ALAMEDA Alliance FOR HEALTH

# Member Handbook

Alameda Alliance for Health

**Alliance Group Care Program**

Combined Evidence of Coverage (EOC) and Disclosure Form

2023

# Other languages and formats

## Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. We provide written translations from qualified translators. Call the Alliance Member Services Department at **1.510.747.4567** or toll-free at (TTY **1.800.735.2929** or **711**). The call is toll-free.

There are many self-service features available to you through the Alliance Member Portal. You can select your primary care provider (PCP), request a replacement member ID card, and view your eligibility with the plan by logging into your Member Portal account. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

## Other formats

You can get this information in other formats, such as braille, 20-point font large print, audio, and accessible electronic formats, at no cost to you. Call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). The call is toll-free.

## Interpreter services

Alameda Alliance for Health (Alliance) provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. Interpreter, linguistic, and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this handbook in a different language, please call the Alliance Member Services Department at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). The call is toll-free. The Alliance will coordinate interpreter services with scheduled appointments for health care services to ensure you get interpreter services at the time of the appointment.

**English Tagline**

ATTENTION: If you need help in your language call **1.877.932.2738** (TTY: **1.800.735.2929**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1.877.932.2738** (TTY: **1.800.735.2929**). These services are at no cost.

**الشعار بالعربية(Arabic)**

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1.877.932.2738** (TTY: **1.800.735.2929**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1.877.932.2738**. هذه الخدمات مجانية.(TTY: **1.800.735.2929**)

**Հայերեն պիտակ (Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1.877.932.2738** (TTY: **1.800.735.2929**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1.877.932.2738** (TTY: **1.800.735.2929**): Այդ ծառայություններն անվճար են:

**ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)**

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1.877.932.2738** (TTY: **1.800.735.2929**) ។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

**简体中文标语 (Chinese)**

请注意：如果您需要以您的母语提供帮助，请致电**1.877.932.2738** (TTY: **1.800.735.2929**)。 另外还提供针对残疾人士的帮助和服务，例如文盲和需要较大字体阅读，也是方便取用的。请致电**1.877.932.2738** (TTY: **1.800.735.2929**)。这些服务都是免费的。

**مطلب به زبان فارسی (Farsi)**

خواهید به زبان خود کمک دریافت کنید، با توجه: اگر می **1.877.932.2738** (TTY: **1.800.735.2929**) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1.877.932.2738** (TTY: **1.800.735.2929**) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

**हिंदी टैगलाइन (Hindi)**

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1.877.932.2738** (TTY: **1.800.735.2929**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1.877.932.2738** (TTY: **1.800.735.2929**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

**Nqe Lus Hmoob Cob (Hmong)**

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1.877.932.2738** (TTY: **1.800.735.2929**). Muaj cov kev pab txhawb thiab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1.877.932.2738** (TTY: **1.800.735.2929**). Cov kev pab cuam no yog pab dawb xwb.

**日本語表記 (Japanese)**

注意日本語での対応が必要な場合は **1.877.932.2738** (TTY: **1.800.735.2929**) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 **1.877.932.2738** (TTY: **1.800.735.2929**) へお電話ください。これらのサービスは無料で提供しています。

**한국어 태그라인 (Korean)**

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1.877.932.2738** (TTY: **1.800.735.2929**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1.877.932.2738** (TTY: **1.800.735.2929**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

**ແທກໄລພາສາລາວ (Laotian)**

ປະກາດ:ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ**1.877.932.2738** (TTY:**1.800.735.2929**). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ**1.877.932.2738** (TTY:**1.800.735.2929**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

**Mien Tagline (Mien)**

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1.877.932.2738** (TTY: **1.800.735.2929**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1.877.932.2738** (TTY: **1.800.735.2929**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

**ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1.877.932.2738** (TTY: **1.800.735.2929**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ **1.877.932.2738** (TTY: **1.800.735.2929**). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

**Русский слоган (Russian)**

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1.877.932.2738** (линия TTY: **1.800.735.2929**). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1.877.932.2738** (линия TTY: **1.800.735.2929**). Такие услуги предоставляются бесплатно.

**Mensaje en español (Spanish)**

ATENCIÓN: si necesita ayuda en su idioma, llame al **1.877.932.2738** (TTY: **1.800.735.2929**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1.877.932.2738** (TTY: **1.800.735.2929**). Estos servicios son gratuitos.

**Tagalog Tagline (Tagalog)**

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1.877.932.2738** (TTY: **1.800.735.2929**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1.877.932.2738** (TTY: **1.800.735.2929**). Libre ang mga serbisyong ito.

**แท็กไลน์ภาษาไทย (Thai)**

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1.877.932.2738** (TTY: **1.800.735.2929**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1.877.932.2738** (TTY: **1.800.735.2929**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

**Примітка українською (Ukrainian)**

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1.877.932.2738** (TTY: **1.800.735.2929**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1.877.932.2738** (TTY: **1.800.735.2929**). Ці послуги безкоштовні.

**Khẩu Hiệu Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1.877.932.2738** (TTY: **1.800.735.2929**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1.877.932.2738** (TTY: **1.800.735.2929**). Các dịch vụ này đều miễn phí.

# Notice of Nondiscrimination

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:

- Aids and services to people with disabilities to help them communicate better at no cost, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Language services to people whose primary language is not English at no cost, such as:
    - Qualified interpreters.
    - Information written in other languages.

If you need these services, contact:

Alameda Alliance for Health
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**

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form.

To obtain a copy in one of these alternative formats, please call or write to:

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

## 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.

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

- By phone:

  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**
- In writing: Fill out a complaint form or write a letter and send it to:

  Alameda Alliance for Health
  ATTN: Alliance Grievances and Appeals Department
  1240 South Loop Road
  Alameda, CA 94502
- In person: Visit your doctor's office or the Alliance and say you want to file a grievance.
- Electronically: Visit the Alliance website at **www.alamedaalliance.org**.

**Office of Civil Rights – 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:

  U.S. Department of Health and Human Services, Office for Civil Rights
  Toll-Free: **1.800.368.1019**
  People with hearing and speaking impairments (TTY/TDD): **1.800.537.7697**

- 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 **www.hhs.gov/ocr/office/file/index.html**.

- Electronically: Visit the Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

To find out if you are eligible for Alliance Group Care, please contact:

Alameda County Public Authority for In-Home Supportive Services (IHSS)
Phone Number: **1.510.577.3552**
**www.ac-pa4ihss.org/hcw-health-benefits.html**

# Table of contents

# 1. Disclosure, contacts, and benefits and coverage matrix

This booklet gives a summary of benefits for Alameda Alliance for Health (Alliance) members.

## Disclosure

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

The Group Contract (agreement) between the Alliance and the Public Authority for IHSS Workers in Alameda County (Public Authority) must be consulted to determine the exact terms and conditions of coverage. The Alliance can provide a copy of the Alliance Contract upon request. To request a copy, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

The benefit year of this EOC is from January 1 to December 31. You have the right to review this EOC booklet before you enroll. You should read this EOC booklet with care. This way, you will know who or what groups can provide health care services to you. If you have special health care needs, read closely the parts that apply to you.

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

# Contact information

| Entity | Phone Number | Address | Website |
|---|---|---|---|
| Advice Nurse Line | Toll-Free: **1.855.383.7873** | | |
| Alameda Alliance for Health | Main Number: **1.510.747.4500**<br>Toll-Free: **1.877.932.2738**<br>People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929** | 1240 South Loop Road<br>Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Member Services Department | Phone Number: **1.510.747.4567**<br>Toll-Free: **1.877.932.2738**<br>People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929** | Alliance Member Services Department<br>P.O. Box 2818<br>Alameda, CA 94501-0818 | **www.alamedaalliance.org** |
| Alliance Grievance and Appeal Department | Phone Number: **1.510.747.4567**<br>Toll-Free: **1.877.932.2738** | 1240 South Loop Road<br>Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Interpreter Scheduling (to schedule face-to-face interpreters) | Phone Number: **1.510.747.4567**<br>Toll-Free: **1.877.932.2738**<br>People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929** | | |
| Alliance Health Programs | Phone Number: **1.510.747.4577**<br>Toll-Free: **1.877.932.2738** | | **www.alamedaalliance.org** |
| California Children's Services (CCS) | Phone Number: **1.510.208.5970** | 1000 Broadway<br>Suite 500<br>Oakland, CA 94607 | **www.dhcs.ca.gov/services/ccs** |

| Entity | Phone Number | Address | Website |
|---|---|---|---|
| California Department of Managed Health Care (DMHC)/ California HMO Help Center | Toll-Free: **1.888.466.2219**<br>TDD: **1.877.688.9891** | 980 9th Street<br>Suite 500<br>Sacramento, CA 95814 | **www.dmhc.ca.gov** |
| Community Health Center Network (CHCN) | Phone Number: **1.510.297.0200** | 101 Callan Avenue<br>3rd Floor<br>San Leandro, CA 94577 | **www.chcnetwork.org** |
| Dental Services (Contact the Public Authority) | Phone Number: **1.510.577.3552** | 6955 Foothill Blvd.<br>3rd Floor<br>Oakland, CA 94605 | **ac-pa4ihss.org** |
| Interpreter Services (for interpreters by phone) | 24-Hour Hotline: **1.510.809.3986** | | |
| Public Authority for In-Home Supportive Services (IHSS) Workers of Alameda County | Phone Number: **1.510.577.3552** | 6955 Foothill Blvd.<br>3rd Floor<br>Oakland, CA 94605 | **ac-pa4ihss.org** |
| Vision Services (Contact the Public Authority) | Phone Number: **1.510.577.3552** | 6955 Foothill Blvd.<br>3rd Floor<br>Oakland, CA 94605 | **ac-pa4ihss.org** |

# Benefits and coverage matrix

This matrix provides a summary of your benefits and can be used to help you compare benefits. *(See **Chapter 9: Schedule of medical benefits** for further information.)*

## Annual or lifetime maximum

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

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Abortion Services | These services are available without a referral or authorization. However, these services are not covered if performed by an out-of-plan provider. For information, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). | • No copayment |
| Acupuncture | Self-referral to an Alliance provider for 10 visits each benefit year. | • $5 copayment per visit |
| Advice Nurse Line | The Advice Nurse Line is offered 24/7 to all members to help answer health questions about common illnesses and conditions. To access the 24/7 Advice Nurse Line, members can call toll-free at **1.855.383.7873**. | • No copayment |
| Biofeedback Therapy | Biofeedback therapy is covered when medically necessary and prescribed by a licensed physician, surgeon, or licensing psychologist. | • No copayment |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Cataract Spectacles and Cataract Lenses | Cataract spectacles, cataract contact lenses, intraocular lenses, or conventional eyeglasses or contact lenses, as needed, after cataract surgery, aniridia (missing iris) or aphakia (absence of the crystalline lens of the eye). | • No copayment |
| Chiropractic Services | Self-referral to an Alliance provider for 20 visits each benefit year. | • $10 copayment per visit |
| Clinical Trials | Cancer, or other life-threatening diseases, or conditions. | • $10 copayment for office visits<br>• $10 copayment for generic drugs<br>• $15 for brand-name prescription drugs |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Continuity of Care (CoC) | If you are new to the Alliance and have been receiving care from a provider who is not in the Alliance network you may request to continue with the same provider under the following conditions:<br>• Acute condition<br>• Maternal mental health condition<br>• Pregnancy at high risk or in your second/third trimester<br>• Serious chronic condition and you need time to complete treatment<br>• Were previously authorized for surgery and it will occur within 180 days of enrolling with the Alliance<br>• Terminal illness<br><br>For more information, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**) or your doctor. | • No impact on copayment |
| Dental Services | Contact the Public Authority for information about dental services at **1.510.577.3552**. | • Per Public Authority |
| Diabetic Management and Treatment | Services, supplies, and equipment for the treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes, as medically necessary. | • $10 copayment for physician office visits<br>• $10 copayment for generic or $15 for brand-name prescription drugs |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Diagnostic and Laboratory Services | Therapeutic and radiological services (such as x-rays), ECG, EEG, mammography, and other diagnostic laboratory and radiology tests, cancer screening tests, and renal dialysis. | • No copayment |
| Durable Medical Equipment | Medical equipment appropriate for use in the home, oxygen and oxygen equipment, insulin pumps, bone stimulators, phototherapy blankets, dialysis equipment, sleep apnea appliances, and all related necessary supplies. | • No copayment |
| Emergency Health Coverage | 24-hour care for emergency health care services (as defined in **Chapter 8: Emergent, urgent, and routine care** for services both in and out of the Alliance service area). (Copayment is waived if the member is hospitalized.) | • $35 copayment per visit |
| Family Planning Services | Variety of family planning services including counseling, surgical procedures, over-the-counter (OTC) and prescription contraceptives. Infertility treatments are a covered benefit when infertility is a result of surgery, chemotherapy, radiation, or other medical treatment. | • No copayment |
| Hearing Aid Services | • Hearing aids/services – Audiological exam to measure hearing loss and hearing aid evaluation, monaural or binaural hearing aids, including ear mold(s), hearing aid instrument, initial battery, cords, and other ancillary equipment, and office visits for **one (1) year** following the provision of covered hearing aid.<br>• Hearing aid replacement is limited to once every **three (3) benefit years**. | • No copayment |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Home Health Services | Must be prescribed or directed by the attending physician or other appropriate authority designated by the Alliance. You must be unable to leave your home due to a medical condition except with considerable effort and assistance. Your services must require a skilled professional (nurse, rehab therapist). Private duty nursing is not a covered benefit. | • $10 per visit for physical, occupational, and speech therapy performed in the home<br>• $10 for physician visit |
| Hospice Services | Medically necessary nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services, homemaker, volunteer, physical therapy, occupational therapy, and speech therapy. No prior authorization is required for home settingbut is required for an inpatient setting (skilled nursing facility (SNF), hospital). | • No copayment |
| Hospital Services/Inpatient | Inpatient – Semi-private room and board, general nursing care, ancillary services including operating room, intensive care unit, prescribed drugs, laboratory, and radiology, physical, occupational, and speech therapy, short-term inpatient hospice care for respite care, pain control, and symptom management. | • $100 copayment per admission except for pregnancy and maternity care |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Inpatient and Outpatient Alcohol/Substance Use Disorder (SUD) | Inpatient and outpatient alcohol/substance use disorder (SUD) services are covered benefits through the Alliance. For more information, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). | • $100 copayment per inpatient admission<br>• $10 copayment for outpatient SUD office visit benefits<br>• No copayment for outpatient SUD benefits other than office visits |
| Medical Transportation | Air ambulance and ambulance transportation when medically necessary. Services by airplane, passenger car, taxi, or other form of public conveyance are not covered. | • No copayment |
| Mental Health (MH) Services | • Inpatient and outpatient mental health (MH) services, and court ordered CARE agreements in accordance with SB 1338 are covered benefits through the Alliance. For more information, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).<br>• No treatment limitations apply. | • $100 copayment per inpatient admission<br>• $10 copayment for outpatient MH office visit benefits<br>• No copayment for outpatient MH benefits other than office visits |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Organ Transplants | Medically necessary organ, tissue and bone marrow transplants that are not experimental or investigational in nature. Services must be directly related to a covered transplant for a member. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the t member, even if the donor is not a member.. | • No copayment |
| Orthotics and Prosthetics | Medically necessary replacement orthotic and prosthetic devices as prescribed by an Alliance provider. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetes. (*For shoe inserts see **Therapeutic Footwear**.*) | • No copayment |
| Outpatient Services | Diagnostic, surgical, and therapeutic services and supplies for treatment (including radiation and chemotherapy), or surgery in an outpatient hospital setting or ambulatory surgery center. Prior authorization may apply, please reach out to your doctor for your specific service. | • $10 copayment for physical, occupational, and speech therapy<br>• $35 copayment for emergency health care services |
| Phenylketonuria (PKU) | • Testing and treatment of PKU.<br>• Formulas and special food products for the treatment of PKU. | • No copayment |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Physical, Occupational, and Speech Therapy | • Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home when it is medically necessary.<br>• Authorization is for speech and occupational therapy for **six (6) months,** and is subject to review every **six (6) months** and modification when appropriate.<br>• Therapy for pervasive developmental disorder (PDD) or autism is subject to review every **six (6) months** and modification when appropriate. | • $10 copayment for physical, occupational, and speech therapy |
| Physician Office Visits | Office visits, including those provided through telehealth | • $10 copayment except for preventive health services |
| Pregnancy and Maternity Care | • Professional and inpatient hospital services including prenatal and postnatal care, newborn, and nursery care for the member's newborn.<br>• Newborn coverage is limited to the first **30 days** of life. | • No copayment |

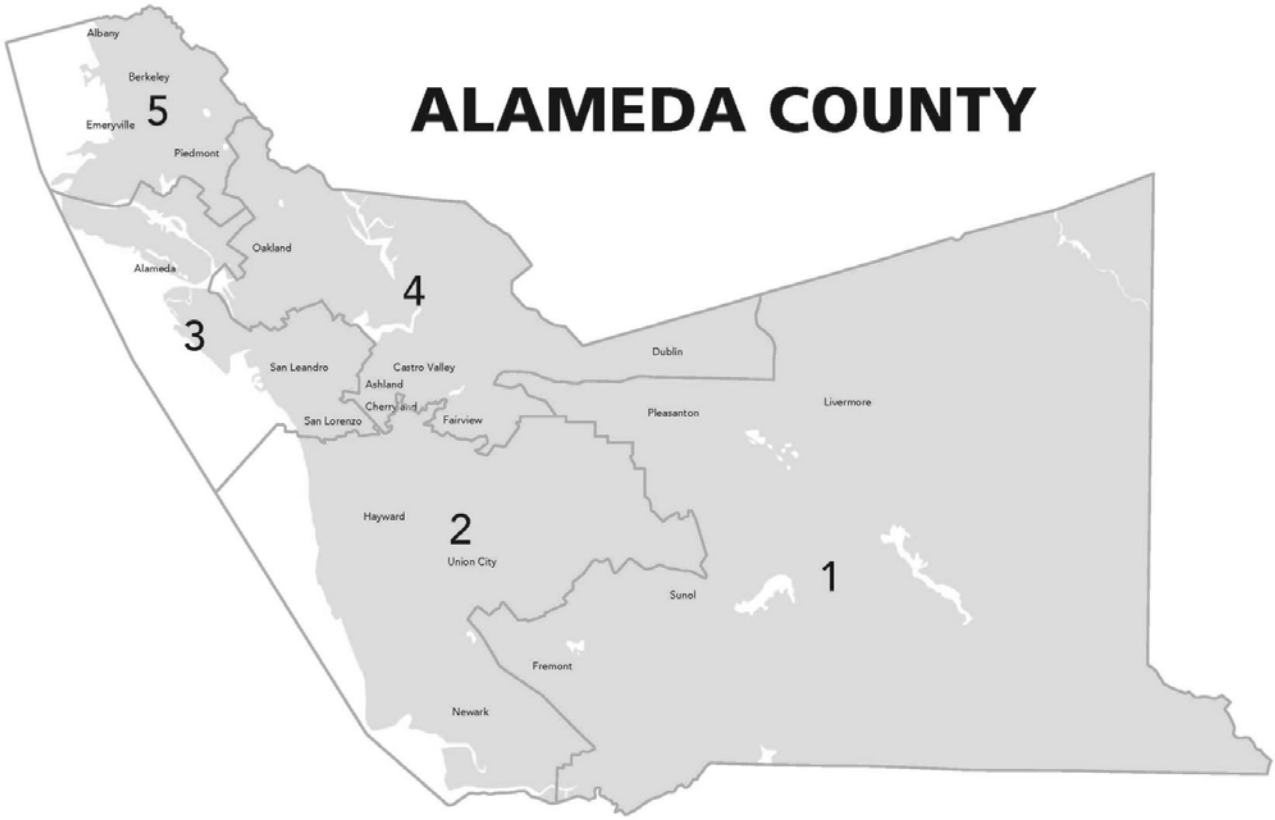
| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Prescription Drug Coverage | • **30-day** supply.<br>• One (1) cycle of tobacco cessation drugs per benefit year. Inpatient drugs – No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the provider's office or an outpatient facility setting. | • $10 copayment for generic drugs<br>• $15 for brand-name prescription drugs<br>• Up to $250 copayment for oral anticancer medications<br>• Up to $500 copayment for bronze products<br>Note: Copayments will not be higher than the in-network pharmacy's retail price for a prescription drug |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Preventive Health Services | • Annual cervical cancer screening tests including PAP smear exams<br>• Breast Cancer Screening including mammography, ultrasound, MRI.<br>• Colon Cancer Screening<br>• Comprehensive preventive care for children<br>  o Periodic health evaluations<br>  o Immunizations<br>  o Laboratory services in connection with periodic health evaluations<br>• Confidential HIV counseling, testing, and vaccine<br>• Immunizations<br>• Osteoporosis screening and testing<br>• Periodic health examinations<br>• Vision and hearing testing<br>• Venereal disease testing | • No copayment |
| Reconstructive Surgery | Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do any of the following: (A) To improve function; (B) To create a normal appearance, to the extent possible; (C) To treat gender dysphoria/gender incongruence. | • No copayment |

| Benefit | Description/Limitations | Copayment |
|---|---|---|
| Second Opinions | If you have questions about a treatment or surgery that your provider says you need, you may ask for a second opinion. To receive a second opinion from a provider in the Alliance network, prior authorization from the Alliance is not required. A prior authorization from the Alliance is required to receive an out-of-network second opinion. Your treating physician will need to submit a prior authorization request to the Alliance. You should speak to your PCP if you want a second opinion referral. All in-network second opinion referrals do not require a prior authorization. | • No impact on copayment |
| Skilled Nursing Care | Medically necessary skilled nursing care including room and board, x-ray and laboratory services, and other ancillary services, medications, and supplies up to **100 days** per benefit year. | • No copayment |
| Therapeutic Footwear | Footwear (shoes, shoe inserts) is covered if you are diabetic only. | • No copayment |
| Urgent Care Services | Services received at an urgent care center. (Copayment is waived if the member is hospitalized.) | • $10 copayment per visit |
| Vision Services | Contact the Public Authority for information about vision services at **1.510.577.3552**. | • Per Public Authority |

# 2. Introduction

## Service area




## Welcome to Alameda Alliance for Health (Alliance)!

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

# This booklet

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

If you have any questions about your coverage or any of the plan benefits, you may call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

# Member services

The Alliance Member Services Representatives can assist you with information about Alliance benefits and services.

We can also:

- Help answer questions about the Alliance.
- Help you choose a primary care provider (PCP).
- Tell you where to get the services you need.
- Provide you with language or translation services if English is not your preferred language. Members with hearing and speaking impairments may use the California Relay Service (CRS) or teletype (TTY).
- Help you schedule an interpreter for your medical appointment.
- Help you with questions about approval for services (the authorizations and the utilization management (UM) process).
- Provide benefits information and plan letters in your language or a format such as braille, large-size print, or audio tape.

To ask for help, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). You can also visit the Alliance website at any time at **www.alamedaalliance.org**.

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

# Member identification (ID) card

All members are given a member identification (ID) card. This card contains important information about your medical benefits. If you have not received it, or if you have lost your Alliance member ID card, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). We will send you a new card.

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

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

# Member rights and responsibilities

**As an Alliance member, you have these rights:**

1. To receive information and advice about the Alliance, its programs, its doctors, the health care network, Advance Directive, and your rights and responsibilities.
2. To receive services and care without discrimination of race, color, ethnicity, national origin, religion, immigration status, age, disability, socioeconomic status, gender identity, or sexual orientation.
3. To be treated with respect at all times.
4. To keep your health information private, receive a copy, review and request changes to your health records.
5. To choose a doctor (also called a primary care provider or PCP) within the Alliance network and help make choices about your health care with your doctor. This includes the right to refuse treatment.

6. To talk freely with your doctors about treatment options for your health and help make choices about your health care with your doctor, this includes the right to refuse treatment.
7. To voice a grievance (or complaint) about the Alliance, its doctors, or the care we provide, or ask for a State Medi-Cal Fair Hearing.
8. To receive translation and interpreter services, and written information in other formats (audio, braille, large size print, etc.).
9. To have access to family planning services, Federally Qualified Health Centers (FQHCs), Indian Health Service (I) facilities, sexually transmitted disease services, emergency services outside the Alliance's network, Minor Consent services, and specialty services (i.e., durable medical equipment (DME)).
10. To leave the Alliance upon request at any time, subject to any restricted disenrollment period.
11. To continue to see your doctor if you are no longer covered by the Alliance under certain circumstances.
12. To be free from any form of restraint or rejection used as a means of pressure, discipline, convenience, or retaliation.
13. To use these rights freely without changing how you are treated by the Alliance, doctors, and the health care network, or the state.
14. To access the Advice Nurse Line, anytime, 24 hours a day, 7 days a week. Group Care members can call toll-free at **1.855.383.7873**.
15. To access telephone triage or screening anytime, 24 hours a day, 7 days a week, by calling your doctor.
16. To access your medical records. You have the right to share the records of any telehealth services provided with your primary care doctor. These records will be shared with your primary care doctor, unless you object.

If you would like more information about your right to make decisions about medical treatment or advance directives, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

**As an Alliance member, you have these responsibilities:**

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

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

# 3. Eligibility, enrollment, effective date of coverage, and member financial responsibility

## Eligibility requirements

You will be enrolled in the Alliance Group Care program in accordance with the rules and regulations set forth by the Public Authority. To contact the Public Authority, please call **1.510.577.3552**.

### Dependents

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

### Other rules of eligibility

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

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

### Notification of eligibility changes

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

# Effective date of coverage

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

## Replacement coverage

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

# Financial responsibilities

## Periodic prepayment fees

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

## Copayments, deductibles, and other charges

There are no deductibles or annual or lifetime financial benefit maximums. However, some benefits have annual maximums based on the frequency of services. Members are financially responsible for the specific copayments listed in the **Benefits and coverage matrix**, **Medical benefits**, and **Mental health** sections of this document.

If you have any questions regarding copayments, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

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

# 4. Choice of physicians, providers, and facilities

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

## Provider and facilities locations

You received a Provider Directory in your enrollment packet. To request another copy, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). You can also view the Provider Directory online at **www.alamedaalliance.org**. The Provider Directory lists all of the providers contracted with the plan who provide services to Alliance Group Care members. The names and locations of PCPs, specialist physicians, non-physician health care practitioners, clinics, skilled nursing facilities, and hospitals are included in the directory. Before selecting a PCP, you should verify if the PCP is accepting new patients by calling the PCP's office.

Some hospitals and other providers do not provide one (1) or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Please call your prospective doctor, medical group, independent practice association, or clinic, or call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**) to ensure that you obtain the health care services that you need.

## Liability of member for payment

Members are not financially responsible for covered services, other than for applicable copayments, if referred and authorized, as medically necessary. If the member receives services and fails to consult their PCP for the necessary approval, or fails to adhere to the Alliance's referral and/or authorization procedures, the member will not be covered for such services and will be liable for the entire payment for those services, except in emergencies.

If you are outside the service area and need non-emergency or non-urgent medical services, contact your PCP to get authorization before you receive these services. Non-emergency or non-urgent services received outside of the Alliance service area or outside of the network without authorization from the Alliance before receiving such services are not covered. However, members will not be liable for payment for emergency services. In the event the plan fails to pay a non-contracting provider for services rendered, the member may be liable to the non-contracting provider for the cost of the services.

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

## How to choose and access a PCP

You are required to have a PCP and should select a PCP within **30 days** of the effective date of coverage. Choose a PCP from the Provider Directory. You may request a paper copy of the Provider Directory by calling the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). You can also visit the Alliance website to view the online Provider Directory at **www.alamedaalliance.org**. Your PCP should be within the Alliance provider network and close to where you work or live. You can also look for a clinic that speaks your preferred language or meets your accessibility needs. If the PCP you choose is not accepting new patients, you will be asked to choose another PCP.

If you do not choose your PCP within **30 days** of when you become a member, we will let you know that we have not received your choice and we will choose a PCP for you. We will make every reasonable effort to match you with a PCP based on your needs. If you are not happy with the choice we make, you can call the Alliance Member Services Department to choose a PCP yourself. For help, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

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

We work with qualified PCPs and specialist doctors. To find out about the background of one of our doctors in our network, such as their specialty or whether they are Board certified, visit our online Provider Directory at **www.alamedaalliance.org**. You can also call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

If you need help in choosing a PCP, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Making an appointment

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

When you call to schedule an appointment, you may not be able to see the provider right away. Alliance providers are required to respond within certain timeframes when scheduling an appointment. (*See **Chapter 5: Timely access to care** for further information*).

## Your initial health exam

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

## Change an appointment

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

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

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

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

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

## Changing your PCP

It is best to stay with the same PCP so they can get to know your needs. However, you may change your PCP for any reason. If you need to change your PCP, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

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

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

We may require you to change your PCP if you:

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

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

# How to get care when your PCP's office is closed

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

You can also call the 24/7 Advice Nurse Line toll-free at **1.855.383.7873**.

# Continuing care

## New members

Under some circumstances, the Alliance will provide Continuity of Care for new members who are receiving medical services from a non-participating provider, such as a physician or hospital, when the Alliance determines that continuing treatment with a non-participating provider is medically appropriate.

If you are a new member or receiving services for a maternal health condition, you may request permission to continue receiving medical services from a non-participating provider if you were receiving this care before enrolling in the Alliance and if you have one (1) of the following conditions:

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

- ***Terminal illness* –** Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed 1**2 months** from the time you enroll with the Alliance.

To obtain a copy of our Continuity of Care policy, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). Normally, eligibility to receive Continuity of Care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable copayments under this plan.

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

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

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

## Terminated providers

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

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

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

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

To obtain a copy of our Continuity of Care policy, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). Normally, eligibility to receive Continuity of Care is based on your medical or maternal mental health condition. Eligibility is not based strictly upon the name of your condition. Continuity of Care does not provide coverage for benefits not otherwise covered under this agreement. If your

request is approved, you will be financially responsible only for applicable copayments under this plan.

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

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

# 5. Timely access to care

The wait times listed below apply to Alliance provider types that are PCPs, ancillary, specialty, and mental health.

| Appointment Type | Conditions | You should be able to get an appointment within: |
|---|---|---|
| Urgent Care | Services that do not require a prior authorization | 48 hours |
| | Services that require a prior authorization | 96 hours |
| Non-urgent Care | For the diagnosis or treatment of injury, illness, or other health problem | 10 business days |
| Non-urgent Specialist Care | Non-urgent appointments with specialist physicians | 15 business days* |
| Non-urgent Mental Health Care | Non-urgent appointments with a non-physician mental health care provider | 10 business days* |
| Non-urgent Ancillary Care | For the diagnosis or treatment of injury, illness, or other health condition | 15 business days* |
| Follow-Up Care Mental Health/ Substance Use Disorder | Mental health/substance use disorder follow-up appointment (non-physician) | 10 business days from prior appointment |

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

**Preventive and follow-up care –** The following preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating health care provider acting within the scope of their practice:

- Comprehensive preventive care of children
  - Periodic health evaluations
  - Immunizations
  - Laboratory services in connection with periodic health evaluations
- Standing referrals for chronic problems
- Pregnancy
- Cardiac conditions
- Mental health conditions
- Lab and radiology services
- Other follow-ups as ordered by your provider

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

**Triage or screening –** The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage a member who may need care, to determine the urgency of the member's need for care.

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

When you have an appointment, please be on time.

To make the most of your time with the PCP:

- Ask questions if you do not understand what you need to know.
- Bring a list of health problems and questions.
- Bring the medicines you are using.
- Remember to bring your Alliance member ID card.

- Tell your PCP what you have already done to treat any conditions you have and any ideas you have for treatment.
- Tell your PCP what you think the problem is, even if you do not think it is important. This may help the PCP.

# 6. How to use your health plan

## Referrals and authorizations for services

### Referrals to specialists

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

If your PCP is a provider with the Community Health Center Network (CHCN), this information will be on your Alliance member ID card. If you see this information on your Alliance member ID card, it means that you will need to see specialists within their network. If you have any questions, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

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

- Alliance specialists' physician office visits
- Diagnostic x-rays, including mammograms
- Laboratory services

### Mental health (MH) services

Mental health (MH) services are covered benefits through the Alliance. For more information on mental health services, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

### Standing referrals

If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing referral to a specialist to receive continuing specialized care. If you receive a standing referral to a specialist, you will not need to get a referral every time you see that specialist.

Additionally, if your condition or disease is life-threatening, degenerative, or disabling, you may need to receive a standing referral to a specialist or specialty care center that has expertise in treating your condition or disease and to have the specialist coordinate your health care.

To get a standing referral, please call your PCP.

## Services that do not require a referral – Alliance providers

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

- Diagnosis and treatment of sexually transmitted infection
- Family planning
- OB/GYN services
- Prenatal care
- Services provided by your PCP
- Abortion services
- Urgent and emergent services *(See **Chapter 8: Emergent, urgent, and routine care** for further information.)*
- Diagnosis and treatment of sexual assault or rape, including the collection of medical evidence about the alleged rape or sexual assault

## Authorizations

The Alliance must approve some medical services, medical equipment, and/or medications before you get them. This process is called utilization management or UM. Your provider knows which services require authorization. Prior approval is done by having your provider submit an authorization request to the Alliance. The authorization is reviewed to ensure that you are receiving services that are medically necessary and are covered by the Alliance. If medically necessary covered service is not available in network within geographic and timely access standards, the Alliance will arrange out-of-network and follow-up services.

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

1. We check if a service is medically needed and covered by the Alliance before making a UM decision. When the Alliance gets an authorization request from a provider, our medical staff (doctors, nurses, and pharmacists) review it. They review each case to make sure you are getting quality care and the most

appropriate treatment for your medical or behavioral condition according to clinical guidelines.
2. We do not reward anyone who makes a UM decision, which includes doctors when they deny coverage for a service to a member.
3. We do not give anyone extra money to keep you from getting the care you need or for getting less care.

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

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

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

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

- Durable medical equipment (DME), such as orthotics, and prosthetics
- Electroconvulsive therapy (ECT)
- Home health care
- Hospice care
- Inpatient drug and alcohol abuse services
- Inpatient hospital services
- Inpatient mental health services
- Outpatient physical, occupational, or speech therapy
- Outpatient transcranial magnetic stimulation (TMS)
- Psychological and neuropsychological testing
- Services from non-Alliance providers

- Skilled nursing facility care
- Some prescriptions

## Second opinions

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

Reasons you may ask for a second opinion include:

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

You should speak to your PCP if you want a second opinion. To receive a second opinion from a provider in the Alliance network, prior authorization from the Alliance is not required. For second opinions from a provider outside of the Alliance network, your treating physician will need to submit a prior authorization request to the Alliance.

The Alliance will tell you within **five (5) business days** if the provider you choose for a second opinion is approved. If your medical condition poses an imminent and serious threat to your health, including, but not limited to, the potential loss of life, loss of limb, loss of bodily function, or substantial impairment, or if a delay would be detrimental to your ability to regain maximum function, your request for a second opinion will be processed within **72 hours** after the Alliance receives your request.

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

If your request to obtain a second opinion is denied and you would like to contest the denial, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

# New technology

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

# 7. Available services

## Abortion services

Abortion services are covered only if provided by an Alliance provider. Members do not need approval from their PCP for this service. Abortion and abortion related services are covered without cost share, deductible, annual or lifetime limits or prior authorization requirements.

## Alliance health education services

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

We are here to help you, please call:

Alliance Health Programs
Phone Number: **1.510.747.4577**

Alliance 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**

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

## Asthma services

Asthma affects both children and adults. It can be very hard to breathe during an asthma episode (attack). The good thing is that most people can learn to control their asthma and stay healthy. Work with your PCP to create an asthma action plan. Your PCP and Alliance

Health Programs can help you learn how to avoid things that trigger asthma and to use medicine the best way. With good management, you can help prevent attacks. Services include outpatient prescription drug benefits for inhaler spacers, nebulizers including face masks and tubing, peak flow meters, and education for asthma when medically necessary for the management and treatment of pediatric asthma.

For more information on asthma, please call Alliance Health Programs at **1.510.747.4577**.

## Breastfeeding services

Breastfeeding has great benefits for the mom and baby. Breastmilk has all the nutrition needed to help your baby stay healthy, and it costs a lot less than formula. The Alliance offers breastfeeding resources such as education referrals, breastfeeding support, and breast pump referrals all at no cost. For more information on breastfeeding services, please call Alliance Health Programs at **1.510.747.4577**.

## California Children's Services (CCS)

As part of the services provided, Alliance members under age 21 requiring specialized medical care may be eligible for California Children's Services (CCS).

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

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

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

The Alliance will continue to provide primary care and comprehensive preventive care for children that includes hospital, medical, and surgical that are not related to the CCS-

eligible condition, as described in this document, and will also work with the CCS Program to coordinate care provided by both the CCS Program and the Alliance.

## Care coordination

The Alliance offers Case Management services to help you coordinate your health care needs at no cost to you. The Alliance will coordinate with other programs to ensure that you receive all medically necessary services, even if those services are covered by another program and not the Alliance. If you have questions or concerns about your health, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Confidential HIV counseling, testing, and treatment services

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

Formulary prescription coverage for antiretroviral medications including PrEP are available in the Pharmacy Benefit without prior authorization/step therapy requirement.

The Alliance covers vaccines for acquired immune deficiency syndrome (AIDS) that are approved for marketing by the federal Food and Drug Administration and recommended by the United States Public Health Service. The Alliance does cover for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has been approved by the federal Food and Drug Administration in the form of an investigational new drug application.

## Diabetes management services

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

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

If you have diabetes, you must take an active part in caring for yourself each day. Through a team effort between you, your PCP, and the Alliance, we can better manage your diabetes. You should have regular check-ups with your PCP to check your feet, blood pressure, and blood glucose. You should also have a diabetic eye exam each year with an eye care doctor. Your PCP can also refer you to a diabetes education program. There you will learn about diabetes self-care, such as taking medicines, testing your blood, meal planning, exercise tips, and how to lower stress. For more information on diabetes education programs, please call Alliance Health Programs at **1.510.747.4577**.

## Drug and alcohol treatment services

Drug and alcohol treatment services (detoxification) are covered benefits through the Alliance. For more information on drug and alcohol treatment services (detoxification), please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Family planning services

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

## Fertility preservation services

The following fertility services are covered when medically necessary in accordance with professionally recognized standards of practice:

- Physician services, including consultation and referral
- Hospital inpatient services and outpatient care services
- Diagnostic laboratory, and diagnostic and therapeutic radiologic services

These services are covered when a medically necessary treatment like surgery, chemotherapy, radiation, or other medical treatment directly or indirectly caused infertility.

## Genetic testing and counseling services

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

## Gynecological services

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

Women should get an annual (yearly) check-up, including a gynecological exam from their PCP or an OB/GYN. A good way to remember these visits is to schedule an appointment around your birthday each year. These check-ups help you stay healthy. If you want more information about these exams, please call Alliance Health Programs at **1.510.747.4577**.

## New baby services

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

## Mental health (MH) services

Mental health (MH) services are covered benefits through the Alliance. For more information on MH services, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Outpatient pharmacy services

A doctor from the Alliance provider network must write your prescriptions except when you receive emergency or urgent care services. You must get the drugs from a pharmacy in the Alliance pharmacy network, except for emergency or urgent care situations. Be sure to bring your Alliance member ID card with you to the pharmacy.

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

The Alliance provides continuation of therapy for members using medically necessary drugs when it can be shown through clinic notes/provider attestation for OTC products or prescription previously approved fill history that the member has been taking the medication.

**Medication Tier** – A group of prescription medication that correspond to a specified cost-sharing tier in the health plan's prescription medication coverage. The tier in which a prescription medication is placed determines the enrollee's portion of the cost.

**Out-of-Pocket Cost** – Copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

**Please Note:** Types of tiers on the Alliance formulary include Tier 2 (generic medications) and Tier 3 (brand medications). Tier 2 medications have a $10 copayment for a **30-day** supply and Tier 3 medications have a $15 copayment for a 30-day supply. The Alliance has a mandatory generic medication program that promotes the use of generic over brand-name options

## Formulary and non-formulary drugs

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

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

To find out if a drug is on the formulary, or to obtain a copy of the formulary, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

The formulary is also available on our website at **www.alamedaalliance.org**. A drug that is on the formulary list does not guarantee that your doctor will prescribe that drug.

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

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

You have the right to request an external review when the Alliance denies a prior authorization (PA) request for a drug that is not covered by the plan or for an investigational drug or therapy. A request for an external review will not prevent you from filing a grievance or Independent Medical Review (IMR) with the California Department of Managed Health Care (DMHC).

Each outpatient prescription request will be reviewed via a PA exception request within **24** (for urgent requests) to **72 hours** (for non-urgent requests) from the time received. Coverage determination documents will be sent to the enrollee (or their designee) and the enrollee's prescribing provider within this time based on urgent or non-urgent status. Coverage determination documents will include information on appeal rights, procedures, and duration of coverage. If the plan fails to respond to a completed prior authorization exception request within **24** (for urgent requests) to **72 hours** (for non-urgent requests), then the request will be approved.

## Brand-name and generic drugs

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

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

### Quantity limits/day supply limit

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

### Step therapy

The Alliance has a "Step therapy" program where some prescription drugs are to be tried first as medically appropriate for a given condition and as prescribed. In this program, the Alliance may require the enrollee to try and fail one or more preferred, cost-effective and/or safe drugs to treat the enrollee's medical condition first before the Alliance will cover an alternative drug. If the enrollee's prescribing provider submits a request for step therapy exception, the Alliance will make exceptions to step therapy when the criteria is met.

### Partial Fill

The Alliance has availability of prescription partial fills of approved medically necessary medications.

## Pregnancy services

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

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

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

# Sexually transmitted disease care

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

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

- Certified midwives and certified nurse practitioners
- Family planning sites
- Primary care providers (PCPs)
- STD testing and treatment sites
- Women's specialists (OB/GYNs)
- Home test kits and lab processing of kits

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

# 8. Emergent, urgent, and routine care

## What to do in an emergency

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

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

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

When you need emergency care, go to the nearest emergency room or call **911**. Show the emergency room staff your Alliance member ID card. If you receive emergency services inside or outside of the plan service area and receive a bill, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

**If you are experiencing a mental health or substance use crisis, or have thoughts of suicide, call or Text "988" or chat 988lifeline.org**

### Post stabilization and follow-up care

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

Once your emergency medical condition has been treated at a hospital and an emergency no longer exists because your condition has become stable, the doctor who

is treating you may want you to stay in the hospital for a while longer before you can safely leave the hospital. The services you receive after an emergency condition is stabilized are called “post-stabilization services.”

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

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

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

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

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

## Getting urgent care services

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

Urgent care services are those services:

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

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

### In Alameda County

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

If you are unable to see your PCP, you may go to any in-network urgent care facility in Alameda County. For a list of contracted urgent care centers, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

### Outside of Alameda County

If you need urgent care services while you are outside of Alameda County, you are encouraged to call your PCP. You can obtain urgent care services without authorization and without calling your PCP. If you get urgent care treatment while outside of the Alliance service area and you get a bill, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). (*See **Chapter 11: Coordination of benefits and third-party liability** for further information.*)

## Non-emergent/urgent services

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

## How to get routine care

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

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

# 9. Schedule of medical benefits

Benefits are subject to referral by your PCP, authorization, applicable copayments, and all other terms, conditions, limitations, and exclusions of this EOC, including those listed in the **Exclusions/limitations** section.

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

## Abortion

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

**Cost to member:**

- $10 copayment per visit.

## Acupuncture

Acupuncture services are provided as a self-referral benefit. Services must be obtained from an Alliance participating provider. They are typically provided only for the treatment of nausea or as a part of comprehensive pain management program for the treatment of chronic pain.

**Cost to member:**

- $5 copayment.

**Exclusions/limitations:**

- Benefits are limited to 10 visits per benefit year.

## Advice Nurse Line

The Advice Nurse Line is offered 24/7 to all members to help answer your health questions regarding common illnesses and conditions, healthy lifestyle tips, health

screenings, and shots. The Advice Nurse Line links you to a registered nurse (RN) who will discuss your health and wellbeing.

The RN will also help you decide what kind of care to seek, including:

- If your health problem can be treated at home;
- If you should see a doctor; or
- If you might need to get urgent or immediate care.

To access the 24/7 Advice Nurse Line, members can call toll-free at **1.855.383.7873**.

# Cataract spectacles and cataract lenses

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

Contact lenses may be determined to be medically necessary in the treatment of these conditions:

- Aniridia
  - Up to **two (2)** medically necessary **contact lenses** per eye (including fitting and dispensing) **in any 12-month period**, whether provided by the plan during the current or a previous **12-month** contract period.
- Aphakia
  - Up to **six (6)** medically necessary **aphakic contact lenses** per eye (including fitting and dispensing) **per calendar year for members**, whether provided by the plan under the current or a previous contract **in the same calendar year.**

**Cost to member:**

- No copayment.

# Chiropractic services

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

**Cost to member:**

- $10 copayment.

**Exclusions/limitations:**

- Benefits are limited to 20 visits per benefit year.

# Clinical trial

Qualifying clinical trials are studies in any phase of development that is conducted in relation to the treatment of any serious or life-threatening disease or condition that has been approved, conducted, or supported by any of the organizations listed in federal law[1]. Treatment includes new drugs or other cancer treatments..

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

- Member must be diagnosed with cancer, or other life-threatening diseases or conditions;
- Member must be accepted into a phase I throughIV clinical trial for cancer or other life-threatening diseases or conditions;
- Clinical trial is approved by one of the following: The National Institutes of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs (need a national clinical trial number);
- Involve a drug that is exempt under the federal regulations from a new drug application.
- Member's treating provider must recommend participation in the clinical trial after determining that participation is potentially meaningful to benefit the member with a signed attestation.

Benefits include the payment of costs associated with delivering healthcare services, including drugs, items, devices, or services that would otherwise be covered if they were not provided in connection with an approved clinical trial program.

Routine patient costs for clinical trials include:

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

**Cost to member:**

- $10 copayment for office visits.
- 10 copayment for a 30-day supply of generic prescription drugs (outpatient medications outside of clinical trial)
- $15 copayment for a 30-day supply of brand-name prescription drugs (outpatient medications outside of clinical trial)

**Exclusions/limitations:**

- Investigational item or service that is the subject of the qualifying clinical trial.
- Any item or service associated with the qualifying clinical trial that is excluded from coverage under the Medi-Cal program
- Any item or service that is provided only to individual to fulfill data collection and analysis needs for the qualifying clinical trial.
- Non clinical expenses associated with the clinical trial that are not considered a covered service.
- .
- Health care services that are customarily provided by the research sponsors at no cost for anyone enrolled in the trial.
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental).
- Outpatient self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications as prescribed by the member's Alliance provider.
- Provision of non-FDA-approved drugs or devices that are the subject of the trial.

- Member is not restricted to participation in a qualifying clinical trials at participating hospitals and physicians in California, unless the protocol for the clinical trial is not provided for at a California hospital or via California physician.

## COVID-19 immunizations, diagnostic and screening testing, therapeutics, and treatment

The Alliance covers COVID-19 testing, vaccines and therapeutics. There is zero cost sharing for these services. No prior authorization is required for COVID-19 diagnostic and screening testing and for related health care services for granted emergency use authorization by the federal Food and Drug Administration. Covered testing includes Members who:

- Have symptoms of COVID-19.
- Have recent known or suspected exposure to SARS-CoV-2.
- Are asymptomatic and do not have recent known or suspected exposure to SARS-CoV-2 if the COVID-19 test reflects an individualized clinical assessment.

In addition, no prior authorization is required for COVID-19 therapeutics if you test positive.

If you have a positive home COVID-19 test, please contact your doctor to find out if COVID-19 therapeutic treatments are right for you.

If you need help contacting your doctor, please call:

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

## Dental services

For information about dental services, contact the Public Authority at **1.510.577.3552**.

# Diabetic management and treatment

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

- Blood glucose monitors and blood glucose testing strips, including blood glucose monitors designed to assist the visually impaired
- Continuous glucose monitor (CGM)
- Glucagon
- Insulin
- Insulin pumps and all related necessary supplies
- Insulin syringes
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Outpatient self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications as prescribed by the member's Alliance provider
- Pen delivery system for the administration of insulin
- Podiatric devices to prevent or treat diabetes complications
- Prescriptive medications for the treatment of diabetes
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

**Cost to member:**

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

# Diagnostic and laboratory services

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

- Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer
- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes

- Tests for management of diabetes, cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (glycohemoglobin)
- Generally accepted cancer screening tests to include breast, cervical, colon, lung, prostate, cancer screening and/or cytology exams on a periodic basis, including any test approved by the FDA upon referral by the member's health care provider and consistent with generally accepted medical practice and scientific evidence
- Diagnosis and testing for osteoporosis. These services may include, but need not be limited to, all Food and Drug administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

**Cost to member:**

- No copayment.

## Durable medical equipment (DME)

Medical equipment appropriate for use in the home that:

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

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

Examples include:

- Home Dialysis equipment and supplies
- Enteral pump and supplies
- Oxygen and oxygen equipment
- Pulmoaides and related supplies
- Nebulizer machines, tubing, and related supplies, and spacer devices for metered dose inhalers
- Ostomy, urological, and incontinence supplies
- Wheelchairs

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

- Comfort or convenience items or luxury equipment or features.
- Disposable supplies except for all ostomy, urinary, and incontinence supplies that are medically necessary and consistent with Rule 1300.67.005(d)(8).
    - Supplies required under this section do not include supplies that are comfort, convenience, or luxury equipment or features.
- Exercise and hygiene equipment; experimental or research equipment.
- Devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile.
- Deluxe equipment.
- More than one (1) piece of equipment that serves the same function.

# Emergency services

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

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

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

**Cost to member:**

- $35 copayment (waived if admitted to the hospital).

# Family planning

Please see your PCP for family planning services.

Family planning services covers counseling and planning for contraception, fitting exam for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). Sterilization of females and women's contraception methods and counseling, as supported by the Health Resources and Services Administration ("HRSA") guidelines are covered as Preventive Care Services.

Sterilization of males is also a covered Family Planning benefit. Covered services are not subject to prior authorization or deductible, coinsurance, or copayments. You may receive Family planning services from a Network Provider that is licensed to provide these services.

Examples of Family planning providers include:

- Your PCP.
- Clinics
- Certified Nurse Midwives and Certified Nurse Practitioners
- OB/GYN specialists
- Physician Assistant.
- Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable and implantable contraceptives. Prescribed contraceptives for women are covered as described in the "Prescription Drugs" section below.

Our plan covers FDA-approved prescription contraceptives or over the counter, including these vaginal, oral, transdermal, and emergency contraceptives devices at a $0 co-pay, such as oral contraceptives, emergency contraception pills, contraceptive rings, contraceptive patches, cervical caps, and diaphragms. Covered contraceptives are only available with a Prescription Drug Order. You must present the Prescription Drug Order at a participating pharmacy to get such drugs or contraceptives. Your medical practitioner can request Alliance authorization for the use of a non-covered contraceptive drug or device if a covered contraceptive is unavailable or deemed medically inappropriate for your medical or personal history. If a covered therapeutic equivalent is deemed medically inadvisable, the Alliance shall defer to the determination and judgment of your doctor and provide coverage for the non-covered drug. These contraceptive drugs and devices are provided at $0 co-pay the Alliance approves the authorization request. In addition, FDA-approved, self-administered hormonal contraceptives are covered for 12 months. A prescription is not required for coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products. Members are not responsible for the cost of preventive medications. Drugs that are covered under the program include over-the-counter drugs and prescription drugs used for preventive health purposes per the American Preventive Services Task Force A and B recommendations.

**Cost to member:**

- No copayment or cost-sharing.

**Exclusions/limitations:**

- In-vitro fertilization.

## Hearing test and aids services

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

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

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

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

## Home health care services

Home health care services are the delivery of skilled medical services such as short-term physical therapy, occupational therapy, speech therapy, and respiratory therapy

when prescribed by a plan practitioner (subject to visit limitations under the Physical/Occupational/ Speech Therapy benefit). These services are provided by Alliance-contracted providers to a homebound member and include visits by RNs, LVNs, and home health aides.

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

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

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

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

**Cost to member:**

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

**Exclusions/limitations:**

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

# Hospice care

The Alliance provides hospice care for its members who are terminally ill. Members have the option to choose this home-based treatment instead of the other benefits for terminal illnesses that are covered by the Alliance. Terminal illness is defined as a

medical condition resulting in a prognosis of life expectancy of **one (1) year** or less if the disease follows its natural course.

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

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

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

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

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

# Hospital services/inpatient

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

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

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

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

**Cost to member:**

- $100 copayment per admission except for pregnancy and maternity care.

**Exclusions/limitations:**

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

# Medical transportation services

- **Emergency ambulance services –** Air ambulance and ambulance transportation to the nearest hospital is covered if the member had reason to believe that the medical condition was an emergency and that the condition required emergency transportation. This includes ambulance transportation services provided through the "**911**" emergency response system.
- **Authorized ambulance services –** Ambulance services to transfer a member to or from a participating hospital or skilled nursing facility in connection with an authorized confinement/admission will be authorized only when transportation by other means would adversely affect the member's medical condition, whether or not such other means of transportation are available.
- **Nonemergency ambulance and psychiatric transport services** – Ambulance services when the Alliance and Alliance network doctor determines a member's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and the use of other means of transportation will endanger the member's health. These services are covered only when the vehicle transports the member to and from the covered service.

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

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

# Mental health (MH) and substance use disorder (SUD) care

Mental health (MH) services are covered by the Alliance. To access MH services, please call Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). All MH conditions identified as a mental disorder in the Diagnostic and Statistical Manual (DSM), Fifth Edition, are covered, including severe mental illnesses (SMI), and court Community Assistance Recovery and Empowerment (CARE) agreements in accordance with SB 1388. The Alliance also covers all substance use disorder (SUD) services.

## Inpatient MH and SUD services

Inpatient mental health (MH) and substance use disorder (SUD) are covered by the Alliance and include room and board, drugs, and services of physicians and other providers who are licensed healthcare professionals acting within the scope of their license..

Inpatient MH and SUD benefits include:

- MH psychiatric hospitalization
- Short term MH Crisis Residential Program in a licensed psychiatric treatment facility with 24 hour a day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- SUD inpatient detoxification, as medically appropriate to remove toxic substances from the system
- SUD inpatient services

## Outpatient MH and SUD services

Outpatient mental health (MH) and substance use disorder (SUD) services are used to provide crisis intervention and treatment of alcoholism, drug abuse, or MH on an outpatient basis as medically appropriate.

Outpatient MH and SUD benefits that are office visits include:

- MH individual and group evaluation and treatment
- Psychological testing when necessary to evaluate a mental health disorder

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

Outpatient MH and SUD benefits other than office visits include:

- Behavioral health treatment for pervasive developmental disorder (PDD)/Autism
- MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program); day treatments programs
- Opioid replacement therapy
- Observation for an acute psychiatric crisis
- SUD intensive outpatient program
- SUD medication and medical treatment for withdrawal
- Transitional residential recovery services which provides counseling and support services in a structured environment

**Cost to member:**

- $100 copayment per admission.
- $10 copayment for outpatient MH and SUD office visit benefits.
- No copayment for outpatient MH and SUD benefits other than office visits.
- No copayment or cost-sharing for court ordered CARE agreement pursuant to SB 1338.

# Organ transplant benefits

Organ transplant benefits include coverage for medically necessary organ, tissue, and bone marrow transplants that are not experimental or investigational.

Organ transplant benefit includes payment for:

- Medically necessary and reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor, if these expenses are directly related to the transplant for a member.
- Testing members' relatives as potential donors.
- Searching for and testing unrelated bone marrow donors through a recognized donor registry.

- Charges associated with procuring donor organs, tissue, or bone marrow through a recognized donor transplant bank are covered if the expenses are directly related to the anticipated transplant for the member.

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

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

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

**Organ donor:**

The Alliance covers organ donation services for actual or potential living donors, in addition to transplant services of organs, tissue, or bone marrow required as follows:

- Coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is an member. Services must be directly related to a covered transplant for the member, which shall include services for harvesting the organ, tissue, or bone marrow and for treatment of any complications.
- Services are directly related to a covered transplant service for member or are required for evaluating potential donors, harvesting the organ, bone marrow, or stem cells, or treating complications resulting from the evaluation or donation. These transplant services exclude blood transfusions or blood products.
- Donor receives covered services no later than 90 days following the harvest or evaluation service;
- Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;
- Donor receives written authorization for evaluation and harvesting services;
- For services to treat complications, the donor either receives non-emergency services after written authorization, or receives emergency services the plan would have covered if the member had received them.

- In the event the member's plan membership terminates after the donation or harvest, but before the expiration of the 90-day time limit for services to treat complications, the plan shall continue to pay for medically necessary services for donor for 90 days following the harvest or evaluation service.

**Exclusions/limitations:**

- Treatment of donor complications related to a stem cell registry donation
- HLA blood screening for stem cell donations, for anyone other than the enrollee's siblings, parents, or children
- Services related to post-harvest monitoring for the sole purpose of research or data collection
- Services to treat complications caused by the donor failing to come to a scheduled appointment or leaving a hospital before being discharged by the treating physician.

# Orthotics and prosthetics

The Alliance covers medically necessary prosthetic and orthotic devices (and replacement) as prescribed by a practitioner.

The benefit includes payment for:

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

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

- Corrective shoes, shoe inserts, and arch supports, except for therapeutic footwear for diabetes.

- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts.
- Dental appliances, but oral devices for sleep apnea is covered.
- Electronic voice-producing machines.
- More than one (1) device for the same part of the body.
- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).
- Over-the-counter items.

## Osteoporosis services

Osteoporosis services include:

- Diagnostic, treatment, and appropriate management of osteoporosis and need not be limited to, all Food and Drug administration approved technologies.

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

- Experimental or investigational drugs, or
- Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, are not covered benefits.

## Outpatient services

Outpatient services include:

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

**Cost to member:**

- $10 copayment per visit for physical therapy, speech therapy, and occupational therapy performed on an outpatient basis.
- $35 copayment for emergency health care services (waived if admitted to the hospital).

**Exclusions/limitations:**

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

# Phenylketonuria (PKU)

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

"Formula" is defined as an enteral product or enteral products for use at home that are prescribed by a physician or nurse practitioner or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of phenylketonuria (PKU).

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

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

**Cost to member:**

- No copayment.

# Physical, occupational, and speech therapy

Habilitative therapy is therapy to help make a part of your body work as normally as possible. Rehabilitative therapy is therapy to help restore a part of your body to its pre-injury condition. Physical, occupational, and speech therapy are types of habilitative and rehabilitative therapy. The Alliance covers such therapy if it is medically necessary.

Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home.

**Cost to member:**

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

**Exclusions/limitations:**

- Limited to short-term therapy for a period not exceeding **60 consecutive calendar days** per condition following the date of the first therapy session.
- The Alliance provides additional therapy beyond the **60 days** if medically necessary and if the condition will improve significantly.
- The **60 days** limitation does not apply to approved treatment plans for pervasive developmental disorder (PDD) or autism. However, treatment plans prescribed by a qualified autism service provider will be reviewed every **six (6) months** and modified when appropriate.

# Physician office visits

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

**Cost to member:**

- $10 copayment for office visits and home visits.
- No copayment for preventive care. *(See **Preventive health services** in this section for further information.)*

# Pregnancy and maternity care

## Prenatal and Postnatal Physician Office Visits and Delivery

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

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

## Inpatient hospital services

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

The Alliance will not restrict its inpatient hospital care to less than **48 hours** following a normal vaginal delivery and not less than **96 hours** following a cesarean section delivery.

However, coverage of inpatient hospital care may be for a time period of less than **48 to 96 hours** if the following two (2) conditions are met:

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

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

**Cost to member:**

- No copayment.

# Prescription drugs

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

The benefit includes payment for:

- Contraceptive drugs and devices, including oral and injectable medications that are FDA-approved. This includes internally time-released contraceptives such as Norplant (no refund if medication is removed). A **12-month** supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time.
- Emergency contraceptive prescription drugs are covered without prior authorization. You should contact your PCP within **72 hours** after the need for emergency contraception to obtain a prescription. Some pharmacists are trained to dispense emergency contraceptives without a prescription, but in most cases, you will need a prescription. If you use a contracted pharmacy, you will be required to pay your prescription copayment. You may obtain the medication at a non-contracted pharmacy, but you may be required to pay for the medication, and submit your receipt to the Alliance for reimbursement, less your copayment.
- Injectable medications (including insulin), needles, and syringes necessary for the administration of a covered injectable medication.
- Blood glucose testing strips in medically appropriate quantities for the monitoring and treatment of insulin-dependent, non-insulin-dependent, and gestational diabetes.
- Ketone urine testing strips for type I diabetes and lancets.
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins that require a prescription.

- Medically necessary drugs administered while a member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when provided through a pharmacy.
- Oral contraceptives pursuant to the Alliance formulary.
- Tobacco cessation drugs are covered for one (1) cycle or course of treatment per benefit year. It is recommended that the member for whom the treatment is prescribed attend a tobacco cessation program. To obtain a current listing of tobacco cessation programs/classes, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

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

To find out if a drug is on the formulary, or to obtain a copy of the formulary, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). The formulary is also available on our website at **www.alamedaalliance.org**. - The presence of a drug on the Alliance formulary does not guarantee that a member will be prescribed that drug by their prescribing physician for a particular medical condition. For some drugs on the Alliance's formulary, limitations may apply.

**Cost to member:**

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

**Exclusions/limitations:**

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

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

# Preventive health services

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

- Vision and hearing tests.
- Services for the detection of asymptomatic diseases, including periodic health examinations, a variety of voluntary family planning services, and prenatal care.
- Comprehensive preventive care for children that includes hospital, medical, and surgical.
    - Periodic health evaluations
    - Immunizations
    - Laboratory services in connection with periodic health evaluations
- Cytology examinations on a reasonable periodic basis (including annual Pap smear exam).
- Immunizations consistent with the most current recommendations by the U.S. Public Health Service.
- Periodic health exams, including all routine diagnostic testing and laboratory services suitable for such examinations.
- Testing for sexually transmitted infections, including confidential HIV/AIDS counseling and testing.

- Effective health education services including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Alliance.

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

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

## Reconstructive surgery

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

- Reconstructive surgical services performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do any of the following: (A) To improve function; (B) To create a normal appearance, to the extent possible; (C) To treat gender dysphoria/gender incongruence.
- Breast prostheses and reconstructive surgery to restore and achieve symmetry and address any complications following a mastectomy are covered. For reconstructive surgical services following a mastectomy or lymph node dissection:
    - The hospital stay associated with a mastectomy or lymph node dissection is determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes.
- All complications of the mastectomy and reconstructive surgery, prosthesis for and reconstruction of the affected breast, and reconstructive surgery on the other breast needed to produce a symmetric appearance are covered.

**Cost to member:**

- No copayment.

# Skilled nursing facility (SNF) services

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

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

- Behavioral health treatment for PDD or autism.
- Blood, blood products, and their administration.
- Durable medical equipment (DME
- that are on the DME formulary, if ordinarily furnished in the SNF and during an authorized stay in the SNF.
- Drugs prescribed by a physician from a plan of care at the skilled nursing facility, and following the Alliance's formulary when administered by medical personnel at a skilled nursing facility.
- General nursing care and special duty nursing when authorized.
- Imaging and laboratory services that skilled nursing facilities ordinarily provide.
- Medical social services.
- Medical supplies
- Physical, occupational, and speech therapy, and other habilitative/rehabilitative services as medically necessary.
    - Individual or group therapy for pervasive developmental disorders, autism or other conditions.
    - May occur in an organized multidisciplinary rehabilitation day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).
- Respiratory therapy administered in the SNF.
- Semi-private room and board, unless a private room is medically necessary and authorized. If a private room is used without authorization, the member will be responsible for the difference between the skilled nursing facility's customary charge for a two (2) bedroom and the private room.

**Cost to member:**

- No copayment.

**Exclusions/limitations:**

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

## Transgender/gender affirmation services

The Alliance covers medically necessary gender affirming services to treat gender dysphoria or gender identity disorder. Covered services include, but are not limited to, mental health evaluation and treatment, surgery, pre-surgical and post-surgical hormone therapy, and speech therapy. Surgical services include but are not limited to, hysterectomy, ovariectomy, orchiectomy, genital surgery, breast surgery, mastectomy, and other reconstructive surgery. Services not medically necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified network provider and facility in conjunction with gender affirming surgery or a documented gender affirming surgery treatment plan. If medically necessary covered service is not available in network within geographic and timely access standards, the Alliance will arrange out-of-network and follow-up services. For more information about out-of-network and follow-up services please see the "Authorizations" section of this handbook.

## Urgent care

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

If you are unable to see your PCP, you may go to any in-network urgent care facility in Alameda County. For a list of contracted urgent care centers, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

If you are outside of the service area and require urgent services, you may receive such services from a non-contracted provider. (*See **Chapter 8: Emergent, urgent, and routine care** for further information.)* If you get urgent care treatment while outside of the Alliance service area and you get a bill, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

**Cost to member:**

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

## Vision services

For information about vision services, contact the Public Authority at **1.510.577.3552**.

# 10. Exclusions and limitations

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

Members may request an IMR of disputed health care services from the California Department of Managed Health Care (DMHC) for situations described in ***Chapter 14. Alliance grievance and appeal procedures***.

These exclusions or limitations do not apply to medically necessary treatment of a mental health or substance use disorder.

**Exclusions/limitations:**

1. All medical and hospital costs when the member is admitted to a hospital by a non-network physician without preauthorization by the Alliance, except in emergencies as described herein, are not covered benefits.
2. All services that would otherwise be covered by CCS are not covered benefits.
3. Amniocentesis, except when medically necessary, is not a covered benefit.
4. Any benefits in excess of limits specified within this EOC.
5. Any services and benefits rendered when the person is not eligible, i.e., prior to the person’s effective date of coverage or after the person’s coverage is terminated, are not covered benefits.
6. Any services or items specified as excluded within this EOC.
7. Appliance therapy for treatment of temporomandibular joint dysfunction (TMJ) is not a covered benefit.
8. Biofeedback therapy is covered when medically necessary and prescribed by a licensed physician, surgeon, or licensing psychologist.
9. Chemical dependency services in a specialized facility for alcoholism, drug abuse, or drug addiction
10. Conventional or surgical orthodontics or orthognathics are not covered benefits.

11. Custodial and domiciliary care for services rendered in the home; hospital (except as provided as part of hospice care); or confinement in a health facility primarily for custodial, maintenance, or domiciliary care, are not a covered benefit. This exclusion does not refer to home-based behavioral health therapy (BHT) for PDD or autism, or gender dysphoria/gender incongruence.
12. Cytotoxic food testing, chelation therapy (except for heavy metal poisoning), and radial keratotomy, unless pre-authorized by the Alliance, are not covered benefits.
13. Examinations and reports to obtain or maintain employment, insurance, governmental licensure, camp or school admissions, employer-requested annual physical exams, or for premarital purposes, are not covered benefits.
14. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered by cataract spectacles, or lenses for aniridia (missing iris) or aphakia (absence of the crystalline lens of the eye)..
15. Hair analysis, unless used as a diagnostic tool for heavy metal poisoning, is not a covered benefit.
16. Home and vehicle improvements, including any modifications or attachments made to dwellings, property, or motor vehicles, including ramps, elevators, stair lifts, swimming pools, air filtering systems, environmental control equipment, spas, hot tubs, or automobile hand controls, are not covered benefits.
17. Learning and self-improvement programs, including the treatment of hyperkinetic syndrome, learning disabilities, or behavioral problems; or incident to reading, vocational, educational, recreational, art, dance, or music therapy; weight control or exercise programs; are not covered benefits, except if part of treatment plan for PDD or autism, or gender dysphoria/gender incongruence.
18. Long-term care benefits including long-term care in a skilled nursing facility and respite care are excluded, except as the Alliance will determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to skilled nursing care and hospice benefits.
19. Medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are:
    a. Experimental or investigational; or
    b. Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, are not covered benefits. (*See **Chapter 14: Alliance grievance and appeal procedures** for further information*.)

20. Medical services that are received in an emergency care setting for conditions that are not emergencies, if you reasonably should have known that an emergency care situation did not exist, are not covered benefits.

21. Non-skilled care is care that can be performed safely and effectively by family members or persons without a certification or the presence of a supervising nurse, except for authorized homemaker services for hospice care. This exclusion does not apply to non-licensed qualified autism service professionals and paraprofessionals who provide care to members with PDD or autism.
22. Private duty nursing of any sort is not a covered benefit unless determined medically necessary by the Alliance.
23. Programs for weight control, or weight loss treatments or supplies, nutritional and/or dietary supplements, except for total parenteral nutrition (TPN), and the treatment of PKU, are not covered benefits unless determined medically necessary by the Alliance.
24. Reversal of voluntary sterilization is not a covered benefit unless determined medically necessary by the Alliance.
25. Services obtained from non-Alliance hospitals, skilled nursing facilities, physicians, or other providers, unless provided in an emergency, or as otherwise described herein, are not covered benefits.
26. Services that are eligible for reimbursement by insurance or covered under any other insurance or health care service plan are not covered benefits.
27. Services, supplies, items, procedures, or equipment that is not medically necessary, unless otherwise specified, are not covered benefits.
28. Surgery for morbid obesity, including gastric bypass, gastric stapling, prescription medications, and other procedures for the treatment of obesity are not covered benefits, unless medically necessary in accordance with professionally recognized standards of practice.
29. These exclusions or limitations do not apply to medically necessary treatment of a mental health or substance use disorder (SUD). The following forms of therapy are not covered benefits – manipulative therapy (except as part of a treatment plan for PDD, autism, or SUD), hypnotherapy, sex therapy or couples counseling or family counseling for conditions other than a “mental disorder”.
30. Medical and hospital services of a member donor, or prospective donor when the recipient of an organ transplant is not a member.
31. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain, for which

benefits are provided or payable under any workers' compensation benefit plan, are not covered benefits.

32. Treatment of infertility is excluded (except when a covered treatment may cause infertility), including but not limited to in-vitro fertilization, Gamete Interfallopian Transfer (GIFT), ZIFT and ovum transplants, or any other form of induced fertilization or artificial insemination.
33. Trimming of corns, calluses, and nails for circulatory conditions are not covered benefits unless determined medically necessary by the Alliance.
34. Vocational rehabilitation is not a covered benefit.
35. Marriage or relationship counseling.
36. Vision and dental care services.

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

# 11. Coordination of benefits and third-party liability

## Coordination of benefits

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

This applies when the member is entitled to:

- Benefits provided as a result of a Workers' Compensation claim
- Benefits provided at no cost or without expectation of payment

## Third-party liability

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

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

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

## Third-party liability member responsibilities

Each member will:

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

# 12. Disenrollment

## Term and termination – Group agreement

### Termination and renewal provisions

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

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

### Effective date of termination

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

### Termination for good cause

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

### Termination for failure to pay

If the Public Authority fails to pay any amount due to the Alliance within **30 days** after the Alliance's notice to the Public Authority of the amount due, and the Alliance bills the Public Authority for the amount due, then the Alliance may terminate the rights of the members involved, effective upon the Alliance's issuance of a written notification of cancellation to the Public Authority. Such rights may be reinstated only by payment of the amounts due and in accordance with the **Reinstatement** sub-section in this EOC.

The Alliance shall continue to provide benefits to members, including those members who are hospitalized or undergoing treatment, until the expiration of the applicable reinstatement period. Thereafter, the Alliance shall not be liable for benefits to members, including those members who are hospitalized or undergoing treatment.

## Reinstatement

Receipt by the Alliance of the proper Periodic Prepayment Fees within **30 days** of the Alliance issuance of the notice of cancellation to the Public Authority for non-payment of Periodic Prepayment Fees shall reinstate the members as though there never was a cancellation. If such payment is received after said **30-day** period, the Alliance, at its option, may either refund the Public Authority the amounts paid and consider the agreement terminated, or issue to the Public Authority, within **30 days** of the receipt of such payment, a new agreement accompanied by written notice clearly stating those respects in which the new agreement differs from the agreement in benefits or other terms.

## Refunds

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

## Changes in law

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

## Election to not renew

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

### Failure to agree on renewal premium

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

## Extension of benefits upon termination

### Continuing care

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

### Totally disabled member

Except as expressly provided in this section, all rights to benefits shall terminate as of the effective date of termination of the agreement.

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

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

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

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

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

# Termination of benefits – individual member

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

## Loss of eligibility

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

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

## Election of other plan coverage

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

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

## Failure to furnish or furnishing incomplete information

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

## Fraud or deception

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

## Disruptive behavior

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

## Nonpayment

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

## Refunds

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

## Review by the California Department of Managed Health Care (DMHC)

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

# 13. Individual continuation of benefits

## Group coverage

Under federal and state laws (known as COBRA and Cal-COBRA), you may be eligible to keep your group health plan benefits for a period of time after your job ends or your hours are cut. Whether you can keep the group health plan benefits and for how long is governed by COBRA and Cal-COBRA. That coverage is also subject to all terms, conditions, limitations, and exclusions of this Alliance Group Care Combined Evidence of Coverage and Disclosure Form. The Public Authority is solely responsible for notifying you if you are eligible for COBRA or Cal-COBRA continuation coverage. The Public Authority will also tell you how long your continuation coverage will last and will explain the terms and conditions to you. For more information, please call the Public Authority at **1.510.577.3552**. The following is a summary of some of the key terms of the programs that will apply if the Public Authority says you are eligible.

### COBRA

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

### Cal-COBRA

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

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

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

## Premium payments for COBRA and Cal-COBRA

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

## Deadlines

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

## Who cannot enroll in federal COBRA or Cal-COBRA?

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

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

## When will your COBRA/Cal-COBRA coverage terminate?

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

- The maximum applicable COBRA period (**36 months**) has expired

- You stop paying premiums or stop paying them on a timely basis
- You have other hospital, medical, or surgical coverage under another group benefit plan that does not contain an exclusion or limitation with respect to any pre-existing conditions applicable to you that would preclude coverage (with certain exceptions in the COBRA laws)
- The date Public Authority is no longer required to provide COBRA or Cal-COBRA coverage for you
- You become eligible for Medicare
- With respect to Cal-COBRA, you are eligible for COBRA coverage and have not yet exhausted that coverage
- The Public Authority ceases to provide any group health plan benefits to any IHSS worker
- The group contract between the Public Authority and the Alliance is terminated or expires for any reason
- You commit fraud or deception in the use of Cal-COBRA benefits or, in the case of COBRA benefits, you engage in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud)
- You no longer reside or work in Alameda County

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

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

# Individual coverage

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

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

## Individual Conversion Plan (ICP)

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

You must notify the Alliance that you wish to convert to the ICP within **31 days** of the end of your Alliance Group Care, COBRA, or Cal-COBRA coverage. You will then have to submit a written application for ICP coverage to the Alliance. That application and the first premium payment must be submitted to the Alliance within **63 days** of the end of your COBRA/Cal-COBRA or Alliance Group Care coverage. If your application is accepted, your Individual Conversion Plan will be effective on the day your prior (COBRA/Cal-COBRA or Alliance Group Care) coverage ended. For an application and premium information, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

You will not be eligible for ICP if:

- The agreement between the Public Authority and the Alliance is terminated or the Public Authority's participation is terminated and the group contract is replaced by similar coverage under another group contract within **15 days** of the date of termination of the group coverage or member's participation
- You failed to pay any amount due to the Alliance
- You were terminated by the Alliance for good cause
- You knowingly furnished incorrect information or otherwise improperly obtained benefits
- The Public Authority health plan is self-insured at the time you apply for the Individual Conversion Plan
- You are covered by or are eligible for benefits under Medicare
- You are covered for similar benefits by an individual policy or contract
- You are covered by or are eligible for benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured
- You were not continuously covered during the entire **three (3) month** period immediately prior to termination of coverage under Alliance Group Care.

# 14. Alliance grievance and appeal procedures

## Complaints and problems/grievance and appeal

As an Alliance member, you have the right to file a complaint (this is also called a grievance) if you are not happy or have an issue with your health care services. To read the full definition of a grievance, please see the "Definitions" section in this member handbook. To file a complaint, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). You have the right to provide written comments, papers, and information that support your views. You may speak for yourself or have someone else speak for you, including a lawyer. You may ask to look at or get a copy of our records that relate to your case at no cost. You or your provider may get a copy of the benefit provision, guideline protocol, or criteria used to make a denial decision at no cost by calling our Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). Using this grievance process does not rule out any potential legal rights or remedies that you may have. Your satisfaction is important to us! An appeal is when you ask for a review of an "action." *(See **Chapter 17: Definitions** for further information.)*

Actions are:

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

If you have a problem with your health care services, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**). If you have a grievance or an

appeal, you may file it by phone or fill out a form. You can appeal a Notice of Action by phone. Your provider may file an appeal for you.

For help, you can call us at:

Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY)**: 711/1.800.735.2929**

You can file your complaint online.

To file a grievance or appeal online:

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

You can also fax a letter that describes your complaint to **1.510.995.3705** or mail the letter to**:**

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

# Timeframes

If you have a problem, you can file a grievance with the Alliance at any time after the event that caused your grievance. To file an appeal you have **180 calendar days** from the date when services or benefits were denied, deferred, or modified.

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

If you need help with 1) a grievance about an emergency, 2) a grievance that has not been acceptably resolved by the health plan, or 3) a grievance that has not been resolved for more than **30 days**, you may call the California Department of Managed Health Care (DMHC) for help toll-free at **1.888.466.2219** (TDD: **1.877.688.9891**).

You need not participate in the Alliance's grievance process before applying to DMHC for review of an urgent grievance. If the Alliance denied your treatment because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an Independent Medical Review (IMR). You can ask for the IMR immediately following the receipt of a Notice of Action but no longer than **180 days** after the receipt of that Notice of Action.

## Independent Medical Review (IMR)

If you are not happy with the Alliance's decision or it has been more than **30 calendar days** since you submitted a complaint with the Alliance, you may file a complaint with DMHC. An Independent Medical Review (IMR) is a review of your case by doctors who are not part of the Alliance, when the denial, modification, or delay based on a decision that the requested service is not medically necessary. In most cases, you must complete the Alliance's appeals process before you apply for an IMR with DMHC. If you would like to request for an IMR, you must submit your request within **six (6) months** of receiving a grievance acknowledgment letter from the Alliance. The DMHC may extend the deadline beyond six (6) months if the circumstances of a case warrants an extension.

To request an IMR, contact:

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

If the IMR is decided in your favor, the Alliance must give you the service or treatment you asked for. This process is no cost.

You can ask for an IMR if the Alliance:

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

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

- Standard IMR: The HMO Help Center at DMHC will review and send an acknowledgment letter within **seven (7) days**. IMR will notify you of a decision within **30 days**.
- Urgent IMR: IMR will notify you of a decision within **three (3)** to **seven (7) days** if your problem is an immediate and serious threat to your health.

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

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

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

## Experimental or investigational denials

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

The letter will tell you about your right to ask for an IMR through DMHC.

To complete an application for an IMR of experimental or investigational therapy, you need one of the following:

- The doctor who is treating you gave us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, that standard therapies would not be right for you, or that there is no more beneficial standard therapy we cover than the therapy being asked for.

  - "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.
  - "Seriously debilitating" means diseases or conditions that cause major damage that cannot be reversed.
- If the doctor who is treating you is an Alliance doctor, they recommended a treatment, drug, device, procedure, or other therapy and certified that the therapy being asked for is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Alliance doctor in certifying their recommendation.
- You (or your Alliance doctor who is a board-certified or board-eligible doctor qualified in the area of practice appropriate to treat your condition) requested a therapy that is 1) based on two (2) documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), and is 2) likely to be more beneficial for you than any available standard therapy. The doctor's certification included a statement of evidence relied upon by the doctor in certifying their recommendation. We do not cover the services of a non-Alliance provider.

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

# California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an

impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **https://www.dmhc.ca.gov/** has complaint forms, IMR application forms and instructions online.

# 15. Other provisions

## Public policy participation

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

If you would like more information about this group or would like to be considered for membership, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

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

## Governing law

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

## Notice of Information Practices

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

# Member satisfaction

The Alliance may request information from you on your experience and satisfaction with the quality, availability, and accessibility of care you received as a member of the Alliance. The results of these surveys will be reported to the appropriate Alliance committees. A member who gives information will not be identified by name or any other means. These surveys will be used regularly by the Alliance to identify and investigate sources of member dissatisfaction with the Alliance (if any), to identify opportunities to improve patient care and outcomes, and to identify satisfactory performance on the part of a participating provider, staff, hospital, or the Alliance.

# Filing claims/reimbursement provisions

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

If you receive a bill (claim) or have to pay a bill for services (e.g., for emergency services) submit a copy of the bill to the Alliance for payment within **180 calendar days** after the bill was paid. If you have paid the bill, also submit a copy of the canceled check or payment receipt, a signed and completed Member Reimbursement Form along with a written explanation as to why you paid out of pocket, to the Alliance for review.

Include the following information attached to the copy of the bill:

- Alliance member's name, address, phone number, Alliance member ID number;
- Name, address, and phone number of the service provider (if not stated on the bill); and
- Date of each service and reason for the service (if not stated on the bill).

Send this information and a copy of the bill within **180 calendar days** of the date the bill was paid to:

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

If the Alliance determines that emergency services obtained by the member are covered, the Alliance will pay the provider directly, or reimburse the member if the services have been paid for by the member. All such charges will be paid within **45 working days** from the Alliance's receipt of the satisfactory information as described above, or you will be notified of the claim status.

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Non-contracted provider services obtained at a network facility while getting covered services at a Network health facility, if you receive covered services from a non-contracted provider, You will pay the network cost sharing amount for these services. Non-contracted providers at network facilities cannot bill You for their services when the services are approved by the Alliance.

For questions regarding medical bills, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Right of health plan to change benefits and charges

The Alliance reserves the right to change the benefits and charges under the Alliance Group Care program. Members will be given a **31-calendar-day** written notice prior to the contract renewal effective date before making any change in benefits and charges. Any changes made to this EOC is subject to prior approval of the DMHC.

## Limitations of other coverage

This health plan coverage is not designed to duplicate any benefits to which members are entitled under government programs, including CHAMPUS, Medi-Cal, Medicare, or Workers' Compensation. By executing an enrollment application, a member agrees to

complete and submit to the Alliance such consents, releases, assignments, and other documents reasonably requested by the Alliance, or in order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.

## Natural disasters, interruptions, and limitations

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

## Independent contractors

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

## Payment of providers

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

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

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

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

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

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

However, except for urgent and emergent care services, if a member goes to a non-contracting provider (a provider not in the Alliance provider network) without approval, the member may have to pay that non-contracting provider for the cost of services. (*See **Filing claims/reimbursement provisions** in this chapter for further information*.)

Provider claims are reimbursed by the Alliance for consultation, or treatment of an enrollee via telehealth on the same basis and to the same extent that the plan would reimburse the same covered in-person service.

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

## Provider termination notification

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

## Workers' compensation

This benefit is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation insurance. For information regarding your Workers' Compensation insurance coverage, please call the Public Authority at **1.510.577.3552**

# Disability access

## Physical access

The Alliance has made every effort to ensure that our offices and the offices and facilities of our providers are accessible to the disabled. If you are not able to locate an accessible provider, we can help you find an alternate provider. For help, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Access for the hearing impaired

Members who have hearing impairments, please call the California Relay Service (CRS)/TTY at **1.800.735.2929** or **711**.

## Access for the vision impaired

For assistance in reading this EOC and other materials, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Disability access grievances

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

## The Americans with Disabilities Act of 1990

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

# 16. Notice of Privacy Practices

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

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

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

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

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

## Types of information we keep

The Alliance receives information on you when you choose the Alliance as your health plan. We get your information from the State of California (for Healthy Families); your application (for Alliance Group Care); your doctor/other health care providers on your behalf; and you.

The information the Alliance collects varies by program. We keep the following information: your contact information, such as your address and phone number; your age; ethnicity; gender; and language. We collect and keep your health care information which is called Protected Health Information or PHI. This includes the doctor you see and their findings about your health; your health care conditions and diagnosis; your health history;

your prescriptions; and lab tests. We collect and keep information about the health and wellness classes you went to and whether you were in other health care programs or plans. We also collect and keep the financial records you present when you apply for coverage. This information helps us provide you with the service you need.

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

## How we may use or share your information

1. **Treatment –** We may use or share your information to help your doctors or hospitals provide health care to you. For example, if you are in the hospital, we may give them your health records sent to us by your doctor. Or we may share this information with a pharmacist who needs it for a prescription for you, or a lab that performs a test for you.
2. **Payment –** We may use or share your information to pay for your health-care-related bills. For example, your doctor will give us the information we need before we pay them. We may also share information with other health care providers so they can be paid.
3. **Health care operations –** We may use or share your information to operate this health plan.
    - For example, we may use or share your information to review and improve the quality of care you receive. It can also be used to review the skills and qualifications of our providers.
    - We may use or share this information so we can approve services or referrals.
    - We may also use or share this information when we need to for medical reviews or case management. For example, we may refer you to an asthma class if you have asthma.
    - We may also use or share this information when we need to for legal services, audits, or business planning and management.
    - We may also share your information with our “business associates” that provide certain plan services for us. We will not share your information with these outside groups unless they agree to protect it. Under California

law, all parties that receive information may not share it again, except as specifically needed or allowed by law.

4. **Appointment reminders –** We may use or share your information to remind you about doctor or health care visits. If you are not home, we may leave this information on your answering machine or leave a message with the person who answers the phone.
5. **Notification and communication with family –** We may share your information to let a family member, your personal representative, or a person responsible for your care know about where you are, your general condition, or your death. In case of a disaster, we may share information with a group like the Red Cross so they can contact you. We may also share information with someone who helps you with your care or helps pay for your care. If you are able to decide, we will let you decide before we share the information. But we may share this information in a disaster even if you do not want us to, so we can respond to the emergency. If you are not able to decide because of your health or you cannot be found, our professional staff will use their best judgment in sharing information with your family and others.
6. **Required by law –** As required by law, we will use or share your information, but we will limit our use or sharing to only what we are allowed to use or share by the law.
7. **Provider peer review –** We may use or share your information to review the skills of your provider or the quality of care you receive.
8. **Group health plans –** If you are a member of a group health plan, we may share information with the sponsor of your group health plan. For instance, if your employer provides your health coverage, we may let your employer know if you are still a member of the plan.
9. **Research –** We may share your information without your written consent if the research meets certain rules.
10. **Marketing –** We may contact you to give you information about products or services. We will not use or share your information for this purpose without your written permission.
11. **Court and administrative proceedings –** We may, and sometimes need to by law, share your information for an administrative or judicial proceeding as we are told to by a court or administrative order if you were told of the request and you did not object or the court or administrative judge did not agree with your objection.

12. **Health monitoring activities –** We may, and sometimes need to by law, share your information with health monitoring agencies for audits, investigations, inspections, and other proceedings, only as allowed by federal and California law.
13. **Public health –** We may, and sometimes need to by law, share your information with public health agencies so they can: prevent or control disease, injury, or disability; report child, elder, or dependent adult abuse or neglect; report domestic violence; report problems to the Food and Drug Administration (FDA) about products and reactions to medications; and report disease or infection exposure.
14. **Law enforcement –** We may share your information with a law enforcement official. This would be to: identify or locate a suspect, fugitive, material witness, or missing person; comply with a court order, warrant, or grand jury subpoena; and other law enforcement purposes.
15. **Public safety –** We may share your information with persons who help prevent or lessen a serious and immediate threat to the health or safety of a person or the public.
16. **Special government functions –** We may share your information for military or national security purposes, to the extent permitted by law. We may also share it with correctional institutions or law enforcement officers that have you in their lawful custody.
17. **Insurers –** We may use or share your information with insurers when we review a health plan application.
18. **Employers –** We may use or share your information with your employer to find out about an illness or injury from work, or for workplace medical surveillance, to the extent that you consent to that use. We may use or share your information with your employer if you consent and/or if permitted by law when there is an employee claim or lawsuit about a medical condition, or if the information is about doing a particular job.
19. Other ways the Alliance may use or share your information:
    - We may, as needed by law, share your information with coroners when they investigate deaths.
    - We may share information with funeral directors, as they need it to carry out duties, to the extent permitted by law.
    - We may share your information with organizations that provide services for organ and tissue transplants.

- We may use or share your information with the FDA when it is about the quality, safety, or effectiveness of an FDA-related product or activity.
- We may use or share your information with conservators/guardians under certain circumstances.
- We may share your information as we need to for workers' compensation.
- If the Alliance is sold or merged with another organization, your information/record will be owned by the new owner. But you will be able to change enrollment to another health plan.
- We may use or share your information in order to protect it when we send it over the Internet.

20. **Interoperability Rule –** We may provide certain information to you through a third-party application as allowed by the Interoperability Rules. The Interoperability Rules require health plans like the Alliance to provide certain health information through a third-party application of your choice. For more information about how to select a third-party application, please see "**Member Privacy Document**" on our website. The Alliance is not responsible for third-party applications and is not responsible for your information once it is transferred to the third-party application at your request.

## When we may not use or share your information

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

## The Alliance may contact you

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

# Your privacy rights

1. **Right to request special privacy protections –** You have the right to ask for limits on certain uses and sharing of your information. You can do this by a written request that tells us what information you want to limit and what ways you want to limit our use or sharing of that information..
2. **Right to request confidential communications –** You have the right to ask that you receive your information in a specific way or at a specific location if the usual way may put you in danger. For example, you may ask that we send information to your work address. Please write us and tell us how you would like to receive your information and why you would be in danger if we did not follow your request. If your request has a cost that you will have to pay, we will let you know.
3. **Right to see and copy –** You have the right to see and copy your information, with limited exceptions. To see your information, you must send a written request and tell us what information you want to see. Also let us know if you want to see it, copy it, or get a copy of it. California law allows us to charge a fair fee to copy records. We may deny your request under limited circumstances.
4. **Right to request information through a third-party application** – You have the right to request certain information through a third-party application of your choice as allowed by the “Interoperability Rules.”
5. **Right to change or supplement –** You have a right to ask that we change your information that you believe is incorrect or incomplete. You must ask us in writing to change your record. Tell us the reasons you believe the information is not correct. We do not have to change your information, and if we deny your request, we will let you know why. We will also tell you how you can disagree with our denial. We may deny your request if we do not have the information. We may also deny your request if we did not create the information (unless the person that created the information is no longer available to make the amendment). We may also deny your request if you would not be permitted to inspect or copy the information, or if the information is correct and complete.
6. **Right to an accounting of how we shared your information –** You have a right to receive a list of how we shared certain information during the **six (6) years** prior to your request. Please note that a fee may apply.
7. **Right to receive notice of privacy breach –** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your Protected Health Information.

8. **Right to a paper copy of this Notice of Privacy Practices –** If you would like more information about these rights or if you would like to use these rights, please call the Alliance Member Services Department Monday through Friday, 8 am to 5 pm at **1.510.747.4567** or toll-free at **1.877.932.2738** (TTY **1.800.735.2929** or **711**).

## Changes to this Notice of Privacy Practices

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

## Complaints

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

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

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

You may also notify the Alliance Privacy Office at:

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

Phone Number: **1.510.747.4500**
People with hearing and speaking impairments (CRS/TTY):**711/1.800.735.2929**

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

# 17. Definitions

Below are some of the terms used in this booklet:

**Active labor –** The period of time when a woman is in the three (3) 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 health condition that is sudden and lasts a limited duration.

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

**Allowable expense –**The maximum amount the Alliance will pay for a covered service.

**Amendment –** A written description of any changes to the Alliance Group Care program which the Alliance will send to members when such changes impact the Evidence of Coverage (EOC). These changes should then be read and attached to your EOC.

**Authorization –** The requirement that certain services be approved by the Alliance or primary care provider (PCP) in order to be covered services.

**Basic health care services** – All of the following:

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

**Behavioral health treatment for pervasive developmental disorder (PDD)/autism –** Professional services and treatment programs, including applied behavioral analysis and evidence-based behavioral intervention programs that develop or restore, to the

maximum extent practicable, the functioning of an individual with pervasive developmental disorder (PDD) or autism and that meet all the following criteria:

- Treatment is prescribed by a physician or a psychologist, licensed pursuant to California law;
- Treatment is provided under a treatment plan prescribed by a qualified autism service (QAS) provider and administered by a QAS provider, or a QAS professional, or a QAS paraprofessional supervised and employed by the QAS provider;
- The treatment plan has measurable goals developed and approved by the QAS provider that is reviewed every **six (6) months** and modified where appropriate; and
- The treatment plan is not used to provide or reimburse for respite, daycare, educational services, or participation in the treatment program.

**Benefits and coverage (covered services) –** Those services, supplies, and drugs that a member is entitled to receive pursuant to the terms of the agreement. A service is not a benefit, even if described as a covered service or benefit in this booklet, if it is not medically necessary, or (except in an emergency) if it is not provided by an Alliance plan provider with authorization as required.

**Benefit year –** The **12-month** period commencing at 12:01 a.m. January 1 and ending December 31.

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

**Claim determination period –** The amount of time the Alliance takes to process a claim after the provider has submitted it to the plan.

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

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

**Dependent –**

- Member's spouse

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

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

**Disenroll –**To stop using the health plan because you lose eligibility, quit the health plan, or because you don't pay your monthly premiums to the Alliance Group Care program.

**Durable medical equipment (DME) –** Certain medically necessary equipment that is:

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

**Emergency services –** 24-hour emergency care both in and out of the Alliance service area. An emergency is a sudden medical or mental health problem with severe symptoms that needs treatment right away.

The problem must be one that a person without medical training could reasonably think will place a person's life or health in serious danger, such as:

- Active labor as defined under ***Active Labor*** in this chapter
- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
    - An immediate danger to themselves or others

- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder

**Enrollee –** A person who is enrolled in a plan and is eligible to receive health care services from the Alliance.

**Exclusion –** A service we do not cover.

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

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

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

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

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

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

**Health care provider –** Refers to the different kinds of providers and specialists who provide care under this plan.

**Health plan or plan –** Alameda Alliance for Health.

**Health care service plan or specialized health care service plan –** Either of the following:

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

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

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

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

**Life-threatening or seriously debilitating condition –** Life-threatening refers to one (1) or all of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
- Seriously debilitating diseases or conditions that cause major irreversible morbidity.

**Limitation –** Any provision other than an exception or a reduction, which restricts coverage under the Alliance.

**Medical director –** A physician or psychologist designated by the Alliance who is responsible for the administration of the Alliance's medical or behavioral programs.

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

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

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

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

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

**Orthotic device –** A medically necessary support or brace designed for the support of a weak or ineffective joint or muscle, or to improve the function of movable body parts.

**Out-of-area services –** Emergent care or urgent care provided outside of the service area which could not be delayed until the member returned to the service area.

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

**Plan or health plan –** Alameda Alliance for Health.

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

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

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

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

**Provider directory –** The list of all the names and addresses of providers who contract with the Alliance.

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

a. To improve function; or

b. To create a normal appearance, to the extent possible.

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

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

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

**Skilled nursing facility (SNF) –** A facility that provides a level of inpatient nursing care that is not of the intensity required of a hospital.

**Specialist physician –** A plan physician who provides services upon referral by a primary care provider (PCP) to members within the range of their designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty.

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

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

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