ALAMEDA Alliance FOR HEALTH

Member Handbook

What you need to know about your benefits

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

2021

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711/1.800.735.2929**). The call is toll-free. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

Other formats

You can get this information for free in other formats, such as braille, 18-point font large print and audio. Call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711/1.800.735.2929**). The call is toll-free.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711/1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

Interpreter services

You do not have to use a family member or friend as an interpreter. For free interpreter, linguistic and cultural services and help available 24 hours a day, 7 days a week, or to get this handbook in a different language, call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (CRS/TTY **711** or **1.800.735.2929**). The call is toll-free.

العربية (Arabic)

انتباه: إذا كنت تتحدث لغة أخرى، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل على الرقم **1.877.932.2738** (CRS/TTY: **711** أو **1.800.735.2929**).

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1.877.932.2738** (CRS/TTY (հեռատիպ) **711** կամ **1.800.735.2929**).

ខ្មែរ (Cambodian)

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាខ្មែរមិនគិតថ្លៃក៏មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅ **1.877.932.2738** (CRS/TTY: **711** ឬ **1.800.735.2929**)។

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1.877.932.2738**（加州中繼轉接電話服務(CRS/TTY專線：**711**或**1.800.735.2929**）。

فارسی (Farsi)

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان بطور رایگان در اختیار شما قرار داده می شود. با **1.877.932.2738** تماس بگیرید (یا (CRS/TTY: **711 1.800.735.2929**.

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1.877.932.2738** (CRS/TTY: **711** या **1.800.735.2929**) पर कॉल करें।

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1.877.932.2738** (CRS/TTY: **711** lossis **1.800.735.2929**).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1.877.932.2738** (CRS/TTY: **711** または **1.800.735.2929**) まで、お電話にてご連絡ください。

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어지원서비스를 무료로 받으실 수 있습니다. **1.877.932.2738** (CRS/TTY: **711** 또는 **1.800.735.2929**) 번으로 전화하십시오.

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາອື່ນ,
ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1.877.932.2738** (CRS/TTY: **711** ຫຼື **1.800.735.2929**).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1.877.932.2738** (CRS/TTY: **711** ਜਾਂ **1.800.735.2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Русский (Russian)

ВНИМАНИЕ! Если вы говорите на русском языке, вы можете воспользоваться бесплатными услугами перевода. Звоните по телефону **1.877.932.2738** (CRS/TTY: **711** или **1.800.735.2929**).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al **1.877.932.2738** (CRS/TTY: **711** o **1.800.735.2929**).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo para sa tulong sa wika nang walang bayad. Tumawag sa **1.877.932.2738** (CRS/TTY: **711** o **1.800.735.2929**).

ภาษาไทย (Thai)

โปรดทราบ: หากท่านพูดภาษาอื่น
ท่านสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร
1.877.932.2738 (CRS/TTY: **711** หรือ **1.800.735.2929**).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1.877.932.2738** (CRS/TTY: **711** hoặc **1.800.735.2929**).

Notice of non-discrimination

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

The Alliance provides:

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

If you need these services, contact the Alliance Member Services Department between Monday – Friday, 8 am – 5 pm by calling **1.510.747.4567** or toll-free at **1.877.932.2738**. Or, if you cannot hear or speak well, please call **1.800.735.2929** or **711** to use the California Relay Service.

HOW TO FILE A GRIEVANCE

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

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**).
Visit online at **www.alamedaalliance.org**.

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

- By phone: Contact:

  Alliance Member Services Department
  Monday – Friday, 8 am – 5 pm
  Phone Number: **1.510.747.4567**
  Toll-Free: **1.877.932.2738**
  People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

- Contact between Monday – Friday, 8 am – 5 pm by calling **1.510.747.4567** or toll-free at **1.877.932.2738**. Or, if you cannot hear or speak well, please call **1.800.735.2929** or **711** to use the California Relay Service.
- In writing: Fill out a complaint form or write a letter and send it to:

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

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

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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

- By phone: Call **1.916.440.7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

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

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

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

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

- By phone: Call **1.800.368.1019**. If you cannot speak or hear well, please call **TTY/TDD 1.800.537.7697** or **711** to use the California Relay Service.
- In writing: Fill out a complaint form or send a letter to:

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

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

Welcome to the Alliance!

Thank you for joining Alameda Alliance for Health (Alliance). The Alliance is a health plan for people who have Medi-Cal. The Alliance works with the State of California to help you get the health care you need. The Alliance contracts with Kaiser Permanente (Kaiser), Community Health Center Network (CHCN), and Children First Medical Group (CFMG) to be a part of the Alliance's provider network. As a Medi-Cal member, you may be eligible to select one of these provider groups as your primary care provider (PCP).

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

These include:

- Having continuity of care medical needs, or
- You must be a qualified, immediate family member living in the same home as a current Kaiser member.

  A family addition may include:

  - A spouse
  - An unmarried dependent child **younger than 21 years of age**
  - A disabled dependent **older than 21 years of age** (legal conservatorship required)
  - Married or unmarried parents or stepparents of children **younger 21 years of age**
  - Foster child, step child or legal guardian; or
- You have been a Kaiser member within the past **six (6) months**. You must be within **six (6) months** of the termination date of the prior Kaiser membership.

To select Kaiser as your PCP, you must call our Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Let us know you want Kaiser to be your health care provider. You will then be screened to see if you meet the criteria. It can take up to **30 days** for your Kaiser coverage to start after you tell us that you would like to select Kaiser as your health care provider.

Please note that if you are approved, your Kaiser coverage generally begins on the first day of the following month.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

If you do not call us to choose Kaiser as your PCP, we cannot guarantee that services will be covered, even if Kaiser agrees to see you for an appointment.

Member Handbook

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

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. It is a summary of the Alliance rules and policies and based on the contract between the Alliance and Department of Health Care Services (DHCS). If you would like more information, call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

You may also ask for another copy of the Member Handbook at no cost to you or visit the Alliance website at **www.alamedaalliance.org** to view the Member Handbook. You may also request, at no cost, a copy of the Alliance non-proprietary clinical and administrative policies and procedures, or how to access this information on the Alliance website.

Contact Us

The Alliance is here to help. If you have questions, call the Alliance Member Services Department, **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). The Alliance is here Monday – Friday, 8 am – 5 pm. The call is toll-free.

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

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

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1. Getting started as a member

How to get help

Alameda Alliance for Health (Alliance) wants you to be happy with your health care. If you have any questions or concerns about your care, the Alliance wants to hear from you!

Member services

The Alliance Member Services Department is here to help you.

The Alliance can:

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

If you need help, call

1.877.932.2738 (TTY/TDD **1.800.735.2929** or **711**). The Alliance Member Services Department is here Monday – Friday, 8 am – 5 pm. The call is toll-free.

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

Who can become a member

You qualify for the Alliance because you qualify for Medi-Cal and live in Alameda County. You may also qualify for Medi-Cal through Social Security because you are receiving

SSI/SSP. You may contact a local Social Security office by calling toll-free **1.800.772.1213**.

For questions about enrollment, call Health Care Options (HCO) at **1.800.430.4263** (TTY/TDD **1.800.430.7077** or **711**). Or visit **www.healthcareoptions.dhcs.ca.gov**.

Transitional Medi-Cal

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

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

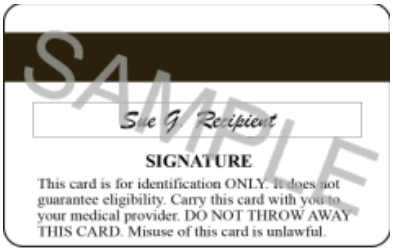
- You started earning more money.
- Your family started receiving more child or spousal support.

You can ask questions about qualifying for Transitional Medi-Cal at your local county health and human services office at **www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx** or call Health Care Options at **1.800.430.4263** (TTY/TDD **1.800.430.7077** or **711**).

Identification (ID) Cards

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

Here is a sample BIC and Alliance member ID card to show you what yours will look like:



ALAMEDA Alliance FOR HEALTH

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

RxBIN: 003585
RxPCN: 56350
Group: MCAL

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

For Physicians, Medical Staff, & Pharmacy:

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

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

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

SAMPLE

If you do not get your Alliance ID card within a few weeks of enrolling, or if your card is

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damaged, lost or stolen, call member services right away. The Alliance will send you a new card for free. Call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

You can also request a new member ID card online at any time by using the Alliance Member Portal at **www.alamedaalliance.org**.

Ways to get involved as a member

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

Member Advisory Committee

The Alliance has a group called the Member Advisory Committee (MAC). This group is made up of Alliance members, community advocates, and providers. You can join this group if you would like.

The group talks about how to improve the Alliance policies and is responsible for:

- Giving feedback on programs and policies.
- Making recommendations on member outreach, education, and meeting member needs.

If you would like to be a part of this group, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

We want to hear from you!

You may receive a survey or phone call asking for your ideas on how we are doing. Please take a few minutes to respond so we can improve our programs for all members.

2. About your health plan

Health plan overview

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

You may talk with one of the Alliance member services representatives to learn more about the health plan and how to make it work for you. Call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

When your coverage starts and ends

When you enroll in the Alliance, you will get an Alliance member ID card within **two (2) weeks** of enrollment. You must show your Alliance member ID card and your Medi-Cal Benefits Identification Card (BIC) when you get any health care services or prescriptions.

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

You may ask to end your Alliance coverage and choose another health plan at any time. For help choosing a new plan, call Health Care Options at **1.800.430.4263** (TTY/TDD **1.800.430.7077** or **711**). Or visit **www.healthcareoptions.dhcs.ca.gov**. You can also ask to end your Medi-Cal.

The Alliance is the health plan for Medi-Cal members in Alameda County. Your coverage with the Alliance might change if you no longer have Medi-Cal or if you move out of the county. The Alliance coverage may also end if your local county health and human services office receives information that changes your eligibility for Medi-Cal. Find your local office at **www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx**. If you

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

go to jail or prison, your coverage with the Alliance will end**.** If you become eligible for a waiver program, your coverage with the Alliance will end, but you will still be enrolled in Medi-Cal. If you are not sure if you are still covered by the Alliance, please call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Managed Long-Term Services and Supports (MLTSS)

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

Special Considerations for American Indians in Managed Care

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

If you are an American Indian, you have the right to get health care services at Indian Health Clinics (IHC). You may also stay with or disenroll from the Alliance while getting health care services from these locations. For information on enrollment and disenrollment call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

How your plan works

The Alliance is a managed care health plan contracted with DHCS. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. The Alliance works with doctors, hospitals, pharmacies and other health care providers in the Alliance service area to give health care to you, the member.

The Alliance Member Services Department will tell you how the Alliance works, how to get the care you need, how to schedule provider appointments within standard access times, and how to find out if you qualify for transportation services.

To learn more, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). You can also find member service information online at **www.alamedaalliance.org**.

Changing health plans

You may leave the Alliance and join another health plan in your county of residence at any time. Call Health Care Options at **1.800.430.4263** (TTY/TDD **1.800.430.7077** or **711**) to choose a new plan. You can call between 8:00 am and 6:00 pm, Monday through Friday. Or visit **www.healthcareoptions.dhcs.ca.gov**.

It takes up to **30 days** to process your request to leave the Alliance and enroll in another plan in your county if there are no issues with the request. To find out the status of your request, call Health Care Options at **1.800.430.4263** (TTY/TDD **1.800.430.7077** or **711**).

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

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

You may ask to leave the Alliance in person at your local county health and human services office. Find your local office at **www.dhcs.ca.gov/services/medical/Pages/CountyOffices.aspx**. Or call Health Care Options at **1.800.430.4263** (TTY/TDD **1.800.430.7077** or **711**).

College students who move to a new county or out of California

If you move to a new county in California to attend college, the Alliance will cover emergency room and urgent care services in your new county for some conditions.

If you are enrolled in Medi-Cal and will attend college in a different county in California, you do not need to apply for Medi-Cal in that county.

When you temporarily move away from home to go to college in another county in California there are **two (2)** options available to you.

You may:

- Notify Alameda County Social Services that you are temporarily moving to attend

college and provide your address in the new county. The county will update the case records with your new address and county code in the State's database. Use this choice if you want to get routine or preventive care in your new county. You may have to change health plans. For questions and to prevent any delay in enrolling in the new health plan, call Health Care Options at **1.800.430.4263** (TTY/TDD **1.800.430.7077** or **711**).

OR

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

If you are leaving California temporarily to attend college in another state and you want to keep your Medi-Cal coverage, contact your eligibility worker at Alameda County Social Services. As long as you are eligible, Medi-Cal will cover emergencies in another state, and emergencies requiring hospitalization in Canada and Mexico if the service is approved and the doctor and hospital meet Medi-Cal rules. If you want Medicaid in another state, you will need to apply in that state. You will not be eligible for Medi-Cal and the Alliance will not pay for your healthcare.

Continuity of care

As a member of the Alliance, you will get your health care from providers in the Alliance network. In some cases, you may be able to go to providers who are not in the Alliance network, which is called continuity of care. If you have continuity of care, you will be able to go to the provider for up to **12 months**, or more in some cases. If your providers do not join the Alliance network by the end of **12 months**, you will need to switch to providers in the Alliance network.

Providers who leave the Alliance

If your provider stops working with the Alliance, you may be able to keep getting services from that provider. This is another form of continuity of care.

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

- Acute conditions
- Chronic physical and behavioral conditions
- Pregnancy
- Maternal mental health services
- Terminal illness
- Care of a newborn child between birth and age **36 months**
- Performance of a surgery or other procedure that is authorized by the Alliance as part of a documented course of treatment and has been recommended and documented by the provider
- For other conditions that may qualify, contact the Alliance Member Services Department

Continuity of care is not available if you have not seen your doctor at least once during the last **12 months**; your doctor is not willing to work with the Alliance or if the Alliance has documented quality of care concerns with your doctor.

To learn more about continuity of care and eligibility qualifications, and to hear about all available services, call the Alliance Member Services Department.

Costs

Member costs

The Alliance serves people who qualify for Medi-Cal. In most cases, the Alliance members do **not** have to pay for covered services, premiums or deductibles. Members enrolled in California Children's Health Insurance Program (CCHIP) in Santa Clara, San Francisco and San Mateo counties and members in the Medi-Cal for Families Program may have a monthly premium and copayments. Except for emergency care, you may have to pay for care from providers who are out of the network. For a list of covered services, go to "Benefits and services."

For members with a share of cost

You may have to pay a share of cost each month. The amount of your share of cost

depends on your income and resources. Each month you will pay your own medical bills until the amount that you have paid equals your share of cost. After that, your care will be covered by the Alliance for that month. You will not be covered by the Alliance until you have paid your entire share of cost for the month. After you meet your share of cost for the month, you can go to any Alliance doctor. If you are a member with a share of cost, you do not need to choose a PCP.

How a provider gets paid

The Alliance pays providers in these ways:

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

To learn more about how the Alliance pays providers, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Asking the Alliance to pay a bill

If you get a bill for a covered service, do not pay the bill. Call member services right away at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

If you pay for a service that you think the Alliance should cover, you can file a claim. Use a claim form and tell the Alliance in writing why you had to pay. Call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**) to ask for a claim form. The Alliance will review your claim to decide if you can get money back.

Requests for Reimbursement

If you pay for a service that you think the Alliance should cover, you will need to complete

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

The Alliance will accept and review requests for reimbursement for a health expense that is received within **180 calendar days** after the date the bill was paid. The Alliance cannot accept bills received more than **180 calendar days** after the date the bill was paid. If the provider is not contracted with the Alliance, reimbursement will be limited to the Medi-Cal rate for the service(s) provided. This rate may be less than the amount you paid or the amount the provider billed for the service.

To request a reimbursement form, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**).

You can also print a copy of the Member Request for Reimbursement Form on the Alliance website at **www.alamedaalliance.org.**

3. How to get care

Getting health care services

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

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

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

You may choose the same PCP or different PCPs for all family members with the Alliance.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in the Provider Directory. It has a list of all PCPs in the Alliance network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). You can also find the Provider Directory on the Alliance website at **www.alamedaalliance.org.**

If you cannot get the care you need from a participating provider in the Alliance network, your PCP must ask the Alliance for approval to send you to an out-of-network provider.

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

Initial health assessment (IHA)

The Alliance recommends that, as a new member, you visit your new PCP within the first **120 days** for an initial health assessment (IHA). The purpose of the IHA is to help your

PCP learn your health care history and needs. Your PCP may ask you some questions about your health history or may ask you to complete a questionnaire. Your PCP will also tell you about health education counseling and classes that may help you.

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

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

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

Routine care

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

Your PCP will:

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

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

To learn more about health care and services your plan covers, and what it does not cover, read "**Benefits and Services**" in this handbook.

Urgent care

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

For urgent care, call your PCP. If you cannot reach your PCP, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). Or you can call the Advice Nurse Line anytime, 24 hours a day, 7 days a week, toll-free at **1.888.433.1876**. The Advice Nurse Line allows you to talk with a registered nurse to get answers to your health questions, to help you decide if you should go to the ER, and to learn more about common illnesses and conditions.

If you need urgent care out of the area, go to the nearest urgent care facility. Urgent care needs could be a cold, sore throat, fever, ear pain, sprained muscle or maternity services. You do not need pre-approval (prior authorization). If you need mental health urgent care, call your county Mental Health Plan or the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.877.932.2738** or **711**). You may call your county Mental Health Plan or your Alliance Behavioral Health Organization any time, 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, visit **www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx**.

Emergency care

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

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, your health (or your unborn baby's health) could be in danger, or a body function, body organ or body part could be seriously harmed. Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

- Chest pain
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts

Do not go to the ER for routine care. You should get routine care from your PCP, who knows you best. If you are not sure if your medical condition is an emergency, call your PCP. You may also call the 24/7 Advice Nurse Line toll-free at **1.888.433.1876.** If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in the Alliance network. If you go to an ER, ask them to call the Alliance. You or the hospital to which you were admitted should call the Alliance within 24 hours after you get emergency care. If you are traveling outside the U.S., other than to Canada or Mexico, and need emergency care, the Alliance will **not** cover your care.

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

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

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

Sensitive care

Minor consent services

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

- Outpatient mental health care for:
    - Sexual assault
    - Physical assault
    - When you have thoughts of hurting yourself or others
- HIV/AIDS prevention/testing/treatment

- Sexually transmitted infections prevention/testing/treatment
- Substance use disorder services

If you are under **18 years old**, you can go to a doctor without permission from your parents or guardian for these types of care:

- Family planning/birth control (including sterilization)
- Abortion services

For pregnancy testing, family planning services, birth control, or sexually transmitted infection services, the doctor or clinic does not have to be part of the Alliance network. You can choose any provider and go to them for these services without a referral or pre-approval (prior authorization). Services from an out-of-network provider not related to sensitive care may not be covered. For help finding a doctor or clinic giving these services, or for help getting to these services (including transportation), you can call

1.510.747.4567 or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). You may also call the 24/7 Advice Nurse Line toll-free at **1.888.433.1876**.

Minors can talk to a representative in private about their health concerns by calling the

24/7 Advice Nurse Line toll-free at **1.888.433.1876.**

Adult sensitive services

As an adult (**18 years or older**), you may not want to go to your PCP for certain sensitive or private care. If so, you may choose any doctor or clinic for the following types of care:

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

The doctor or clinic does not have to be part of the Alliance network. You can choose any provider and go to them without a referral or pre-approval (prior authorization) for these services. Services from an out-of-network provider not related to sensitive care may not be covered. For help finding a doctor or clinic giving these services, or for help getting to these services (including transportation), you can call **1.510.747.4567** or toll-free at

1.877.932.2738 (TTY/TDD **1.800.735.2929** or **711**). You may also call the 24/7 Advice Nurse Line toll-free at **1.888.433.1876.**

Advance directives

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

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

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

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

You can call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** for more information.

Organ and tissue donation

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

Where to get care

You will get most of your care from your PCP. Your PCP will give you all of your routine preventive (wellness) care. You will also go to your PCP for care when you are sick.
Be sure to call your PCP before you get non-emergency medical care. Your PCP will refer (send) you to specialists if you need them.

To get help with your health questions, you can also call the Advice Nurse Line anytime,

24 hours a day, 7 days a week, toll-free at **1.888.433.1876**.

If you need urgent care, call your PCP. Urgent care is care you need within 48 hours but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain or sprained muscle.

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

Moral objection

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

Some hospitals and other providers do not offer one or more of the services listed below. These services are available and the Alliance must ensure you or your family member sees a provider or is admitted to a hospital that will perform the following covered services:

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

You should get more information before you enroll. Call the new doctor, medical group, independent practice association or clinic that you want. Or call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**) to make sure you can get the health care services you need.

Provider Directory

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

The Alliance Provider Directory lists hospitals, pharmacies, primary care providers (PCPs), specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, Federally Qualified Health Centers (FQHCs), outpatient mental health providers, long-term services and supports (LTSS), Freestanding Birth Centers (FBCs),

Indian Health Service Facilities (IHFs) and Rural Health Clinics (RHCs).The Provider Directory has the Alliance network provider names, specialties, addresses, phone numbers, business hours and languages spoken. It tells if the provider is taking new patients. It also gives the level of physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars. If you want information about a doctor's education, training, and board certification, please call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

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

If you need a printed Provider Directory, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Provider network

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

Note: American Indians may choose an IHC as their PCP.

If your PCP, hospital or other provider has a moral objection to providing you with a covered service, such as family planning or abortion, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). For more about moral objections, read the "Moral objection" section earlier in this chapter.

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

In network providers

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

To get a Provider Directory of network providers, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). You can also find the Provider Directory online at **www.alamedaalliance.org**.

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

Except for emergency care, you may have to pay for care from providers who are out of network.

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

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

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

If you need help with out-of-network services, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Outside the service area

If you are outside of the Alliance service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

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

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

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

If you have questions about out-of-network or out-of-service area care, call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY)

711/**1.800.735.2929**). If the office is closed and you want help from a representative, call the Advice Nurse Line anytime, 24 hours a day, 7 days a week, toll-free at **1.888.433.1876**.

Additional Service Providers

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

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

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

If you need services at any of these provider networks, please call the provider and let them know that you are an Alliance Medi-Cal member and are calling to schedule an exam or appointment. The provider will need to confirm that you are eligible and will get approval to provide services to you. If you go to an out-of-network provider or get services without approval, you will need to pay in full for those services.

If you have questions about these services, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**).

Doctors

You will choose your doctor or a primary care provider (PCP) from the Alliance Provider Directory. The doctor you choose must be a participating provider. This means the provider is in the Alliance network. To get a copy of the Alliance Provider Directory, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929**or **711**). Or find it online at **www.alamedaalliance.org**.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

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

If you had a doctor before you were a member of the Alliance, and that doctor is not part of the Alliance network, you may be able to keep that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

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

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

If you want to change your PCP, you must choose a PCP from the Alliance Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Hospitals

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

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in the network. The hospitals in the Alliance network are listed in the Provider Directory. Hospital services, other than emergencies, must have pre-approval (prior authorization).

Timely access to care

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

Travel time and distance to care

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

If the Alliance is not able to provide care to you within these travel time and distance

standards, DHCS may approve a different standard, called an alternative access standard. For the Alliance time and distance standards for where you live, visit **www.alamedaalliance.org**. Or call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).If you need care from a provider and that provider is located far from where you live, call member services at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). They can help you find care with a provider located closer to you. If the Alliance cannot find care for you with a closer provider, you can ask the Alliance to arrange transportation for you to go to your provider, even if that provider is located far from where you live.

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

Primary care provider (PCP)

You must choose a PCP within **30 days** of enrolling in the Alliance. Depending on your age and sex, you may choose a general practitioner, ob/gyn, family practitioner, internist or pediatrician as your primary care provider (PCP). A nurse practitioner (NP), physician assistant (PA) or certified nurse midwife may also act as your PCP. If you choose an NP, PA or certified nurse midwife, you may be assigned a doctor to oversee your care.

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

If you do not choose a PCP within **30 days** of enrollment, the Alliance will assign you to a PCP. If you are assigned to a PCP and want to change, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). The change happens the first day of the next month.

Your PCP will:

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

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

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

You can find the Alliance Provider Directory online at **www.alamedaalliance.org**. Or you can request a Provider Directory to be mailed to you by calling **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

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

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

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

To change your PCP, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

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

If you change PCPs, you will get a new Alliance member ID card in the mail. It will have the name of your new PCP. Call member services if you have questions about getting a new ID card, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**).

Appointments

When you need health care:

- Call your PCP
- Have your Alliance member ID number ready on the call
- Leave a message with your name and phone number if the office is closed

- Take your BIC and Alliance member ID card to your appointment
- Ask for transportation to your appointment, if needed
- Ask for language assistance or interpreting services, if needed
- Be on time for your appointment
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

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

Payment

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

If you do get a bill, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). Tell the Alliance the amount charged, the date of service and the reason for the bill. You are **not** responsible to pay a provider for any amount owed by the Alliance for any covered service. Except for emergency care or urgent care, you may have to pay for care from providers who are not in the network. If you need covered health care services, you may be able to get them at an out-of-network provider at no cost to you, as long as they are medically necessary, not available in the network and pre-approved by the Alliance.

If you get a bill or are asked to pay a co-pay that you think you did not have to pay, you can also file a claim form with the Alliance. You will need to tell the Alliance in writing why you had to pay for the item or service. The Alliance will read your claim and decide if you can get money back. For questions or to ask for a claim form, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Referrals

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

Other services that might need a referral include in-office procedures, X-rays, lab work physical therapy, and chronic problems that may need specialty care services.

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

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

If you have trouble getting a standing referral or want a copy of the Alliance referral policy, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

You do not need a referral for:

- PCP visits
- Obstetrics/Gynecology (OB/GYN) visits
- Urgent or emergency care visits
- Adult sensitive services, such as sexual assault care
- Family planning services (to learn more, call Office of Family Planning Information and Referral Service at **1.800.942.1054**)
- HIV testing and counseling (**12 years or older**)
- Sexually transmitted infection services (**12 years or older**)
- Acupuncture (the first two services per month; additional appointments will need a referral)
- Chiropractic services (a referral may be required when provided by out-of-network FQHCs, RHCs and IHCs)
- Podiatry services
- Eligible dental services
- Initial mental health assessment
- Preventive Services, such as pediatric well-child visits.
- Prenatal care

Minors also do not need a referral for:

- Outpatient mental health services for:

  - Sexual assault
  - Physical assault
  - When you have thoughts of hurting yourself or others (minors **12 years or older**)
- Pregnancy care
- Sexual assault care
- Substance use disorder treatment (minors **12 years or older**)

Pre-approval (prior authorization)

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

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

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

- Hospitalization, if not an emergency
- Services out of the Alliance service area, if not an emergency or urgent
- Outpatient surgery
- Long-term care at a nursing facility
- Specialized treatments

For some services, you need pre-approval (prior authorization). Under Health and Safety Code Section 1367.01(h)(1), the Alliance will decide routine pre-approvals (prior authorizations) within **five (5) working days** of when the Alliance gets the information reasonably needed to decide.

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

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

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

You never need pre-approval (prior authorization) for emergency care, even if it is out of the network and out of your service area. This includes labor and delivery if you are pregnant. You do not need pre-approval (prior authorization) for sensitive services, such as family planning, HIV/AIDS services, and outpatient abortions.

Second Opinions

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

If you want to get a second opinion, you can choose an in-network provider of your choice. For help choosing a provider, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

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

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

If the Alliance denies your request for a second opinion, you may appeal. To learn more about appeals, go to “Appeals” in this handbook.

Women's health specialists

You may go to a women's health specialist within the Alliance network for covered care necessary to provide women's routine and preventive health care services. You do not need a referral from your PCP to get these services. For help finding a women's health specialist, you can call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711)**. You may also call the 24/7 Advice Nurse Line toll-free at **1.888.433.1876**.

4. Benefits and services

What your health plan covers

This section explains your covered services as a member of the Alliance. Your covered services are free as long as they are medically necessary and provided by an in-network provider. You must ask us for pre-approval (prior authorization) if the care is out-of-network except for sensitive services, emergencies or urgent care services. Your health plan may cover medically necessary services from an out-of-network provider. But you must ask the Alliance for this. Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed disease, illness or injury. For more details on your covered services, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

The Alliance offers services such as:

- Outpatient (ambulatory) services
- Telehealth services
- Mental health services (outpatient)
- Emergency services
- Hospice and palliative care
- Hospitalization
- Maternity and newborn care
- Rehabilitative and habilitative (therapy) services and devices
- Laboratory and radiology services, such as X-rays
- Preventive and wellness services and chronic disease management
- Diabetes Prevention Program
- Substance use disorder treatment services

- Pediatric services
- Vision services
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)
- Long-term services and supports (LTSS)

Read each of the sections below to learn more about the services you can get.

Medi-Cal benefits covered by the Alliance

Outpatient (ambulatory) services

Adult Immunizations

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

Allergy care

The Alliance covers allergy testing and treatment, including allergy desensitization, hyposensitization or immunotherapy.

Anesthesiologist services

The Alliance covers anesthesia services that are medically necessary when you get outpatient care.

For dental procedures, we cover the following services when authorized by the Alliance:

- IV sedation or general anesthesia services administered by a medical professional
- Facility services related to the sedation or anesthesia in an outpatient surgical center, Federally Qualified Health Center (FQHC), dental office, or hospital setting

Chiropractic services

The Alliance covers chiropractic services, limited to the treatment of the spine by manual

manipulation. Chiropractic services are limited to two services per month in combination with acupuncture, audiology, occupational therapy and speech therapy services. The Alliance may pre-approve other services as medically necessary.

The following members are eligible for chiropractic services:

- Children under age 21
- Pregnant women through the end of the month that includes **60 days** following the end of a pregnancy
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility
- All members when services are provided at hospital outpatient departments, FQHCs or RHCs that are in the Alliance network

Dialysis/hemodialysis services

The Alliance covers dialysis treatments. The Alliance also covers hemodialysis (chronic dialysis) services if your PCP and the Alliance approve it.

Outpatient surgery

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

Physician services

The Alliance covers physician services that are medically necessary.

Podiatry (foot) services

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

Treatment therapies

The Alliance covers different treatment therapies, including:

- Chemotherapy
- Radiation therapy

Telehealth services

Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider. Or telehealth may involve sharing information with your provider without a live conversation. You can receive many services through telehealth. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. You can contact your provider to learn which types of services may be available through telehealth.

Mental health services

Outpatient mental health services

- The Alliance covers a member for an initial mental health assessment without needing pre-approval (prior authorization). You may get a mental health assessment at any time from a licensed mental health provider in the Alliance network without a referral.
- Your PCP or mental health provider will make a referral for additional mental health screening to a specialist within the Alliance network to determine your level of impairment. If your mental health screening results determine you are in mild or moderate distress or have impairment of mental, emotional or behavioral functioning, the Alliance can provide mental health services for you. The Alliance covers mental health services such as:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated to evaluate a mental health condition
    - Development of cognitive skills to improve attention, memory and problem solving
    - Outpatient services for the purposes of monitoring medication therapy
    - Outpatient laboratory, medications, supplies and supplements
    - Psychiatric consultation

- For help finding more information on mental health services provided by the Alliance, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).
- If your mental health screening results determine you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider will refer you to the county mental health plan to get an assessment. To learn more, read "What your health plan does not cover" on page

Emergency services

Inpatient and outpatient services needed to treat a medical emergency

The Alliance covers all services that are needed to treat a medical emergency that happens in the U.S. or requires you to be in a hospital in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, a prudent layperson could expect it to result in:

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

  A pharmacist or hospital emergency room may give you a **72-hour** emergency supply of a prescription drug if they think you need it. The Alliance will pay for the emergency supply.

Emergency transportation services

The Alliance covers ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside

the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico.

Hospice and palliative care

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

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

Hospice care includes:

- Nursing services
- Physical, occupational or speech services
- Medical social services
- Home health aide and homemaker services
- Medical supplies and appliances
- Drugs and biological services
- Counselling services
- Continuous nursing services on a 24-hour basis during periods of crisis and as necessary to maintain the terminally ill member at home
- Inpatient respite care for up to five consecutive days at a time in a hospital, skilled nursing facility or hospice facility
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing facility or hospice facility

Palliative care is patient- and family-centered care that improves quality of life by anticipating, preventing and treating suffering. Palliative care does not require the member to have a life expectancy of **six** (**6) months** or less. Palliative care may be provided at the same time as curative care.

Hospitalization

Anesthesiologist services

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

Inpatient hospital services

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

Surgical Services

The Alliance covers medically necessary surgeries performed in a hospital.

Maternity and newborn care

The Alliance covers these maternity and newborn care services:

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

Prescription Drugs

Covered drugs

Your provider can prescribe you drugs that are on the Alliance Medication Formulary, subject to exclusions and limitations. The Alliance Medication Formulary is sometimes called a formulary. Drugs on the Medication Formulary are safe and effective for their prescribed use. A group of doctors and pharmacists update this list.

- Updating this list helps make sure the drugs on it are safe and effective.

- If your doctor thinks you need to take a drug that is not on this list, your doctor will need to call the Alliance to ask for pre-approval before you get the drug.

To find out if a drug is on the Alliance Medication Formulary or to get a copy of the formulary, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**. You may also find the Alliance Medication Formulary at **www.alamedaalliance.org**.

Sometimes the Alliance needs to approve a drug before a provider can prescribe it. The Alliance will review and decide these requests within 24 hours.

- A pharmacist or hospital emergency room may give you a 72-hour emergency supply if they think you need it. The Alliance will pay for the emergency supply.
- If the Alliance says no to the request, the Alliance will send you a letter that lets you know why and what other drugs or treatments you can try.

Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with the Alliance. You can find a list of pharmacies that work with the Alliance in the Alliance Provider Directory at **www.alamedaalliance.org**. You can also find a pharmacy near you by calling **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**.

Once you choose a pharmacy, take your prescription to the pharmacy. Your provider may also send it to the pharmacy for you. Give the pharmacy your prescription with your Alliance ID card. Make sure the pharmacy knows about all medications you are taking and any allergies you have. If you have any questions about your prescription, make sure you ask the pharmacist.

The Provisional Postpartum Care Extension Program

The Provisional Postpartum Care Extension (PPCE) Program provides extended coverage for Medi-Cal members who have a maternal mental health condition during pregnancy or the time period after pregnancy.

The Alliance covers maternal mental health care for women during pregnancy and for up to **two (2) months** after the end of pregnancy. The PPCE program extends that coverage for up to **12 months** after the diagnosis or from the end of the pregnancy, whichever is later.

To qualify for the PPCE program, your doctor must confirm your diagnosis of a maternal mental health condition within **150 days** after the end of pregnancy. Ask your doctor about these services if you think you need them. If your doctor thinks you should have the

services from PPCE, your doctor completes and submits the forms for you.

Rehabilitative and habilitative (therapy) services and devices

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

The plan covers:

Acupuncture

The Alliance covers acupuncture services to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of needles) are limited to two services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services when provided by a physician, dentist, podiatrist or acupuncturist. The Alliance may pre-approve (prior authorize additional services as medically necessary.

Audiology (hearing)

The Alliance covers audiology services. Outpatient audiology is limited to two services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services. The Alliance may pre-approve (prior authorize) additional services as medically necessary.

Behavioral health treatments

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

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

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

Cancer clinical trials

The Alliance covers routine patient care costs for patients accepted into Phase I, Phase II, Phase III or Phase IV clinical trials if it is related to the prevention, detection or treatment of cancer or other life-threatening conditions and if the study is conducted by the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS). Studies must be approved by the National Institutes of Health, the FDA, the Department of Defense or the Veterans Administration.

Cardiac rehabilitation

The Alliance covers inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment (DME)

The Alliance covers the purchase or rental of DME supplies, equipment and other services with a prescription from a doctor. Prescribed DME items may be covered as medically necessary to preserve bodily functions essential to activities of daily living or to prevent major physical disability. The Alliance does not cover comfort, convenience or luxury equipment, features and supplies, and other items not generally used primarily for health care.

Enteral and parenteral nutrition

These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. Enteral and parenteral nutrition products are covered when medically necessary.

Hearing aids

The Alliance covers hearing aids if you are tested for hearing loss and have a prescription from your doctor. The Alliance may also cover hearing aid rentals, replacements and batteries for your first hearing aid.

Home health services

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

Medical supplies, equipment and appliances

The Alliance covers medical supplies that are prescribed by a doctor.

Occupational therapy

The Alliance covers occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction and consultative services. Occupational therapy services are limited to two services per month in combination with acupuncture, audiology, chiropractic and speech therapy services. The Alliance may pre-approve (prior authorize) additional services as medically necessary.

Orthotics/prostheses

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

Ostomy and urological supplies

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

Physical therapy

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

Pulmonary rehabilitation

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

Reconstructive Services

The Alliance covers surgery to correct or repair abnormal structures of the body to improve or create a normal appearance to the extent possible. Abnormal structures of the

body are those caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease, or breast reconstruction after a mastectomy. Some limitations and exceptions may apply.

Skilled nursing facility services

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

Speech therapy

The Alliance covers speech therapy that is medically necessary. Speech therapy services are limited to two services per month, in combination with acupuncture, audiology, chiropractic and occupational therapy services. The Alliance may pre-approve (prior authorize) additional services as medically necessary.

Transgender Services

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

Laboratory and radiology services

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

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- American Academy of Pediatrics Bright Futures recommendations
- Preventive services for women recommended by the American College of Obstetricians and Gynecologists
- Help to quit smoking, also called smoking cessation services

- United States Preventive Services Task Force Grade A and B recommended preventive services

Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. The Alliance PCP and ob/gyn specialists are available for family planning services.

For family planning services, you may also choose a doctor or clinic not connected with The Alliance without having to get pre-approval (prior authorization) from the Alliance. Services from an out-of-network provider not related to family planning may not be covered. To learn more, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program. It is designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The program lasts one year. It can last for a second year for members who qualify. The program-approved lifestyle supports and techniques include, but are not limited to:

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

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

Substance use disorder services

The plan covers:

- Alcohol misuse screenings and illicit-drug screenings

Pediatric services

The plan covers:

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

    - Treatment for vision and hearing, which could be eyeglasses and hearing aids
    - Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
    - Case management and health education
    - Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.
- Care coordination to help you or your child get the right care even if the Alliance is not responsible for paying for that care. These services include:
    - Treatment and rehabilitative services for mental health and substance use disorders
    - Treatment for dental issues, which could be orthodontics

Vision services

The plan covers:

- Routine eye exam once every **24 months**; the Alliance may pre-approve (prior authorize) additional services as medically necessary.
- Eyeglasses (frames and lenses) once every **24 months**; contact lenses when required for medical conditions such as aphakia, aniridia, and keratoconus.

Non-emergency medical transportation (NEMT)

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

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

transportation impossible.

NEMT must be used when:

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

To ask for NEMT services that your doctor has prescribed, please call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738 or** ModivCare (formerly LogistiCare), toll-free at **1.855.891.7171** at least **three (3) business days** (Monday-Friday) before your appointment. For urgent appointments, please call as soon as possible. Please have your member ID card ready when you call.

Limits of NEMT

There are no limits for receiving NEMT to or from medical, dental, mental health and substance use disorder appointments covered under Medi-Cal when a provider has prescribed it for you. Some pharmacy services are covered under NEMT such as pharmacy trips for medication. For more information or to ask for NEMT services related to pharmacy, please call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** or ModivCare (formerly LogistiCare), toll-free at **1.855.891.7171**. If the appointment type is covered by Medi-Cal but not through the health plan, the Alliance will provide or help you schedule your transportation.

What does not apply?

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

Cost to member

There is no cost when transportation is authorized by the Alliance.

Non-medical transportation (NMT)

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

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

The Alliance allows you to use a car, taxi, bus or other public/private way of getting to your medical appointment for Medi-Cal-covered services. The Alliance gives mileage reimbursement when transportation is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

Before getting approval for mileage reimbursement, you must state to the Alliance by phone, by email or in person that you tried to get all other reasonable transportation choices and could not get one. The Alliance allows the lowest cost NMT type that meets your medical needs.

To ask NMT for services that have been authorized, call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** or ModivCare (formerly LogistiCare), toll-free at **1.855.891.7171** at least **three (3) business days** (Monday-Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have your member ID card ready when you call.

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

Limits of NMT

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

What does not apply?

NMT does not apply if:

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

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

- You are in a wheelchair and are unable to move in and out of the vehicle without help from the driver.
- The service is not covered by Medi-Cal.

Cost to member

There is no cost when transportation is authorized by the Alliance.

Long-term services and supports (LTSS)

The Alliance covers these LTSS benefits for members who qualify:

- Skilled nursing facility services as approved by the Alliance
- Home and Community Based Services as approved by the Alliance

Care coordination

The Alliance offers services to help you coordinate your health care needs at no cost to you. If you have questions or concerns about your health or the health of your child, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Health Homes Program

The Alliance covers Health Homes Program (HHP) services for members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long-term services and supports (LTSS) for members with chronic conditions.

You may be contacted if you qualify for the program. You can also call the Alliance, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call the Alliance to find out the conditions that qualify, and you meet one of the following:
    - You have three or more of the HHP eligible chronic conditions
    - You stayed in the hospital in the last year
    - You visited the emergency department three or more times in the last year;

or

- You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP services

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers and others, to coordinate your care. The Alliance provides HHP services, which include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support services
- Referral to community and social supports

Other Medi-Cal programs and services

Specialty mental health services

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

- Outpatient services:
  - Mental health services (assessments, plan development, therapy, rehabilitation and collateral)
  - Medication support services

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

- Residential services:
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services:
  - Acute psychiatric inpatient hospital services
  - Psychiatric inpatient hospital professional services
  - Psychiatric health facility services

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

Substance use disorder services

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

Dental services

Medi-Cal covers some dental services, including:

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

- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planning
- Periodontal maintenance
- Complete and partial dentures
- Orthodontics for children who qualify
- Topical fluoride

If you have questions or want to learn more about dental services, call the Medi-Cal Dental Program at **1.800.322.6384** (TTY/TDD **1.800.735.2922** or **711**). You may also visit the Medi-Cal Dental Program website at **www.denti-cal.ca.gov**.

California Children's Services (CCS)

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

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

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

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

- Congenital heart disease
- Cancers

- Tumors
- Hemophilia
- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts
- Cerebral palsy
- Seizures under certain circumstances
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

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

To learn more about CCS, you can visit the CCS web page at **www.dhcs.ca.gov/services/ccs**. Or call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Institutional long-term care

The Alliance covers long-term care for the month you enter a facility and the month after that. The Alliance **does not** cover long-term care if you stay longer.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

FFS Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

Services you cannot get through the Alliance or Medi-Cal

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

- Experimental services
- Fertility preservation
- In Vitro Fertilization (IVF)
- Permanent home modifications
- Vehicle modifications
- Cosmetic Surgery

To learn more call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

5. Rights and responsibilities

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

Your rights

The Alliance members have these rights:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including covered services and member rights and responsibilities.
- To be able to choose a primary care provider within the Alliance network.
- To have timely access to network providers.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get free oral interpretation services for your language.
- To get free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with the Alliance and are still not happy with the decision, or if you did not get a decision on your appeal after **30 days**, including information on the

circumstances under which an expedited hearing is possible.

- To disenroll from the Alliance and change to another health plan in the county upon request.
- To access Minor Consent Services.
- To get written member-informing materials in alternative formats (such as braille, large-size print and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the Alliance, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside the Alliance network pursuant to the federal law.

Your responsibilities

Alliance members have these responsibilities:

- Tell the Alliance and your doctors what we need to know (to the extent possible) so we can provide care.
- Follow care plans and advice for care that you have agreed to with your doctors.
- Learn about your health problems and help to set treatment goals that you agree with, to the degree possible.
- Work with your doctor.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

- Always present your Alliance member ID card when getting services.
- Ask questions about any medical condition and make certain you understand your doctor's explanations and instructions.
- Give your doctors and the Alliance correct information.
- Help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
- Make and keep medical appointments and inform your doctor at least **24 hours** in advance when an appointment must be cancelled.
- Treat all Alliance staff and health care staff with respect and courtesy.
- Use the emergency room (ER) only in case of an emergency or as directed by your doctor.

Notice of privacy practices

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

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

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

Alameda Alliance for Health
ATTN: Member Services Department
1240 South Loop Road
Alameda, CA 94502
Phone Number: **1.510.747.4567**
Toll-Free **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Notice about laws

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

Notice about Medi-Cal as a payer of last resort

Sometimes someone else has to pay first for the services the Alliance provided to you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

DHCS has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. If you are injured, and someone else is liable for your injury, you or your legal representative must notify DHCS within **30 days** of filing a legal action or a claim. Submit your notification online:

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

To learn more, call **1.916.445.9891**.

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

Medi-Cal members may also have other health coverage (OHC) provided to them at no cost. By law, members are required to exhaust all services provided by the OHC before using services through the MCP. If you do not apply for or keep no-cost or state-paid OHC, your Medi-Cal benefits and/or eligibility will be denied or stopped. Federal and state laws require Medi-Cal members to report private health insurance. To report or change private health insurance, go to **http://dhcs.ca.gov/mymedi-cal**. Or go through your health plan. Or call **1.800.541.5555** (TTY/TDD **1.800.430.7077** or **711**). Outside of California, call **1.916.636.1980**. If you do not report changes to your OHC promptly, and because of this, get Medi-Cal benefits that you are not eligible for, you may have to repay DHCS.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

Notice about estate recovery

The Medi-Cal program must seek repayment from the estates of certain deceased Medi-Cal members from payments made, including managed care premiums for nursing facility services, home and community-based services, and related hospital and prescription drug services provided to the deceased Medi-Cal member on or after the member's 55th birthday. If a deceased member does not leave an estate or owns nothing when they die, nothing will be owed.

To learn more about the estate recovery, go to **http://dhcs.ca.gov/er**. Or call **1.916.650.0490** or get legal advice.

Notice of Action

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

6. Reporting and solving problems

There are two kinds of problems that you may have with the Alliance:

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

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

You should always contact the Alliance first to let us know about your problem. Call us between Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). Tell us about your problem. You can also visit our website at **www.alamedaalliance.org.**

If your grievance or appeal is still not resolved, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC) and ask them to review your complaint or conduct an Independent Medical Review. You can call the DMHC at **1.888.466.2219** (TTY/TDD **1.877.688.9891** or **711**) or visit the DMHC website for more information: **www.dmhc.ca.gov.**

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can also help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 am and 5:00 pm at **1.888.452.8609**.

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call**1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

To report incorrect information about your additional health insurance, please call Medi-Cal Monday through Friday, between 8:00 am and 5:00 pm at **1.800.541.5555**.

Complaints

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

- **By phone:** Call at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**) between Monday – Friday, 8 am – 5 pm. Give your health plan ID number, your name and the reason for your complaint.
- **By mail:** Call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the reason for your complaint. Tell us what happened and how we can help you.

  Mail the form to:

  Alameda Alliance for Health
  ATTN: Alliance Grievance and Appeals Department
  1240 South Loop Road
  Alameda, CA 94502
  Fax: **1.855.891.7258**

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

If you need help filing your complaint, we can help you. We can give you free language services. Call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

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

If you want us to make a fast decision because the time it takes to resolve your complaint would put your life, health or ability to function in danger, you can ask for an expedited

(fast) review. To ask for an expedited review, call us at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**) and we will make a decision within **72 hours** of receiving your complaint.

Appeals

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

You must file an appeal within **60 calendar days** from the date on the NOA you got from the Alliance. If you are currently getting treatment and you want to continue getting treatment, then you must ask the Alliance for an appeal within **10 calendar days** from the date the NOA was delivered to you, or before the date the Alliance says services will stop. When you request an appeal under these circumstances, treatment will continue upon your request. We may require you to pay for the cost of services if the final decision denies or changes a service.

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

- **By phone:** Call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**) between Monday – Friday, 8 am – 5 pm. Give your name, health plan ID number and the service you are appealing.
- **By mail:** Call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the service you are appealing.

  Mail the form to:

  Alameda Alliance for Health
  ATTN: Alliance Grievance and Appeals Department
  1240 South Loop Road
  Alameda, CA 94502
  Fax: **1.855.891.7258**

  Your doctor's office will have appeal forms available.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

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

If you need help filing your appeal, we can help you. We can give you free language services. Call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

Within **five (5) days** of getting your appeal, we will send you a letter letting you know we got it. Within **30 days**, we will tell you our appeal decision. If the Alliance does not tell you its appeal decision within **30 days** you can request a State Hearing and an Independent Medical Review. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has final say.

If you or your doctor wants us to make a fast decision because the time it takes to resolve your appeal would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**). We will make a decision within **72 hours** of receiving your appeal about whether we will expedite your appeal.

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

If you filed an appeal and got a letter from the Alliance telling you we did not change our decision, or you never got a letter telling you of our decision and it has been past **30 days**, you can:

- Ask for a **State Hearing** from the California Department of Social Services (CDSS), and a judge will review your case.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have the Alliance decision reviewed or ask for an **Independent Medical Review (IMR)** from the DMHC. During DMHC's IMR and an outside doctor who is not part of the Alliance will review your case. DMHC's toll-free telephone number is **1.888.466.2219** and the TDD line is **1.877.688.9891**. You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: **www.dmhc.ca.gov**.

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

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

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

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

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

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

You may be able to get an IMR right away without filing an appeal first. This is in cases where your health problem is urgent.

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

Here is how to ask for an IMR. The term "grievance" is for "complaints" and "appeals":

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.510.747.4567** or toll-free at **1.877.932.2738 (TTY 1.800.735.2929** or **711)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than **30 days**, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1.888.466.2219)** and a TDD line **(1.877.688.9891)** for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

State Hearings

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

You must ask for a State Hearing within **120 days** from the date on the Alliance notice telling you of the appeal decision. Your PCP can ask for a State Hearing for you with your written permission.

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

- **By phone:** Call the CDSS Public Response Unit at **1.800.952.5253** (TTY/TDD **1.800.952.8349** or **711**).
- **By mail**: Fill out the form provided with your appeals resolution notice. Send it to:

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

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY/TDD **1.800.735.2929** or **711**).

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

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

Fraud, waste and abuse

If you suspect that a provider or a person who gets Medi-Cal has committed fraud, waste or abuse, it is your right to report it by calling the confidential toll-free number **1.800.822.6222** or submitting a complaint online at **www.dhcs.ca.gov/**.

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711**/**1.800.735.2929**).
Visit online at **www.alamedaalliance.org**.

Provider fraud, waste and abuse includes:

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

Fraud, waste and abuse by a person who gets benefits includes:

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

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

Send your report to:

Alameda Alliance for Health
Attn: Compliance
1240 South Loop Road
Alameda, CA 94502
Phone Number: **1.510.747.4500**
People with hearing and speaking impairments (CRS/TTY)**: 711/1.800.735.2929**
Anonymous Compliance Hotline: **1.855.747.2234**

7. Important numbers and words to know

Important phone numbers

Advice Nurse Line
Toll-Free: **1.888.433.1876**

Alameda Alliance for Health – Member Services Department
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Alameda County Behavioral Health Care Services - ACCESS Program
Toll-Free: **1.800.491.9099**

Alameda County Social Services Agency (Medi-Cal Center)
Phone Number: **1.510.777.2300**
Toll-Free: **1.800.698.1118**

Beacon Health Options (Alliance's Behavioral Health Benefit Manager)
Toll-Free: **1.855.856.0577**

California Children's Services (CCS)
Phone Number: **1.510.208.5970**

California Department of Health Care Services (DHCS) – Medi-Cal Managed Care
Phone Number: **1.916.449.5000**

California Department of Managed Health Care (DMHC) – HMO Help Center
Toll-Free: **1.888.466.2219**
People with hearing and speaking impairments (TDD): **1.877.688.9891**

California Home Medical Equipment (CHME)
Toll-Free: **1.800.906.0626**

Please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY) **711/1.800.735.2929**). Visit online at **www.alamedaalliance.org**.

California Relay Service (for the hearing impaired)
Toll-Free: **1.800.735.2929**
People with hearing and speaking impairments (CRS): **711**

Children First Medical Group (CFMG)
Phone Number: **1.510.428.3154**

Community Health Center Network (CHCN)
Phone Number: **1.510.297.0200**

Denti-Cal
Toll-Free: **1.800.322.6384**
People with hearing and speaking impairments (TTY): **1.800.735.2922**

Health Care Options (HCO)
Toll-Free: **1.800.430.4263**
People with hearing and speaking impairments (TTY): **1.800.430.7077**

March Vision Care
Toll-Free: **1.844.336.2724**

Medi-Cal Rx
Toll-Free: **1.800.977.2273**
People with hearing and speaking impairments (TTY/TDD): **1.800.977.2273 and press 5 or 711**)

Regional Center of the East Bay
Phone Number: **1.510.618.6100**

Words to know

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

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

American Indian: An individual, defined in title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (Indian Health Service, an Indian Tribe, Tribal Organization,

or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

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

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

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

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

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

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

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

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

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

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

Complaint: A member's verbal or written expression of dissatisfaction about the Alliance, a provider, or quality of services provided. A complaint is the same as a grievance.

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

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

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. You are automatically enrolled in a

COHS plan if you meet enrollment rules. Enrolled recipients choose their health care provider from among all COHS providers.

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

Coverage (covered services): The health care services provided to members of the Alliance, subject to the terms, conditions, limitations and exclusions of the Medi-Cal contract and as listed in this Evidence of Coverage (EOC) and any amendments.

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

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

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

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

Early and periodic screening, diagnostic, and treatment (EPSDT): EPSDT services are a benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early.

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

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

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

Emergency medical transportation: Transportation in an ambulance or emergency

vehicle to an emergency room to get emergency medical care.

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

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

Family planning services: Services to prevent or delay pregnancy.

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

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

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

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

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

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

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

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

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

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

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

You do **not** need a referral from your PCP for some types of service, such as family

planning, emergency care, ob/gyn care or sensitive services.

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

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

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

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

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

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

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

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

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

Indian Health Clinic (IHC): A health clinic operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the medical care you need.

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

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

Palliative care: Care to reduce physical, emotional, social and spiritual discomforts for a member with a serious illness.

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

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

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

Plan: Go to "Managed care plan."

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition. Post-stabilization care services are covered and paid for.

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

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

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

Primary care: Go to "Routine care."

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

- You have an emergency
- You need ob/gyn care
- You need sensitive services
- You need family planning services/birth control

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- Ob/gyn
- Indian Health Clinic (IHC)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (pre-approval): A formal process requiring a health care provider to get approval to provide specific services or procedures.

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

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

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

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

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

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

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

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

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

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

Sensitive services: Services for family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions.

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

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

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

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Visit online at **www.alamedaalliance.org**.

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

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

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

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

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

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