance fail to reach agreement, prior to 90 days of the renewal date, of the Periodic Prepayment Fees to be paid under the agreement as of the renewal date.

Extension of Benefits upon Termination

Continuing Care

If the agreement is terminated pursuant to the conditions stated above, any member who is institutionalized in a plan provider or undergoing treatment for an ongoing condition on the effective date of termination shall, subject to payment of periodic prepayment fees and applicable copayments, receive all benefits authorized by the Alliance prior to the effective termination date for such course of treatment until either: (a) the expiration of such benefits; (b) a determination by a plan provider that institutionalization is no longer medically required; or (c) 30 days after the effective date of termination of the agreement, whichever occurs first.

Totally Disabled Member

Except as expressly provided in this section, all rights to benefits shall terminate as of the effective date of termination of the agreement. Under Section 1399.62 of the Act, if a member becomes totally disabled with a condition for which benefits are covered under the agreement, and upon the date of termination of the agreement, such member continues to be totally disabled, then such member shall be covered, subject to all limitations, exclusions, conditions, and restrictions of the agreement, including payment of copayments and Periodic Prepayment Fees, for the disabling condition until:

1. The end of the 12th month after termination of the Agreement;
2. The member is no longer totally disabled; or
3. At such time as member obtains coverage under a replacement contract or policy issued without limitation as to the disabling condition, whichever occurs first.

The Public Authority shall provide proof of continuing total disability to the Alliance at no less than 31 day intervals during the period that extended benefits are available, along with appropriate certification from a plan provider as to the members continuing total disability.

If the agreement is terminated pursuant to the conditions stated above, any member who is institutionalized in a plan provider or undergoing treatment for an ongoing condition on the effective date of termination shall, subject to payment of Periodic Prepayment Fees and applicable copayments, receive all benefits authorized by the Alliance prior to the effective termination date for such course of treatment until either:

1. The expiration of such benefits;
2. A determination by a plan provider that institutionalization is no longer medically required; or
3. 30 days after the effective date of termination of this agreement, whichever occurs first.

Termination of Benefits – Individual Member

Your health care coverage with Alliance Group Care can end for several reasons. If this happens you may be able to continue your health coverage through COBRA or Cal-COBRA. (*See Section 13: Continuation of Benefits for further information*). The Alliance cannot end your health benefits because of your health needs or medical condition. But your health coverage can be terminated for one of the reasons below.

Loss of Eligibility

Your health care coverage with Alliance Group Care can end if you cease to meet the eligibility requirements set forth by the Public Authority.

The Public Authority shall continue to be liable for Periodic Prepayment Fees during the period between loss of eligibility and receipt of notice by the Alliance. Plan providers may bill a member for services rendered to such member subsequent to the plan provider's advisement by the Alliance of the member's ineligibility.

Election of Other Plan Coverage

If you elect coverage under any other plan which is offered by, through, or in connection with the Public Authority, then your coverage and benefits will terminate.

The Public Authority will notify the Alliance immediately when a member elects other coverage.

Failure to Furnish or Furnishing Incomplete Information

If a member fails to furnish information required to be furnished to the Alliance under the agreement or the Public Authority, then the Alliance may terminate the rights of the member effective 15 days after receipt by the member of written notice of termination from the Alliance, unless the member furnishes the Alliance or the Public Authority with the required information within such 15-day period.

Fraud or Deception

Members shall warrant in their enrollment applications that all information contained in applications, questionnaires, forms, or statements submitted to the Alliance incident to enrollment, are true, correct, and complete. If any member engages in fraud or deception in providing information to the Alliance or to a plan provider in obtaining benefits or knowingly permits such fraud or deception by another, including but not limited to a member permitting use of his or her identification card by any other person or using another person's card or an

invalid card, then the Alliance may terminate the rights of any member involved, effective immediately upon the mailing of written notice to such member.

Disruptive Behavior

The Alliance can demand your disenrollment from the Alliance Group Care program if you are repeatedly verbally abusive, harassing, or disruptive, or if you physically assault or threaten an Alliance staff member, doctors, office/clinic/hospital staff, patients, or other members.

Nonpayment

If a member fails to pay or fails to make satisfactory arrangements to pay, any amount due the Alliance or a plan provider within 15 days after the Alliance's or plan provider's notice to the member of any amount due, and the Alliance or plan provider bills the member for the amount due, then the Alliance may terminate the right of the member involved, effective immediately upon the Alliance's mailing of the written notice to the member and to the Public Authority.

Refunds

If the rights of a member hereunder are terminated, monies, if any, received from the terminated member applicable to periods after the effective date of termination, plus amounts due the member on claims, if any, less any amounts due to the Alliance or plan providers from member, shall be refunded to member within 30 days, and neither the Alliance nor plan providers shall have any further liability or responsibility to such member under this agreement.

Review by the Department of Managed Health Care (DMHC)

DMHC is responsible for regulating health care service plans, including the plan's enrollment and disenrollment decisions. An applicant or member who alleges that an enrollment has been cancelled or not renewed because of the member's health status or their requirements for health services, may request a review by DMHC. Online forms and instructions are available on the DMHC internet website **www.dmhc.ca.gov**.

13. Individual Continuation of Benefits

Group Coverage

Under federal and state laws (known as COBRA and Cal-COBRA), you may be eligible to keep your group health plan benefits for a period of time after your job ends or your hours are cut. Whether you can keep the group health plan benefits and for how long is governed by COBRA and Cal-COBRA. That coverage is also subject to all terms, conditions, limitations, and exclusions of this Alliance Group Care Combined Evidence of Coverage and Disclosure Form. The Public Authority is solely responsible for notifying you if you are eligible for COBRA or Cal-COBRA continuation coverage. The Public Authority will also tell you how long your continuation coverage will last and will explain the terms and conditions to you. You may call the Public Authority for more information. (*Please See the Contact Information List for further information*.) The following is a summary of some of the key terms of the programs that will apply, if the Public Authority says you are eligible.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be entitled to keep your group health plan for 18 months or more when your job ends or your hours are cut. If the Social Security Administration says you are disabled, you may keep your plan for 29 months, unless you are no longer disabled.

Cal-COBRA

Under the California Continuation Benefits Replacement Act (Cal-COBRA), you may apply to keep your group health coverage if:

- You have exhausted your coverage under COBRA; and
- Your coverage under COBRA lasted less than 36 months.

In this case, you may be able to keep group coverage for up to a total of 36 months from the date your COBRA coverage began.

Premium Payments for COBRA and Cal-COBRA

You will have to pay the full premium for COBRA coverage. The Public Authority has a third party administrator (TPA) to whom you will send your payment. The TPA will forward your premiums to the Alliance. The Public Authority will tell you the name and address of its TPA after your job ends or your hours are cut.

Deadlines

Under both COBRA and Cal-COBRA, you will get a notice in the mail from the Public Authority or its TPA about your COBRA/Cal-COBRA rights soon after your job ends or your hours are cut. That notice will tell you how much you will have to pay and where to send your payment. If you do not get a notice in the mail, call the Public Authority right away and ask for it. **You will have 60 days after being notified to sign up or lose your right to do so.**

Who cannot enroll in Federal COBRA or Cal-COBRA?

You cannot enroll in the Alliance's COBRA or Cal-COBRA continuation coverage if:

- You are enrolled in, or become eligible to enroll in Medicare;
- You are fired for gross misconduct;
- You did not enroll within 60 days after you were notified of your right to Federal COBRA or Cal-COBRA;
- You did not pay your first premium on time;
- You are covered by another health plan;
- You do not work or reside in Alameda County;
- The Public Authority is no longer required to provide COBRA or Cal-COBRA coverage;
- The Public Authority no longer provides group health plan benefits to any IHSS worker;
- The Public Authority no longer contracts with the Alliance;
- In the case of Cal-COBRA, you are eligible for COBRA and have not exhausted those benefits.

When Will Your COBRA/Cal-COBRA Coverage Terminate?

Your coverage under COBRA and Cal-COBRA will end when:

- The maximum applicable COBRA period (36 months) has expired;
- You stop paying premiums or stop paying them on a timely basis;
- You have other hospital, medical, or surgical coverage under another group benefit plan that does not contain an exclusion or limitation with respect to any pre-existing conditions applicable to you that would preclude coverage (with certain exceptions in the COBRA Laws);
- The date Public Authority is no longer required to provide COBRA or Cal-COBRA coverage for you;
- You become eligible for Medicare;
- With respect to Cal-COBRA, you are eligible for COBRA coverage and have not yet exhausted that coverage;

- The Public Authority ceases to provide any group health plan benefits to any IHSS worker;
- The group contract between the Public Authority and the Alliance is terminated or expires for any reason;
- You commit fraud or deception in the use of Cal-COBRA benefits or, in the case of COBRA benefits, you engage in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud); or
- You no longer reside or work in Alameda County.

In the case of Cal-COBRA, you are covered by Chapter 6A of the Public Health service Act, 42 USC Section 300bb-1, et seq. That section concerns continuing group health care benefits for certain state or local government employees.

The Public Authority will notify you and the Alliance of the effective date and expiration date of your continuation benefits.

Individual Coverage

You may be eligible to purchase individual conversion coverage from the Alliance if after your job ends or your hours are reduced:

- You are not eligible to keep your group health plan benefits under COBRA or Cal-COBRA; or
- If you have already exhausted your COBRA or Cal-COBRA group benefits.

Individual Conversion Plan (ICP)

You may be eligible for the Alliance Individual Conversion Plan (ICP). The ICP is non-group coverage, available without evidence of insurability. Non-group coverage is normally more costly than group coverage and may not have the same benefits. So if you are eligible to continue group coverage you probably should do so. But if you are not eligible for group coverage, the ICP allows you to keep some coverage to protect your health. Other insurers may also sell non-group coverage, but they may want to review your medical history before selling you a policy. Please examine your options carefully before buying the ICP or any non-group coverage.

You must notify the Alliance that you wish to convert to the ICP within 31 days of the end of your Alliance Group Care, COBRA or Cal-COBRA coverage. You will then have to submit a written application for ICP coverage to the Alliance. That application and the first premium payment must be submitted to the Alliance within 63 days of the end of your COBRA/Cal-COBRA or Alliance Group Care coverage. If your application is accepted, your Individual Conversion Plan will be effective back to the day your prior (COBRA/Cal-COBRA or Alliance Group Care) coverage ended. For an application and for premium information, please call the Alliance Member Services Department. (*See the Contact Information List for phone number*.)

You will not be eligible for the Individual Conversion Plan if:

- The Agreement between the Public Authority and the Alliance is terminated or the Public Authority's participation is terminated and the group contract is replaced by similar coverage under another group contract within 15 days of the date of termination of the group coverage or member's participation;
- You failed to pay any amount due to the Alliance;
- You were terminated by the Alliance for good cause;
- You knowingly furnished incorrect information or otherwise improperly obtained benefits;
- The Public Authority health plan is self-insured at the time you apply for the Individual Conversion Plan;
- You are covered by or are eligible for benefits under Medicare;
- You are covered for similar benefits by an individual policy or contract; or
- You are covered by or are eligible for benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.

You were not continuously covered during the entire three (3) month period immediately prior to termination of coverage under Alliance Group Care.

14. Alliance Grievance and Appeal Procedures

Complaints and Problems/Grievance and Appeal

As an Alliance member, you have the right to file a complaint (this is also called a grievance) if you are not happy or have an issue with your health care services. To file a complaint, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*) You have the right to provide written comments, papers and information that support your views. You may speak for yourself or have someone else speak for you, including a lawyer. You may ask to look at or get a free copy of our records that relate to your case. You or your provider may get a free copy of the benefit provision, guideline protocol, or criteria used to make a denial decision by calling our Member Services Department. Using this grievance process does not rule out any potential legal rights or remedies that you may have. Your satisfaction is important to us! See the "Definitions" section for more information about what a grievance is. **An appeal is when you ask for review of an "action."**

Actions are:

- When you receive a "Notice of Action" about a denial or limited authorization of a requested service
- When you receive a "Notice of Action" about a reduction, suspension, or termination of a previously authorized service
- A failure to provide services in a timely manner (this may also be a cause of a grievance)
- A failure of the Alliance or the State to act within the timeframes for grievances and appeals (this may also be a cause of a grievance)

If you have a problem with your health care services, please call the Alliance Member Services Department. If you have a grievance or an appeal, you may file it by phone or fill out a form. You can appeal a Notice of Action by phone. Your provider may file an appeal for you.

For help, you can call us at:

Phone Number: **510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY)**: 711/1.800.735.2929**

You can file your complaint online. To file a grievance or appeal online:

1. Log in to your Member Portal at **www.alamedaalliance.org**.
2. Click on "Help Center."
3. Select "File a Grievance or Appeal" from the "Help Center" drop-down menu and follow the instructions on the page.

You can also fax a letter that describes your complaint to **1.855.891.7258**, or mail the letter to**:**

G&A Unit
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Timeframes

If you have a problem, you can file a grievance with the Alliance at any time after the event that caused your grievance. To file an appeal you have 60 calendar days of the date where services or benefits were denied, deferred or modified.

The Alliance will review your grievance or appeal and send you an acknowledgment letter within five (5) days. The Alliance will work to resolve the issue within 30 calendar days, or sooner, based on your health condition. If you think waiting 30 days will cause danger to your life, health or ability to attain, maintain, or regain maximum function, be sure to explain why when you file your grievance or appeal. The Alliance will work to resolve the issue within 72 hours. At the time you file your appeal, you can ask the Alliance to continue your services until the grievance or appeal process is complete.

If you need help with: 1) a grievance about an emergency, 2) a grievance that has not been acceptably resolved by the health plan, or 3) a grievance that has not been resolved for more than 30 days, you may call DMHC for help. *(Please see the section entitled "California Department of Managed Health Care" on page 77 for DMHC contact information.)* You need not participate in the Alliance's grievance process before applying to DMHC for review of an urgent grievance. If the Alliance denied your treatment because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an IMR. You can ask for the IMR immediately following the receipt of a Notice of Action but no longer than 6 months after the receipt of that Notice of Action.

Independent Medical Review (IMR)

If you are not happy with the Alliance's decision or it has been more than 30 days since you submitted a complaint with the Alliance, you may file complaint with DMHC. An IMR is a review of your case by doctors who are not part of the Alliance. In most cases, you must complete the Alliance's appeals process before you apply for an IMR with DMHC. If you would like to request for an IMR, you must submit your request within six (6) months of receiving a grievance acknowledgment letter from the Alliance. To request an IMR, contact:

HMO Help Center at the Department of Managed Health Care (DMHC)
Toll-Free: **1.888.466.2219**
Hearing impaired callers use TDD: **1.877.688.9891**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
IP-Relay service: **www.IP-relay.com**
You can find DHMC forms and a guide at: **www.dmhc.ca.gov**

If the IMR is decided in your favor, the Alliance must give you the service or treatment you asked for. This process is free of charge.

You can ask for an IMR if the Alliance:

- Denies, changes, or delays a service or treatment because it has been determined as not medically necessary
- Will not cover an experimental or investigational treatment for a serious medical condition
- Will not pay for emergency or urgent medical services that you have already received

If you qualify for IMR, you will be issued one of the following:

Standard IMR: The HMO Help Center at DMHC will review and send an acknowledgment letter within seven (7) days. IMR will notify you of a decision within 30 days.

Urgent IMR: IMR will notify you of a decision within three (3) to seven (7) days if your problem is an immediate and serious threat to your health.

Note: If you do not qualify for IMR, the issue will be reviewed under the Standard grievance and appeals process.

If you decide not to use the IMR process, you may be giving up your rights to pursue legal action against the Alliance about the service or treatment you are asking for.

DMHC is in charge of making sure all managed care health plans do what the law says they should do. You may call DMHC with any complaints you have about the Alliance.

Experimental or Investigational Denials

If we deny a medical service because it is experimental or investigational, we will let you know in writing within five (5) days of when we made our decision as to why we denied the service and what other treatment options may be covered.

The letter will tell you about your right to ask for an IMR through DMHC. (*You can find more information about IMRs on page 72.*) To complete an application for an IMR of an experimental or investigational therapy, you need one of the following:

- The doctor who is treating you gave us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be right for you, or that there is no more beneficial standard therapy we cover than the therapy being asked for.
    - "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.
    - "Seriously debilitating" means diseases or conditions that cause major damage that cannot be reversed.
- If the doctor who is treating you is an Alliance doctor, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the therapy being asked for is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Alliance doctor in certifying his or her recommendation.
- You (or your Alliance doctor who is a board-certified or board-eligible doctor qualified in the area of practice appropriate to treat your condition) requested a therapy that is 1) based on two (2) documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), and is 2) likely to be more beneficial for you than any available standard therapy. The doctor's certification included a statement of evidence relied upon by the doctor in certifying his or her recommendation. We do not cover the services of a non-Alliance provider.

You do not have to file a grievance with us before you apply for an IMR for experimental or investigational denials.

California Department of Managed Health Care (DMHC)

DMHC is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first call the Alliance Member Services Department at **510.747.4567** or toll-free at **1.877.932.2738** and use the Alliance'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 the Alliance, or a grievance that has remained unresolved for more than 30 days, you may call the department

for assistance. You may also be eligible for an IMR. If you are eligible for 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 phone number **1.888.466.2219** and a TDD line **1.877.688.9891** for the hearing and speech impaired. The DMHC's web site **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

15. Other Provisions

Public Policy Participation

The Alliance has a Member Advisory Committee (MAC) to help our Board of Governors. This committee makes sure that plan policies meet members' needs and concerns. The MAC is made up of members of our health plan, representatives from county and community agencies, providers and clinics in our network, and a member of our governing Board of Governors.

If you would like more information about MAC or would like to be considered for membership, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

The Alliance is a publicly sponsored health plan. The Alliance's Board of Governors meetings are open to the public.

Governing Law

The Alliance is subject to the requirements of the California Knox-Keene Act, Chapter 2.2 of Division 2 of the California Health and Safety Code, and the regulations set forth in Title 28 of the California Administrative Code. Any provision required to be included in this benefit program by either the Knox-Keene Act or the regulations shall be binding on the Alliance even if it is not included in this EOC or the health plan contract.

Notice of Information Practices

The Insurance Information and Privacy Protection Act provides that the Alliance may collect personal information from persons other than the individual or individuals applying for insurance coverage. The Alliance will not disclose any personal or privileged information about an individual that the Alliance may have collected or received in connection with an insurance transaction, unless the disclosure is made with the written authorization of the individual or individuals or as allow by law. Individuals who have applied for insurance coverage through the Alliance have a right of access to, and collection of, personal information that may have been collected in connection with the application for insurance coverage.

Member Satisfaction

The Alliance may request information from you on your experience and satisfaction with the quality, availability, and accessibility of care you received as a member of the Alliance. The results of these surveys will be reported to the appropriate Alliance committees. A member who gives information will not be identified by name or any other means. These surveys will be used regularly by the Alliance to identify and investigate sources of member dissatisfaction with

the Alliance (if any), to identify opportunities to improve patient care and outcomes, and to identify satisfactory performance on the part of a participating provider, staff, hospital, or the Alliance.

Filing Claims/Reimbursement Provisions

Sometimes non-Plan physicians, pharmacies, and hospitals require immediate payment for services. For instance, you may pay a bill (claim) or have to pay when treated for out-of-area emergencies. If, as a result of an out-of-area urgent care or emergent care visit, a member is unable to use an Alliance plan provider, pharmacy, or hospital, the Alliance will arrange to pay the non-plan provider(s) directly, or reimburse the member. Reimbursements will be in accordance with Alliance reimbursement policies.

If you receive a bill (claim) or have to pay a bill for services (e.g., for emergency services) submit a copy of the bill to the Alliance for payment within one hundred eighty (180) days of the date of service. If you have paid the bill, also submit a copy of the cancelled check or payment receipt to the Alliance for review. Include the following information attached to the copy of the bill:

- Alliance member's name, address, phone number, Alliance Member ID number;
- Name, address, and phone number of the service provider (if not stated on the bill); and
- Date of each service and reason for the service (if not stated on the bill).
- Send this information and a copy of the bill within 180 days of the date of service to:

Alameda Alliance for Health
P.O. Box 2818
Alameda, CA 94501-0818

Failure to furnish such proof within the required time will not invalidate nor reduce any claim if it was not reasonably possible to provide such proof within the required time period.

In the event that the Alliance determines that emergency services obtained by the member are covered, the Alliance will pay the provider directly, or reimburse the member if the services have been paid for by the member. All such charges will be paid within 30 days from the Alliance's receipt of the satisfactory information as described above, or you will be notified of the claim status.

Member will be liable for payment to non-Alliance providers for the cost of service, unless such visit had a prior approval from the Alliance; or was for urgent or emergency care.

Call Member Services with questions regarding medical bills. (*See the Contact Information List for further information.*)

Right of Health Plan to Change Benefits and Charges

The Alliance reserves the right to change the benefits and charges under the Alliance Group Care Program. Members will be given 31 calendar days written notice prior to the contract renewal effective date before making any change in benefits and charges.

Limitations of Other Coverage

This health plan coverage is not designed to duplicate any benefits to which Members are entitled under government programs, including CHAMPUS, Medi-Cal, Medicare or Workers' Compensation. By executing an enrollment application, a member agrees to complete and submit to the Alliance such consents, releases, assignments, and other documents reasonably requested by the Alliance, or order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.

Natural Disasters, Interruptions, and Limitations

Circumstances beyond the Alliance's control (for example, natural disaster, war, riot, civil insurrection, epidemic, or complete or partial destruction of facilities) may result in your inability to obtain the medically necessary covered services of this plan. In such an event, the Alliance will make a good faith effort to provide or arrange for the services that you need. Under these conditions, go to the nearest provider or hospital for emergency services.

Independent Contractors

The Alliance providers are neither agents nor employees of the Alliance but are independent contractors. The Alliance regularly credentials the physicians who provide services to members. However, in no instance shall the Alliance be liable for negligence, or wrongful acts, or omissions by any person who provides services to members, including any physician, hospital, other provider, or their employees.

Payment of Providers

The Alliance contracts with a network of local physicians and medical groups, as well as pharmacies, hospitals, and ancillary providers to provide services to its members. For tertiary care, the Alliance contracts with tertiary care facilities. Contracts are based upon specific reimbursement agreements.

PCPs receive per member, per month capitation payment, except for immunizations for which the PCP is reimbursed on a fee-for-service basis. Specialist or referral physicians and ancillary providers are reimbursed on a fee-for-service basis.

Capitation is a method of payment for health services whereby the PCP is paid a fixed, per capita amount for each member served, without regard to the actual number or nature of services provided to each member.

Fee-for-service is a method of charging whereby a provider bills for each encounter or service rendered.

Participating hospitals are reimbursed for services based on a negotiated rate. Hospitals outside the Alliance service area that perform emergency or tertiary services are also reimbursed at a rate negotiated between the hospital and the Alliance.

By law, every contract between the Alliance and a provider says that if the Alliance does not pay that provider, the member will not have to pay the provider what the Alliance owes that provider.

However, except for urgent and emergent care services, if a member goes to a non-contracting provider (a provider not in the Alliance Provider Network) without approval, the member may have to pay that non-contracting provider for the cost of services. (*See the Filing Claims/Reimbursement Provisions sub-section for further information*.)

The Alliance may also offer financial incentives (i.e. bonuses) to providers. These incentives are based on terms included in the providers' contracts. This information is available to members upon request.

Provider Termination Notification

The Alliance shall provide members who are receiving treatment from, or have selected a provider in that medical group or individual practice association, with a written notice of the termination 30 days prior to termination of a provider contract with an entire medical group or individual practice association.

Workers' Compensation

This benefit is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation insurance. Please contact the Public Authority for information regarding your Workers' Compensation insurance coverage.

Disability Access

Physical Access

The Alliance has made every effort to ensure that our offices and the offices and facilities of our providers are accessible to the disabled. If you are not able to locate an accessible provider, please call the Alliance Member Services Department and a Member Services Representative will help you find an alternate provider. (*See the Contact Information List for further information.*)

Access for the Hearing Impaired

Hearing impaired callers may contact a Member Services Representative through the California Relay Service (CRS) TTY Line. (*See the Contact Information List for further information.*)

Access for the Vision Impaired

For assistance in reading this EOC and other materials, please call the Alliance Member Services Department. (*See the Contact Information List for further information.*)

Disability Access Grievances

If you believe the Alliance or its providers have failed to respond to your disability access needs, you may file a grievance with the plan. (*See Section 14: Alliance Grievance and Appeal Procedures for further information.*)

The Americans with Disabilities Act of 1990

The Alliance will comply with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

16. Alameda Alliance for Health Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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
1240 South Loop Road
Alameda, CA 94502
Phone Number: **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 (for Healthy Families); your application (for Alliance Group Care); 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 his/her 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

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.

   *****IMPORTANT*****
   Please note that we do not have a complete copy of your Medical Records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.
4. **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 if 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.
5. **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.

6. **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. (*See the Contact Information List for further information.*)

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: Member Grievances
P.O. Box 2818
Alameda, CA 94501
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY):**711/1.800.735.2929**

You may also let the Secretary of the U.S. Department of Health and Human Services 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: **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
1240 South Loop Road
Alameda, CA 94502
Phone Number: **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.

17. Definitions

Here are some of the terms used in this booklet:

Acute - A health condition that is sudden and lasts a limited duration.

Agreement or Service Agreement - The contract between the Alliance and the Public Authority for In-Home Supportive Services Workers in Alameda County.

Allowable Expense - the maximum amount the Alliance will pay for a covered service.

Amendment - A written description of any changes to the Alliance Group Care Program which the Alliance will send to members when such changes impact the Evidence of Coverage. These changes should then be read and attached to your Evidence of Coverage.

Authorization - The requirement that certain services be approved by the Alliance or Primary Care Provider in order to be covered services.

Basic Health Care Services - All of the following:

- Physician services, including consultation and referral.
- Hospital inpatient services and ambulatory care services.
- Diagnostic laboratory and diagnostic and therapeutic radiological services.
- Home health services.
- Preventive health services.
- Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

Behavioral Health Treatment for Pervasive Developmental Disorder (PDD)/Autism – Professional services and treatment programs, including applied behavioral analysis and evidence-based behavioral intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with PDD or autism and that meet all the following criteria:

- Treatment is prescribed by a physician or a psychologist, licensed pursuant to California law;
- Treatment is provided under a treatment plan prescribed by a qualified autism service (QAS) provider and administered by a QAS provider, or a QAS professional or a QAS paraprofessional supervised and employed by the QAS provider;
- The treatment plan has measurable goals developed and approved by the QAS provider that is reviewed every six (6) months and modified where appropriate; and

- The treatment plan is not used to provide or reimburse for respite, day care, educational services, or participation in the treatment program.

Benefits and Coverage (Covered Services) - Those services, supplies, and drugs which a member is entitled to receive pursuant to the terms of the Agreement. A service is not a Benefit, even if described as a covered service or benefit in this booklet, if it is not medically necessary, or (except in an Emergency) if it is not provided by an Alliance Plan Provider with an Authorization as required

Benefit Year - The 12-month period commencing at 12:01 a.m. October 1 and ending September 30.

California Children's Services (CCS) - A program that provides services for children up to age 21 for certain medical conditions.

Claim Determination Period - The amount of time the Alliance takes to process a claim after the provider has submitted it to the plan.

Copayment - The member's share of the costs to be paid at the time certain services are received.

Cosmetic Surgery - Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Dependent -

- Member's spouse
- Member's or spouse's unmarried children (including adopted children) who are under the age 19
- Other unmarried dependent persons who meet all of the following requirements:
    - He or she is under 19
    - He or she receives from you or your spouse all of their support and maintenance
    - He or she permanently resides with the member
- Member or spouse is the court-appointed guardian (or was before the person reached age 18), or whose parent is an enrolled member
- Dependent under your family coverage

Disability - A mental or physical injury, illness, or a condition as defined by California Government Code, Section 12926.

Disenroll - Means to stop using the health plan because you lose eligibility, quit the health plan, or because you don't pay your monthly premiums to the Alliance Group Care Program.

Durable Medical Equipment (DME) - Certain medically necessary equipment that is:

- For repeated use
- Used for a medical purpose
- Generally not useful to someone who is not ill or hurt

Emergency Services - 24-hour emergency care both in and out of the Alliance service area. An emergency is a sudden medical or mental health problem with severe symptoms that needs treatment right away. The problem must be one that a person without medical training could reasonably think will place a person's life or health in serious danger, such as:

- Active labor as defined under "Active Labor" in this Section of the EOC
- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following
    - An immediate danger to herself/himself or others
    - Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder

Enrollee - A person who is enrolled in a plan and is eligible to receive health care services from the Plan.

Exclusion - A service we do not cover.

Experimental or Investigational - Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficiency have not been determined for use in the treatment of a particular illness, injury, or medical condition for which it is recommended or prescribed.

Evidence of Coverage (EOC) or Combined Evidence of Coverage and Disclosure Form - Any certificate, agreement, contract, brochure, or letter of entitlement issued to a member or enrollee setting forth the coverage to which the member or enrollee is entitled.

Exception - Any provision in a plan contract whereby coverage for a specified hazard or condition is entirely eliminated.

Formulary - A list of drugs or items that have been approved for members that meet certain criteria.

Grievance **-** A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a member or a member's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Group Contract **-** A contract, which by its terms limits the eligibility of members and enrollees to a specified group. (The Agreement between the Alliance and the Public Authority for In-Home Supportive Services Workers in Alameda County.)

Health Care Provider **-** Refers to the different kinds of providers and specialists who are covered under this plan.

Health Plan or Plan **-** Alameda Alliance for Health.

Health Care Service Plan or Specialized Health Care Service Plan **-** means either of the following:

1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees; or
2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

Hospital **-** A health care facility accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), as either:

a) An acute care hospital;
b) A psychiatric hospital; or
c) A hospital operated primarily for the treatment of alcoholism and/or substance abuse. A facility which is primarily a rest home, nursing home, or home for the aged, or a distinct part of a skilled nursing facility portion of a hospital is not included.

Inpatient **-** An individual who has been admitted to a hospital as a registered bed patient and receives covered services under the direction of a physician.

Life-Threatening or Seriously Debilitating Condition **-** Life-threatening refers to one or all of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival

Seriously debilitating means diseases or conditions that cause major irreversible morbidity.

Limitation - Any provision other than an exception or a reduction, which restricts coverage under the plan.

Medical Director - A physician, designated by the Alliance, who is responsible for the administration of the Alliance's medical programs.

Medically Necessary - Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Member - A person who joins the Alliance to receive his or her health care. In this booklet, a member is also referred to as "you." (*See also the definition for "Subscriber".*)

Member Identification (ID) Card - The identification card provided to members by the Alliance that includes the member number, PCP information, and important phone numbers.

Mental Health (MH) Services - Psychoanalysis, psychotherapy, counseling, medical management, or other services most commonly provided by a qualified psychiatrist, psychologist, clinical social worker, marriage, family and child counselor or other mental health professional or paraprofessional, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition. Mental or emotional disorders include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Non-formulary Drug - A drug that is not listed on the Formulary that requires an authorization from the Alliance in order to be covered.

Orthotic Device - A medically necessary support or brace designed for the support of a weak or ineffective joint, muscle, or improve the function of movable body parts.

Out-of-Area Services **-** Emergent Care or Urgent Care provided outside of the Service Area which could not be delayed until member returned to the service area.

Person **-** Any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

Plan or Health Plan **-** Alameda Alliance for Health.

Plan Contract **-** A contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes group contracts. (Contract between the Alliance and its members or enrollees that is represented by this Combined Evidence of Coverage and Disclosure Form.)

Plan Provider **-** A physician, clinic, hospital, skilled nursing facility, or other health professional, facility or home health agency who, or which, at the time care is rendered to a member, has a contract in effect with Alameda Alliance for Health to provide covered services to its members. A plan provider can also be a qualified professional or paraprofessional with whom Alameda Alliance for Health has contracted to provide services for pervasive developmental disorder or autism.

Primary Care Provider (PCP) **-** A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist (OB/GYN), who has contracted with the Alliance or works at a clinic contracted with the Alliance to provide primary care to members and to refer, authorize, supervise, and coordinate the provision of all benefits to members in accordance with the agreement.

Prosthetic Device **-** A medically necessary item that replaces all or part of an organ or limb.

Provider Directory **-** The list of all the names and addresses of providers who contract with Alameda Alliance for Health.

Reconstructive Surgery **-** Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

a) To improve function; or
b) To create a normal appearance, to the extent possible.

Reduction **-** Any provision in a plan contract which reduces the amount of a plan benefit to some amount or period less than would be otherwise payable for medically authorized expenses or services had such a reduction not been used.

Severe Mental Illness – Refers to the following mental disorders of a person of any age: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder (PDD) or autism, anorexia nervosa, and bulimia nervosa.

Service Area **-** A geographical area designated by the plan within which a plan shall provide health care services (Alameda County).

Skilled Nursing Facility **-** A facility that provides a level of inpatient nursing care that is not of the intensity required of a hospital.

Specialist Physician **-** A plan physician who provides services upon referral by a Primary Care Provider to members within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty.

Subscriber **-** The person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan. (*See also the definition for "Member"*.)

Terminated Provider **-** A plan provider whose contract to provide services to members is terminated or not renewed by the Health Plan. (*See also the definition for "Plan Provider".)*

Urgent Care **-** Services needed to prevent serious deterioration of a member's health resulting from unforeseen illness or injury for which treatment cannot be delayed.