ALAMEDA Alliance FOR HEALTH

Member Handbook

What you need to know about your benefits

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

2024

Alameda County

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

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. Alameda Alliance for Health (Alliance) provides written translations from qualified translators. Call the Alliance Member Services Department at 1-510-747-4567 (TTY 1-800-735-2929 or 711). The call is free. Read this Member Handbook to learn more about health care language assistance services such as interpreter and translation services.

Other formats

You can get this information 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 free.

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

Interpreter services

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

Tagline (English tagline)

ATTENTION: If you need help in your language, call 1-877-932-2738 (TTY: 1-800-735-2929 or 711). 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 or 711). These services are free.

الشعار بالعربية (Arabic tagline)

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

Հայերեն պիտակ (Armenian tagline)

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:s

简体中文标语 (Chinese – Simplified tagline)

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)。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 1.877.932.2738 (TTY: 1.800.735.2929)。这些服务都是免费的。

简体中文标语 (Chinese – Traditional tagline)

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，例如盲文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 tagline)

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

हिंदी टैगलाइन (Hindi tagline)

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 tagline)

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

日本語表記 (Japanese tagline)

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 tagline)

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 tagline)

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

Mien Tagline (Mien tagline)

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.

ឃ្មាសម្គាល់ជាភាសាខ្មែរ (Mon-Khmer, Cambodian tagline)

សម្គាល់៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-877-932-2738 (TTY: 1-800-735-2929)។ ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ
ដូចជាឯកសារសរសេរជាអក្សរស្ទាប និងអក្សរពុម្ពធំ ក៏អាចរកបានដែរ។ សូមទូរសព្ទទៅលេខ 1-877-932-2738 (TTY: 1-800-735-2929)។ សេវាទាំងនេះមិនគិតថ្លៃនោះទេ។

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi tagline)

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 tagline)

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 tagline)

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 tagline)

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 tagline)

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 tagline)

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 tagline)

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

Welcome to the Alliance!

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

Member Handbook

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

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

In this Member Handbook, the Alliance is sometimes referred to as "we" or "us." Members are sometimes called "you." Some capitalized words have special meaning in this Member Handbook.

To ask for a copy of the contract between the Alliance and DHCS, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). You may ask for another copy of the Member Handbook at no cost to you. You can also find the Member Handbook on the Alliance website at www.alamedaalliance.org. You can also ask for a free copy of the Alliance non-proprietary clinical and administrative policies and procedures. They are also on the Alliance website.

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

Contact us

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

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

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

Table of contents

1. Getting started as a member

How to get help

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

Member services

The Alliance member services is here to help you.

The Alliance can:

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

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

You can also visit Member Services online at any time 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 and click on Member Portal in the top right corner.

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

Who can become a member

Every state may have a Medicaid program. In California, Medicaid is called **Medi-Cal**.

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

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

Transitional Medi-Cal

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

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

- You started earning more money, or
- Your family started getting more child or spousal support

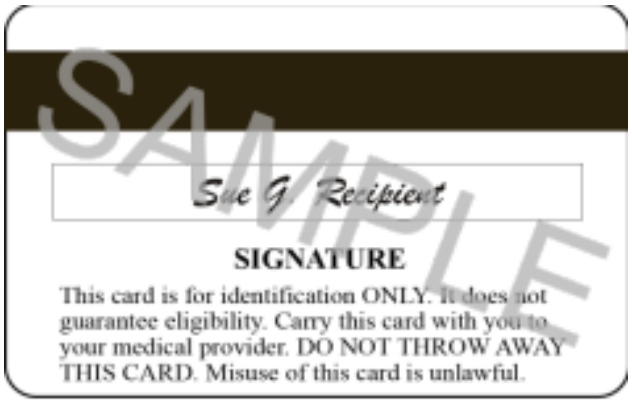
You can ask questions about qualifying for Transitional Medi-Cal at your local county health and human services office at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx. Or call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

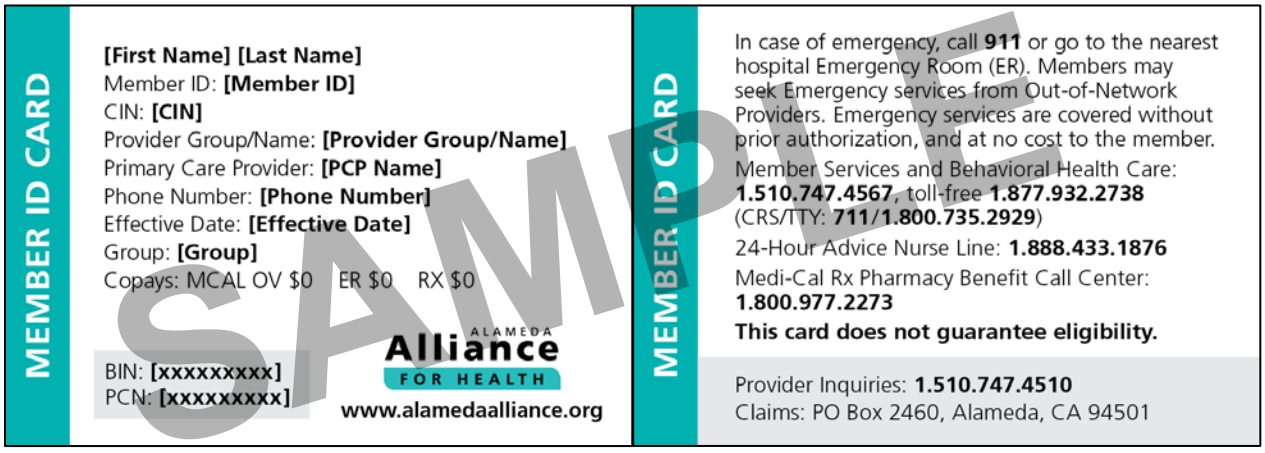
Identification (ID) cards

As a member of the Alliance, you will get our Alliance member identification (ID) card. You must show your Alliance member ID card **and** your Medi-Cal Benefits Identification Card (BIC) when you get health care services or prescriptions. Your BIC card is the Medi-Cal Benefits Card sent to you by the State of California. You should always carry all health cards with you.

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

Your BIC and Alliance member ID cards look like these:





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

You can also print a temporary Alliance member ID card by logging into your Alliance Member Portal account. To access the Alliance Member Portal, please visit www.alamedaalliance.org and click on Member Portal in the top right corner.

You can also come onsite to the Alliance during lobby hours between Tuesday through Thursday, 9 am to 11 am and 2 pm to 4 pm. Lobby hours are subject to change, for the most updated hours, please visit www.alamedaalliance.org/contact-us.

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

2. About your health plan

Health plan overview

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

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

When your coverage starts and ends

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

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

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

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

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

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

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

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

Special considerations for American Indians in managed care

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

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

The Alliance must provide care coordination for you, including out-of-network case management. If you ask to get services from an IHCP and there is no available in-network IHCP, the Alliance must help you find an out-of-network IHCP. To learn more, read “Provider network” in Chapter 3 of this handbook.

How your plan works

The Alliance is a managed care health plan contracted with DHCS. The Alliance works with doctors, hospitals, and other health care providers in the Alliance service area to provide health care to our members. As a member of the Alliance, you may qualify for some services provided through FFS Medi-Cal. These include outpatient prescriptions, non-prescription drugs, and some medical supplies through Medi-Cal Rx.

The Alliance Member Services Department will tell you how the Alliance works, how to get the care you need, how to schedule provider appointments in during office hours, how to request no-cost interpreting and translation services or written information in alternative formats, and how to find out if you qualify for transportation services.

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

Changing health plans

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

It takes up to 30 days or more to process your request to leave the Alliance and enroll in another plan in your county. To find out the status of your request, call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

If you want to leave the Alliance sooner, you can call Health Care Options to ask for an expedited (fast) disenrollment.

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

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

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

Students who move to a new county or out of California

You can get emergency care and urgent care anywhere in the United States, including the U.S. Territories. Routine and preventive care are covered only in your county of residence. If you are a student who moves to a new county in California to attend higher education, including college, the Alliance will cover emergency room and urgent care services in your new county. You can also get routine or preventive care in your new county, but you must notify the Alliance. Read more below.

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

If you temporarily move away from home to be a student in another county in California, you have two choices.

You can:

- Tell your eligibility worker at Alameda County Social Services that you are temporarily moving to attend a school for higher education and give them your address in the new county. The county will update the case records with your new address and county code. You must do this if you want to keep getting routine or preventive care while you live in a new county. If the Alliance does not serve the county where you will attend college, you might have to change health plans. For questions and to prevent delay joining the new health plan, call Health Care Options toll-free at 1-800-430-4263 (TTY 1-800-430-7077 or 711).

  Or

- If the Alliance does not serve the new county where you attend college, and you do not change your health plan to one that serves that county, you will only get emergency room and urgent care services for some conditions in the new county. To learn more, read Chapter 3, “How to get care.” For routine or preventive health care, you would need to use the Alliance network of providers located in the head of household’s county of residence.

If you are leaving California temporarily to be a student in another state and you want to keep your Medi-Cal coverage, contact your eligibility worker at Alameda County Social Services. As long as you qualify, Medi-Cal will cover emergency services and urgent care in another state. If the Alliance approves the service and the doctor and hospital meet Medi-Cal rules, Medi-Cal will also cover emergency care that requires hospitalization in Canada and Mexico.

Routine and preventive care services, including prescription drugs, are not covered when you are outside of California. You will not qualify for Medi-Cal. The Alliance will not pay for your health care. If you want Medicaid in another state, you will need to apply in that state. Medi-Cal does not cover emergency, urgent, or any other health care services outside of the United States, except for Canada and Mexico as noted in Chapter 3.

Continuity of care

Continuity of care for an out-of-network provider

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

In some cases, you might be able to get care from providers who are not in the Alliance network. If you were required to change your health plan or to switch from FFS to managed care, or you had a provider who was in network but is now outside the network, you might be able to keep your provider even if they are not in the Alliance network. This is called continuity of care.

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

If you need to get care from a provider who is outside the network, call the Alliance to ask for continuity of care.

You may be able to get continuity of care for up to 12 months or more if all of these are true:

- You have an ongoing relationship with the out-of-network provider before enrollment in the Alliance
- You went to the out-of-network provider for a non-emergency visit at least once during the 12 months before your enrollment with the Alliance
- The out-of-network provider is willing to work with the Alliance and agrees to the Alliance's contract requirements and payment for services
- The out-of-network provider meets the Alliance's professional standards
- The out-of-network provider is enrolled and participating in the Medi-Cal program

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

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

The Alliance is not required to provide continuity of care for an out-of-network provider for certain ancillary (supporting) services such as radiology, laboratory, dialysis centers, or transportation. You will get these services with a provider in the Alliance network.

To learn more about continuity of care and if you qualify, call the Alliance Member Services Department.

Completion of covered services from an out-of-network provider

As a member of the Alliance, you will get covered services from providers in the Alliance network. If you are being treated for certain health conditions at the time you enrolled with the Alliance or at the time your provider left the Alliance network, you might also still be able to get Medi-Cal services from an out-of-network provider.

You might be able to continue care with an out-of-network provider for a specific time period if you need covered services for these health conditions:

Health condition	Time period
Acute conditions (a medical issue that needs fast attention)	For as long as your acute condition lasts
Serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time)	For an amount of time required to finish your course of treatment and to safely move you to a new doctor in the Alliance network
Pregnancy and postpartum (after birth) care	During your pregnancy and up to 12 months after the end of pregnancy
Maternal mental health services	For up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later
Care of a newborn child between birth and 36 months old	For up to 12 months from the start date of the coverage or the date the provider's contract ends with the Alliance
Terminal illness (a life-threatening medical issue)	For as long as your illness lasts. You may still get services for more than 12 months from the date you enrolled with the Alliance or the time the provider stops working with the Alliance
Performance of a surgery or other medical procedure from an out-of-network provider as long as it is covered, medically necessary, and authorized by the Alliance as part of a documented course of treatment and recommended and documented by the provider	The surgery or other medical procedure must take place within 180 days of the provider's contract termination date or 180 days from the effective date of your enrollment with the Alliance

For other conditions that might qualify, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

If an out-of-network provider is not willing to keep providing services or does not agree to the Alliance's contract requirements, payment, or other terms for providing care, you will not be able to get continued care from the provider. You may be able to keep getting services from a different provider in the Alliance network.

For help choosing a contracted provider to continue with your care or if you have questions or problems getting covered services from a provider who is no longer in the Alliance network, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

The Alliance is not required to provide continuity of care for services Medi-Cal does not cover or that are covered under Medi-Cal's contract with DHCS. To learn more about continuity of care, eligibility, and available services, call the Alliance Member Services Department.

Costs

Member costs

The Alliance serves people who qualify for Medi-Cal. In most cases, the Alliance members do not have to pay for covered services, premiums, or deductibles.

If you are an American Indian, you do not have to pay enrollment fees, premiums, deductibles, co-pays, cost sharing, or other similar charges. The Alliance must not charge any American Indian member who gets an item or service directly from an IHCP or through a referral to an IHCP or reduce payments due to an IHCP by the amount of any enrollment fee, premium, deductible, copayment, cost sharing, or similar charge.

If you are enrolled in the California Children's Health Insurance Program (CCHIP) in Santa Clara, San Francisco, or San Mateo counties or are enrolled in Medi-Cal for Families, you might have a monthly premium and co-pays.

Except for emergency care, urgent care, or sensitive care, you must get pre-approval (prior authorization) from the Alliance before you visit a provider outside the Alliance network. If you do not get pre-approval (prior authorization) and you go to a provider outside the network for care that is not emergency care, urgent care, or sensitive care, you might have to pay for care you got from that provider. For a list of covered services, read Chapter 4, “Benefits and services” in this handbook. You can also find the Provider Directory on the Alliance website at www.alamedaalliance.org.

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

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

How a provider gets paid

The Alliance pays providers in these ways:

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

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

Providers may also get paid through incentive programs offered by the Alliance or the state, such as the Pay-for-Performance program (P4P), Incentive Payment Program under California Advancing and Innovating Medi-Cal (CalAIM), and/or Proposition 56 (Prop 56). These are additional payments made from the Alliance to providers for meeting metrics or requirements.

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

If you get a bill from a health care provider

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

If you get a bill from a pharmacy for a prescription drug, supplies, or supplements, call Medi-Cal Rx Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week. For TTY users, press 7 or dial 711, Monday through Friday, 8 am to 5 pm. You can also go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Asking the Alliance to pay you back for expenses

If you paid for services that you already got, you might qualify to be reimbursed (paid back) if you meet **all** of these conditions:

- The service you got is a covered service that the Alliance is responsible for paying. The Alliance will not reimburse you for a service that the Alliance does not cover.
- You got the covered service after you became an eligible Alliance member.
- You ask to be paid back within one year from the date you got the covered service.
- You show proof that you paid for the covered service, such as a detailed receipt from the provider.
- You got the covered service from a Medi-Cal enrolled provider in the Alliance network. You do not need to meet this condition if you got emergency care, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval (prior authorization).
- If the covered service normally requires pre-approval (prior authorization), you need to give proof from the provider that shows a medical need for the covered service.

The Alliance will tell you if they will reimburse you in a letter called a Notice of Action (NOA). If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, the Alliance will pay you back for the full amount you paid. We must reimburse you within 45 working days of receipt of the claim.

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

If the provider is enrolled in Medi-Cal but is not in the Alliance network and refuses to pay you back, the Alliance will pay you back, but only up to the amount that FFS Medi-Cal would pay. The Alliance will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval (prior authorization). If you do not meet one of the above conditions, the Alliance will not pay you back.

The Alliance will not pay you back if:

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

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

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

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

3. How to get care

Getting health care services

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

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

New members with only Medi-Cal coverage must choose a primary care provider (PCP) in the Alliance network. New members with both Medi-Cal and comprehensive other health coverage do not have to choose a PCP.

The Alliance network is a group of doctors, hospitals, and other providers who work with the Alliance. You must choose a PCP within 30 days from the time you become a member of the Alliance. If you do not choose a PCP, the Alliance will choose one for you.

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

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

If you cannot get the care you need from a participating provider in the Alliance network, your PCP or specialist in the Alliance's network must ask the Alliance for approval to send you to an out-of-network provider. This is called a referral. You do not need a referral to go to an out-of-network provider to get sensitive care services listed under the heading "Sensitive care" later in this chapter.

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

The Medi-Cal Rx program administers outpatient prescription drug coverage. To learn more, read "Other Medi-Cal programs and services" in Chapter 4.

Primary care provider (PCP)

Your primary care provider (PCP) is the licensed provider you go to for most of your health care. Your PCP also helps you get other types of care you need. You must choose a PCP within 30 days of enrolling in the Alliance. Depending on your age and sex, you can choose a general practitioner, OB/GYN, family practitioner, internist, or pediatrician as your PCP.

A nurse practitioner (NP), physician assistant (PA), or certified nurse midwife can also act as your PCP. If you choose an NP, PA, or certified nurse midwife, you can be assigned a doctor to oversee your care. If you are in both Medicare and Medi-Cal, or if you also have other comprehensive health care insurance, you do not have to choose or be assigned to a PCP in the Alliance network.

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

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

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

Your PCP will:

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

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

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

Choice of doctors and other providers

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

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

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

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

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

Some things to think about when picking a PCP:

- Does the PCP take care of children?
- Does the PCP work at a clinic I like to use?
- Is the PCP accepting new patients?
- Is the PCP's office close to my home, work, or my children's school?
- Is the PCP's office near where I live and is it easy to get to the PCP's office?
- Do the doctors and staff speak my language?
- Does the PCP work with a hospital I like?
- Does the PCP provide the services I need?
- Do the PCP's office hours fit my schedule?
- Does the PCP work with specialists I use?

Initial Health Appointment (IHA)

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

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

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

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

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

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups, health education, and counseling.

The Alliance recommends that children, especially, get regular routine and preventive care. Alliance members can get all recommended early preventive services recommended by the American Academy of Pediatrics and the Centers for Medicare and Medicaid Services. These screenings include hearing and vision screening, which can help ensure healthy development and learning. For a list of pediatrician-recommended services, read the "Bright Futures" guidelines from the American Academy of Pediatrics at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Routine care also includes care when you are sick. The Alliance covers routine care from your PCP.

Your PCP will:

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

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

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

To learn more about health care and services your plan covers, and what it does not cover, read Chapter 4, “Benefits and services” and Chapter 5, “Child and youth well care” in this handbook.

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

Provider network

The Medi-Cal provider network is the group of doctors, hospitals, and other providers that work with the Alliance to provide Medi-Cal covered services to Medi-Cal members.

Depending on the PCP that you select, you may be assigned to a medical group. This means that in most cases, you will need to see doctors in the medical group’s network.

The Alliance has three (3) major medical groups:

- Alameda Alliance for Health (Alliance) – Direct Network
- Community Health Center Network (CHCN) – Medical Group
- Children’s First Medical Group (CFMG) - Medical Group

The Alliance is a managed care health plan. You must get most of your covered services through the Alliance from our in-network providers. You can go to an out-of-network provider without a referral or pre-approval for emergency care or for family planning services. You can also go to an out-of-network provider for out-of-area urgent care when you are in an area that we do not serve. You must have a referral or pre-approval for all other out-of-network services, or they will not be covered.

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

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

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

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

Additional service providers

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

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

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

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

In-network providers

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

To get a Provider Directory of in-network providers, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

You can also find the Provider Directory online at www.alamedaalliance.org. To get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711). Or go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

You must get pre-approval (prior authorization) from the Alliance before you go to a provider outside the Alliance network, including inside the Alliance service area, except in these cases:

- If you need emergency care, call 911 or go to the nearest hospital.
- If you are outside the Alliance service area and need urgent care, go to any urgent care facility.
- If you need family planning services, go to any Medi-Cal provider without pre-approval (prior authorization).
- If you need mental health services, go to an in-network provider or a county mental health plan provider, without pre-approval (prior authorization).

If you are not in one of the cases listed above and you do not get pre-approval (prior authorization) before getting care from a provider outside the network, you might be responsible for paying for any care you got from out-of-network providers.

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

Out-of-network providers are health care providers that do not have an agreement to work with the Alliance. Except for emergency care, you might have to pay for any care you get from out-of-network providers if you do not get pre-approval from the Alliance. If you need medically necessary health care services that are not available in the network, you might be able to get them from an out-of-network provider at no cost to you.

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

For urgent care inside the Alliance service area, you must go to an Alliance in-network urgent care provider. You do not need pre-approval (prior authorization) to get urgent care from an in-network provider. You do need to get pre-approval (prior authorization) to get urgent care from an out-of-network provider inside the Alliance service area.

If you get urgent care from an out-of-network provider inside the Alliance service area, you might have to pay for that care. You can read more about emergency care, urgent care, and sensitive care services in this chapter.

Note: If you are an American Indian, you can get care at an IHCP outside of our provider network without a referral. An out-of-network IHCP can also refer American Indian members to an in-network provider without first requiring a referral from an in-network PCP.

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

Outside the service area

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

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

If you paid for emergency care requiring hospitalization in Canada or Mexico, you can ask the Alliance to pay you back. We will ask you to send us information, such as proof of payment, and the Alliance will review your request.

If you are in another state or are in a US Territory such as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, or US Virgin Islands, you are covered for emergency care. Not all hospitals and doctors accept Medicaid. (Medi-Cal is what Medicaid is called in California only.) If you need emergency care outside of California, tell the hospital or emergency room doctor as soon as possible that you have Medi-Cal and are a member of the Alliance.

Ask the hospital to make copies of your Alliance ID card. Tell the hospital and the doctors to bill the Alliance. If you get a bill for services you got in another state, call the Alliance right away. We will work with the hospital and/or doctor to arrange for the Alliance to pay for your care.

If you are outside of California and have an emergency need to fill outpatient prescription drugs, have the pharmacy call Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711).

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

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

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

Delegated Model

Depending on the PCP that you select, you may be assigned to a medical group. This means that in most cases, you will need to see doctors in the medical group’s network.

The Alliance has three (3) major medical groups:

- Alameda Alliance for Health (Alliance) – Direct Network
- Community Health Center Network (CHCN) – Medical Group
- Children’s First Medical Group (CFMG) - Medical Group

The Alliance can help you find a doctor in your medical group’s network.

Laboratory/Pathology

Except for emergency and urgent care services, Alliance members use Quest Diagnostics in most cases for office or outpatient laboratory and pathology services.

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

Alameda Health System (AHS)

Members who are assigned to Alameda Health System (AHS) can receive laboratory services through their following AHS clinics:

Eastmont Wellness
6955 Foothill Blvd.
Oakland, CA 94605
Phone Number: 1-510-567-5700

Hayward Wellness
664 Southland Mall Dr.
Hayward, CA 94545
Phone Number: 1-510-266-1700

Highland Wellness
1411 East 31st St.
Oakland, CA 94602
Phone Number: 1-510-437-5039

Newark Wellness
6066 Civic Terrace Ave.
Newark, CA 94560
Phone Number: 1-510-505-1600

How managed care works

The Alliance is a managed care plan. The Alliance provides care to members who live or work in Alameda County. In managed care, your PCP, specialists, clinic, hospital, and other providers work together to care for you.

The Alliance contracts with medical groups to provide care to Alliance members. A medical group is determined by who you chose as a PCP and made up of doctors who are PCPs and specialists. The medical group works with other providers such as laboratories and durable medical equipment suppliers. The medical group is also connected with a hospital. Check your Alliance ID card for the names of your PCP, medical group, and hospital.

When you join the Alliance, you choose or are assigned to a PCP. Your PCP is part of a medical group. Your PCP and medical group direct the care for all of your medical needs. Your PCP may refer you to specialists or order lab tests and X-rays. If you need services that require pre-approval (prior authorization), the Alliance or your medical group will review the pre-approval (prior authorization) and decide whether to approve the service.

In most cases, you must go to specialists and other health professionals who work with the same medical group as your PCP. Except for emergencies, you must also get hospital care from the hospital connected with your medical group.

Sometimes, you might need a service that is not available from a provider in the medical group. In that case, your PCP will refer you to a provider who is in another medical group or is outside the network. Your PCP will ask for pre-approval (prior authorization) for you to go to this provider.

In most cases, you must have prior authorization from your PCP, medical group, or the Alliance before you can go to an out-of-network provider or a provider who is not part of your medical group. You do not need pre-approval (prior authorization) for emergency services, family planning services, or in-network mental health services.

Members who have both Medicare and Medi-Cal

Members with other primary coverage such as Medicare do not need to be assigned a PCP through the Alliance and can still see doctors in the Alliance network. For more information on your Medicare coverage, call 1-800-MEDICARE (1-800-633-4227). In most cases, Medicare will cover your care first and the Alliance may cover a portion. The Alliance may also cover services that are covered by Medi-Cal and are not covered by Medicare.

Doctors

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

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

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

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

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

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

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

Hospitals

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

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

Women’s health specialists

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

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

Provider Directory

The Alliance Provider Directory lists providers in the Alliance network or in the CHCN and CFMG medical group. The network is the group of providers that work with the Alliance or your medical group.

The Alliance Provider Directory lists hospitals, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, FQHCs, outpatient mental health providers, managed long-term services and supports (MLTSS), Freestanding Birth Centers (FBCs), IHCPs, and RHCs.

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

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

You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at https://medi-calrx.dhcs.ca.gov/home/. You can also find a pharmacy near you by calling Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711).

Timely access to care

Your in-network provider must provide timely access to care based on your health care needs. At minimum, they must offer you an appointment listed in the time frames in the table below.

Appointment type	You should be able to get an appointment within:
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours

Appointment type	You should be able to get an appointment within:
Urgent care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent (routine) primary care appointments	10 business Days
Non-urgent (routine) specialist care appointments	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days
Non-urgent (routine) mental health provider (non-doctor) follow-up care appointments	10 business days
Non-urgent (routine) appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness, or other health condition	15 business days

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

Sometimes waiting longer for an appointment is not a problem. Your provider might give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health. Also, if you prefer to wait for a later appointment that will better fit your schedule or go to another provider of your choice, your provider or the Alliance will respect your wish.

Your doctor may recommend a specific schedule for preventive services, follow-up care for ongoing conditions, or standing referrals to specialists depending on your needs.

Tell us if you need interpreter services when you call the Alliance or when you get covered services. Interpreter services, including sign language, are available at no cost to you. We highly discourage the use of minors or family members as interpreters. To learn more about interpreter services we offer, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

If you need interpreter services, including sign language, at a Medi-Cal Rx pharmacy, call Medi-Cal Rx Customer Service at 1-800-977-2273, 24 hours a day, 7 days a week. For TTY users, press 7 or dial 711, Monday through Friday, 8 am to 5 pm.

Travel time or distance to care

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

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

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

If you need help with pharmacy providers, call Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711).

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

Appointments

When you need health care:

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

If you have an emergency, call **911** or go to the nearest emergency room. If you need help deciding how urgently you need care and your PCP is not available to speak with you, call the 24/7 Advice Nurse Line toll-free at 1-888-433-1876.

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

Getting to your appointment

If you don't have a way to get to and from your appointments for covered services, the Alliance can help arrange transportation for you. Depending on your situation, you may qualify for either Medical Transportation or for Non-Medical Transportation. These transportation services are not for emergencies and may be available at no cost to you.

If you are having an emergency, call **911**. Transportation is available for services and appointments not related to emergency care. They may be available at no cost to you.

To learn more, read, "Transportation benefits for situations that are not emergencies" below.

Canceling and rescheduling

If you can't get to your appointment, call your provider's office right away. Most doctors require you to call 24 hours (1 business day) before your appointment if you have to cancel. If you miss repeated appointments, your doctor might stop providing care to you and you will have to find a new doctor.

Payment

You do **not** have to pay for covered services unless you have a share of cost for long-term care. To learn more, read "For members with long-term care and a share of cost" in Chapter 2. In most cases, you will not get a bill from a provider. You must show your Alliance ID card and your Medi-Cal BIC when you get health care services or prescriptions, so your provider knows who to bill. You can get an Explanation of Benefits (EOB) or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). If you get a bill for prescriptions, call Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711). Or visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Tell the Alliance the amount you are being charged, the date of service, and the reason for the bill. You do not need to pay providers for any amount owed by the Alliance for any covered service.

You must get pre-approval (prior authorization) from the Alliance before you visit an out-of-network provider except when:

- You need emergency services, in which case dial **911** or go to the nearest hospital
- If you are outside the Alliance service area and need urgent care, go to any urgent care facility
- You need family planning services or services related to testing for sexually transmitted infections, or other sensitive services in which case you can go to any Medi-Cal provider without pre-approval (prior authorization)

You need mental health services, in which case you can go to an in-network provider or to a county mental health plan provider without pre-approval (prior authorization). If you get care from an out-of-network provider and you did not get pre-approval (prior authorization) from the Alliance, you might have to pay for the care you got. If you need to get medically necessary care from an out-of-network provider because it is not available in the Alliance network, you will not have to pay as long as the care is a Medi-Cal covered service and you got pre-approval (prior authorization) from the Alliance for it. To learn more about emergency care, urgent care, and sensitive services, go to those headings in this chapter.

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

For questions, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). To request a reimbursement, please complete the Member Request for Reimbursement Form. To access the form, please log into your Alliance Member Portal account. To access the Alliance Member Portal, please visit www.alamedaalliance.org and click on Member Portal in the top right corner. You can also search for 'member forms' on the Alliance website at www.alamedaalliance.org.If you get services in the Veterans Affairs system or get non-covered or unauthorized services outside of California, you might be responsible for payment.

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

The Alliance will not pay you back if:

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

Referrals

If you need a specialist for your care, your PCP or another specialist will give you a referral to one. A specialist is a provider who focuses on one type of health care service. The doctor who refers you will work with you to choose a specialist. To help make sure you can go to a specialist in a timely way, DHCS sets time frames for members to get appointments. These time frames are listed in “Timely access to care” in this handbook. Your PCP’s office can help you set up an appointment with a specialist.

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

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

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

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

You do **not** need a referral for:

- PCP visits
- Obstetrics/Gynecology (OB/GYN) visits

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

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

Minors can also get certain outpatient mental health services, sensitive services, and substance use disorder services without parent's consent. To learn more, read "Minor consent services" in this chapter and "Substance use disorder treatment services" in Chapter 4 of this handbook.

California Cancer Equity Act referrals

Effective treatment of complex cancers depends on many factors. These include getting the right diagnosis and getting timely treatment from cancer experts. If you are diagnosed with a complex cancer, the new California Cancer Care Equity Act allows you to ask for a referral from your doctor to get cancer treatment from an in-network National Cancer Institute (NCI)-designated cancer center, NCI Community Oncology Research Program (NCORP)-affiliated site, or a qualifying academic cancer center.

If the Alliance does not have an in-network NCI-designated cancer center, the Alliance will allow you to ask for a referral to get cancer treatment from one of these out-of-network centers in California, if one of the out-of-network centers and the Alliance agree on payment, unless you choose a different cancer treatment provider.

If you have been diagnosed with cancer, contact the Alliance to find out if you qualify for services from one of these cancer centers.

Ready to quit smoking? To learn about services in English, call 1-800-300-8086. For Spanish, call 1-800-600-8191.

To learn more, go to www.kickitca.org.

Pre-approval (prior authorization)

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

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

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

- Hospitalization, if not an emergency
- Services out of the Alliance service area, if not an emergency or urgent care
- Outpatient surgery
- Long-term care or skilled nursing services at a nursing facility
- Specialized treatments, imaging, testing, and procedures
- Medical transportation services when it is not an emergency

Emergency ambulance services do not require pre-approval (prior authorization).

Under Health and Safety Code Section 1367.01(h)(1), the Alliance has 5 business days from when the Alliance gets the information reasonably needed to decide (approve or deny) pre-approval (prior authorization) requests. For requests a provider made or when the Alliance finds that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, the Alliance will make an expedited (fast) pre-approval (prior authorization) decision.

The Alliance will give you notice as quickly as your health condition requires and no later than 72 hours after getting the request for services.

Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

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

The Alliance will contact you if we need more information or more time to review your request.

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

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

Second opinions

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

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

The Alliance will pay for a second opinion if you or your in-network provider asks for it, and you get the second opinion from an in-network provider. You do not need pre-approval (prior authorization) from the Alliance to get a second opinion from an in-network provider. Your in-network provider can help you get a referral for a second opinion if you need one.

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

If the Alliance denies your request for a second opinion, you can file a grievance. To learn more about grievances, read “Complaints” in Chapter 6 of this handbook.

Sensitive care

Minor consent services

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

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

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

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

- Outpatient mental health care for:
    - Sexual assault
    - Incest

    - Physical assault
    - Child abuse
    - When you have thoughts of hurting yourself or others
- HIV/AIDS prevention, testing, and treatment
- Sexually transmitted infections prevention, testing, and treatment
- Substance use disorder treatment
    - To learn more, read “Substance use disorder treatment services” in Chapter 4 of this handbook.

For pregnancy testing, family planning services, birth control services, or services for sexually transmitted infections, the doctor or clinic does not have to be in the Alliance network. You can choose any Medi-Cal provider and go to them for these services without a referral or pre-approval (prior authorization).

For minor consent services that are not specialty mental health services, you can go to an in-network provider without a referral and without pre-approval (prior authorization). Your PCP does not have to refer you and you do not need to get pre-approval (prior authorization) from the Alliance to get covered minor consent services.

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

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

The Alliance will not send information about getting sensitive services to parents or guardians. To learn more about how to ask for confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7 of this handbook.

Adult sensitive care services

As an adult 18 years or older, you may not want to go to your PCP for certain sensitive or private care. You can choose any doctor or clinic for these types of care:

- Family planning and birth control including sterilization for adults 21 and older
- Pregnancy testing and counseling

- HIV/AIDS prevention and testing
- Sexually transmitted infections prevention, testing, and treatment
- Sexual assault care
- Outpatient abortion services

For sensitive care, the doctor or clinic does not have to be in the Alliance network. You can choose to go to any Medi-Cal provider for these services without a referral or pre-approval (prior authorization) from the Alliance. If you got care not listed here as sensitive care from an out-of-network provider, you might have to pay for it.

If you need help finding a doctor or clinic for these services, or help getting to these services (including transportation), call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Or call the 24/7 Advice Nurse Line toll-free at 1-888-433-1876.

The Alliance will not disclose medical information related to sensitive services to any other member without written authorization from you, the member receiving care. To learn more about how to ask for confidential communications related to sensitive services, read “Notice of privacy practices” in Chapter 7.

Moral objection

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

Some hospitals and providers do not provide one or more of these services even if they are covered by Medi-Cal:

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

To make sure you choose a provider who can give you the care you and your family needs, call the doctor, medical group, independent practice association, or clinic you want. Or call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Ask if the provider can and will provide the services you need.

These services are available to you. The Alliance will make sure you and your family members can use providers (doctors, hospitals, clinics) who will give you the care you need. If you have questions or need help finding a provider, call the Alliance at the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Urgent care

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

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

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

Urgent care needs could be:

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

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

You must get urgent care services from an in-network provider when you are inside the Alliance's service area. You do not need pre-approval (prior authorization) for urgent care from in-network providers inside the Alliance's service area. If you are outside the Alliance's service area, but inside the United States, you do not need pre-approval (prior authorization) to get urgent care.

Go to the nearest urgent care facility. Medi-Cal does not cover urgent care services outside the United States. If you are traveling outside the United States and need urgent care, we will not cover your care.

If you need mental health urgent care, call your county mental health plan or the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711). Call your county mental health plan or your Alliance Behavioral Health Organization any time, 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, go to http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

If you get medicines as part of your covered urgent care visit, the Alliance will cover them as part of your covered visit. If your urgent care provider gives you a prescription to take to a pharmacy, Medi-Cal Rx will decide if it is covered. To learn more about Medi-Cal Rx, read "Prescription drugs covered by Medi-Cal Rx" in "Other Medi-Cal programs and services" in Chapter 4.

Emergency care

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

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

If you are outside the United States, only emergency care requiring hospitalization in Canada and Mexico are covered. Emergency care and other care in other countries are not covered.

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

Examples may include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain
- Trouble breathing
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts (this may be covered by county mental health plans)

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

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

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

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

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

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

Advice Nurse Line

The Advice Nurse Line can give you free medical information and advice 24 hours a day, every day of the year.

Call the Advice Nurse Line toll-free at 1-888-433-1876 or 711 to:

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

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

Advance directives

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

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

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

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

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

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

Organ and tissue donation

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

4. Benefits and services

What your health plan covers

This chapter explains your covered services as a member of the Alliance. Your covered services are free as long as they are medically necessary and provided by an in-network provider. You must ask us for pre-approval (prior authorization) if the care is out-of-network except for certain sensitive services and emergency care. Your health plan might cover medically necessary services from an out-of-network provider, but you must ask the Alliance for pre-approval (prior authorization) for this.

Medically necessary services are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under the age of 21, Medi-Cal services include care that is medically necessary to fix or help relieve a physical or mental illness or condition. For more on your covered services, call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Members under 21 years old get extra benefits and services. To learn more, read Chapter 5, “Child and youth well care.”

Some of the basic health benefits the Alliance offers are listed on the next page. Benefits with a star (*) need pre-approval (prior authorization).

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

- Acupuncture*
- Acute (short-term treatment) home health therapies and services
- Adult immunizations (shots)
- Allergy testing and injections
- Ambulance services for an emergency
- Anesthesiologist services
- Asthma prevention
- Audiology*
- Behavioral health treatments*
- Biomarker testing
- Cardiac rehabilitation
- Chiropractic services*
- Chemotherapy & Radiation therapy
- Cognitive health assessments
- Community health worker services
- Dental services - Limited (performed by medical professional/primary care provider (PCP) in a medical office
- Dialysis/hemodialysis services
- Doula services
- Durable medical equipment (DME)*
- Dyadic services
- Emergency room visits
- Enteral and parenteral nutrition*
- Family planning office visits and counseling (you can go to a non-participating provider)
- Habilitative services and devices*
- Hearing aids
- Home health care*
- Hospice care*
- Inpatient medical and surgical care*
- Lab and radiology*
- Long-term home health therapies and services*
- Maternity and newborn care
- Major organ transplant*
- Occupational therapy*
- Orthotics/prostheses*
- Ostomy and urological supplies
- Outpatient hospital services
- Outpatient mental health services
- Outpatient surgery*
- Palliative care*
- PCP visits
- Pediatric services
- Physical therapy*
- Podiatry services*
- Pulmonary rehabilitation
- Rapid Whole Genome Sequencing
- Rehabilitation services and devices*
- Skilled nursing services
- Specialist visits
- Speech therapy*
- Surgical services
- Telemedicine/Telehealth
- Transgender services*
- Urgent care
- Vision services*
- Women’s health services

Definitions and descriptions of covered services are in Chapter 8, “Important numbers and words to know.”

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

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

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

Medically necessary services do not include:

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

The Alliance coordinates with other programs to be sure you get all medically necessary services, even if those services are covered by another program and not the Alliance.

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

- Protect life,

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

For members younger than 21 years old, medically necessary services include all covered services listed above plus any other necessary health care, diagnostic services, treatment, and other measures to correct or improve defects and physical and mental illnesses and conditions, the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires.

EPSDT provides prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21. EPSDT covers more services than the benefit for adults. It is designed to make sure children get early detection and care to prevent or diagnose and treat health problems. The EPSDT goal is to make sure every child gets the health care they need when they need it – the right care to the right child at the right time in the right setting.

The Alliance will coordinate with other programs to make sure you get all medically necessary services, even if another program covers those services and the Alliance does not. Read “Other Medi-Cal programs and services” in this chapter.

Medi-Cal benefits covered by the Alliance

Outpatient (ambulatory) services

Adult immunizations

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

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

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

Allergy care

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

Anesthesiologist services

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

Chiropractic services

The Alliance covers chiropractic services, limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to a maximum of 2 services per month without prior authorization. Additional services will require pre-approval (prior authorization) from the Alliance. Limits do not apply to children under age 21. The Alliance may pre-approve other services as medically necessary.

These members qualify for chiropractic services:

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

Cognitive health assessments

The Alliance covers a yearly cognitive health assessment for members 65 years old or older who do not otherwise qualify for a similar assessment as part of a yearly wellness visit under the Medicare program. A cognitive health assessment looks for signs of Alzheimer's disease or dementia.

Community health worker services

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

Services may include:

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

Dialysis and hemodialysis services

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

Medi-Cal coverage does not include:

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

Doula services

The Alliance covers doula services for members who are pregnant or were pregnant in the past year when recommended by a physician or licensed practitioner. Medi-Cal does not cover all doula services. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.

Dyadic services

The Alliance covers medically necessary dyadic behavioral health (DBH) care services for members and their caregivers. A dyad is a child and their parents or caregivers. Dyadic care serves parents or caregivers and child together. It targets family well-being to support healthy child development and mental health.

Dyadic care services include DBH well-child visits, dyadic comprehensive Community Supports services, dyadic psycho-educational services, dyadic parent or caregiver services, dyadic family training, and counseling for child development, and maternal mental health services.

Outpatient surgery

The Alliance covers outpatient surgical procedures. For some procedures, you will need to get pre-approval (prior authorization) before getting those services. Diagnostic procedures and certain outpatient medical or dental procedures are considered elective. You must get pre-approval (prior authorization).

Physician services

The Alliance covers physician services that are medically necessary.

Podiatry (foot) services

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

Treatment therapies

The Alliance covers different treatment therapies, including:

- Chemotherapy
- Radiation therapy

Maternity and newborn care

The Alliance covers these maternity and newborn care services:

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

Telehealth services

Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider by phone, video, or other means. Or telehealth may involve sharing information with your provider without a live conversation. You can get many services through telehealth.

Telehealth may not be available for all covered services. You can contact your provider to learn which services you can get through telehealth. It is important that you and your provider agree that using telehealth for a service is appropriate for you. You have the right to in-person services. You are not required to use telehealth even if your provider agrees that it is appropriate for you.

Mental health services

Outpatient mental health services

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

Your PCP or mental health provider might make a referral for more mental health screening to a specialist in the Alliance network to decide the level of care you need. If your mental health screening results find you are in mild or moderate distress or have impaired mental, emotional, or behavioral functioning, the Alliance can provide mental health services for you.

The Alliance covers mental health services such as:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory, and problem solving
- Outpatient services for the purposes of monitoring medicine therapy
- Outpatient laboratory services
- Outpatient medicines that are not already covered under the Medi-Cal Rx Contract Drugs List (https://medi-calrx.dhcs.ca.gov/home/), supplies and supplements
- Psychiatric consultation
- Family therapy which involves at least 2 family members. Examples of family therapy include, but are not limited to:
    - Child-parent psychotherapy (ages 0 through 5)
    - Parent child interactive therapy (ages 2 through 12)
    - Cognitive-behavioral couple therapy (adults)

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

If treatment you need for a mental health disorder is not available in the Alliance network or your PCP or mental health provider cannot give the care you need in the time listed above in “Timely access to care,” the Alliance will cover and help you get out-of-network services.

If your mental health screening shows that you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider can refer you to the county mental health plan to get the care you need.

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

To learn more, read “Other Medi-Cal programs and services” on page 99 under, “Specialty mental health services.”

Emergency care

Inpatient and outpatient services needed to treat a medical emergency

The Alliance covers all services needed to treat a medical emergency that happens in the U.S. (including territories such as Puerto Rico, U.S. Virgin Islands, etc.). The Alliance also covers emergency care that requires hospitalization in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury.

The condition is so serious that, if it does not get immediate medical attention, a prudent (reasonable) layperson (not a health care professional) could expect it to result in:

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

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

If a pharmacist at an outpatient pharmacy gives you an **emergency supply** of a medication, that emergency supply will be covered by Medi-Cal Rx and not the Alliance. If the pharmacy needs help giving you an emergency medication supply, have them call Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711).

Emergency transportation services

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

Hospice and palliative care

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

Hospice care

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

Hospice care includes:

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

Palliative care

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

Palliative care includes:

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

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

Hospitalization

Anesthesiologist services

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

Inpatient hospital services

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

Rapid Whole Genome Sequencing

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

RWGS is a new way to diagnose conditions in time to affect Intensive Care Unit (ICU) care of children one year of age or younger. If your child qualifies for California Children's Services (CCS), CCS may cover the hospital stay and the RWGS.

Surgical services

The Alliance covers medically necessary surgeries performed in a hospital.

The Postpartum Care Extension (PPCE) program

The Alliance covers post-partum care for up to 12 months after the end of the pregnancy regardless of income, citizenship, or immigration status. No other action is needed.

Rehabilitative and habilitative (therapy) services and devices

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

The Alliance covers rehabilitative and habilitative services described in this section if all of the following requirements are met:

- The services are medically necessary
- The services are to address a health condition
- The services are to help you keep, learn, or improve skills and functioning for daily living
- You get the services at an in-network facility, unless an in-network doctor finds it medically necessary for you to get the services in another place or an in-network facility is not available to treat your health condition

The Alliance covers these rehabilitative/habilitative services:

Acupuncture

The Alliance covers acupuncture services to prevent, change, or relieve the perception of severe, ongoing chronic pain resulting from a generally recognized medical condition.

Outpatient acupuncture services, with or without electric stimulation of needles, are limited to 4 services per month. Limits do not apply to children under age 21. The Alliance may pre-approve (prior authorize) more services as medically necessary.

Audiology (hearing)

The Alliance covers audiology services. Outpatient audiology is limited to 2 services per month, (limits do not apply to children under age 21). The Alliance may pre-approve (prior authorize) more services as medically necessary.

Behavioral health treatments

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

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

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

Cardiac rehabilitation

The Alliance covers inpatient and outpatient cardiac rehabilitative services.

Durable medical equipment (DME)

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

Generally, the Alliance does not cover:

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

In some cases, these items may be approved when your doctor submits a request for pre-approval (prior authorization).

Enteral and parenteral nutrition

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

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

Hearing aids

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

Hearing aids for members under age 21:

In Alameda County, state law requires children who need hearing aid to be referred to the California Children's Services (CCS) program to decide if the child qualifies for CCS. If the child qualifies for CCS, CCS will cover the costs for medically necessary hearing aids. If the child does not qualify for CCS, we will cover medically necessary hearing aids as part of Medi-Cal coverage.

Hearing aids for members ages 21 and older:

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

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

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

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

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

- Replacement hearing aid batteries

Home health services

The Alliance covers health services given in your home when found medically necessary and prescribed by your doctor or by a physician assistant, nurse practitioner, or clinical nurse specialist.

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

Home health services are limited to services that Medi-Cal covers, including:

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

Medical supplies, equipment, and appliances

The Alliance covers medical supplies prescribed by doctors, physician assistants, nurse practitioners, and clinical nurse specialists. Some medical supplies are covered through Fee-for-Service (FFS) Medi-Cal Rx and not by the Alliance. When FFS covers supplies, the provider will bill Medi-Cal.

Medi-Cal does **not** cover:

- Common household items including, but not limited to:
  - Adhesive tape (all types)
  - Rubbing alcohol
  - Cosmetics
  - Cotton balls and swabs
  - Dusting powders
  - Tissue wipes
  - Witch hazel
- Common household remedies including, but not limited to:
  - White petrolatum
  - Dry skin oils and lotions
  - Talc and talc combination products
  - Oxidizing agents such as hydrogen peroxide
  - Carbamide peroxide and sodium perborate
- Non-prescription shampoos
- Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid, and zinc oxide paste
- Other items not generally used primarily for health care, and that are regularly and primarily used by persons who do not have a specific medical need for them

Occupational therapy

The Alliance covers occupational therapy services including occupational therapy evaluation, treatment planning, treatment, instruction, and consultative services. Occupational therapy services are limited to 2 services per month (limits do not apply to children under age 21). The Alliance may pre-approve (prior authorize) more services as medically necessary.

Orthotics/prostheses

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

Ostomy and urological supplies

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

Physical therapy

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

Pulmonary rehabilitation

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

Skilled nursing facility services

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

Speech therapy

The Alliance covers speech therapy that is medically necessary. Speech therapy services are limited to 2 services per month, in combination with acupuncture, audiology, chiropractic, and occupational therapy services. Limits do not apply to children under age 21. The Alliance may pre-approve (prior authorize) more services as medically necessary.

Transgender services

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

Clinical trials

The Alliance covers routine patient care costs for patients accepted into clinical trials, including clinical trials for cancer, listed for the United States at https://clinicaltrials.gov.

Medi-Cal Rx, a Medi-Cal FFS program, covers most outpatient prescription drugs. To learn more, read “Outpatient prescription drugs” in this chapter.

Laboratory and radiology services

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

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- American Academy of Pediatrics Bright Futures recommendations (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Adverse childhood experiences (ACE) screening
- Asthma prevention services
- Preventive services for women recommended by the American College of Obstetricians and Gynecologists

- Help to quit smoking, also called smoking cessation services
- United States Preventive Services Task Force Grade A and B recommended preventive services

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

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

The Alliance also covers chronic disease management programs focused on the following conditions:

- Diabetes
- Cardiovascular disease
- Asthma
- Depression

For preventive care information for youth 20 years old and younger, read Chapter 5, "Child and youth well care."

Diabetes Prevention Program

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

Techniques include, but are not limited to:

- Providing a peer coach
- Teaching self-monitoring and problem solving

- Providing encouragement and feedback
- Providing informational materials to support goals
- Tracking routine weigh-ins to help accomplish goals

Members must meet certain rules to join DPP. Call the Alliance to learn if you qualify for the program.

Reconstructive services

The Alliance covers surgery to correct or repair abnormal structures of the body to improve or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by congenital defects, developmental abnormalities, trauma, infection, tumors, diseases, or treatment of disease that resulted in loss of a body structure, such as a mastectomy. Some limits and exceptions may apply.

Substance use disorder screening services

The Alliance covers:

- Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

For treatment coverage through the county, read “Substance use disorder treatment services” below in this chapter.

Vision benefits

The Alliance covers:

- Routine eye exam once every 24 months; more frequent eye exams are covered if medically necessary for members, such as those with diabetes
- Eyeglasses (frames and lenses) once every 24 months with a valid prescription
- Replacement eyeglasses within 24 months if your prescription changes or your eyeglasses are lost, stolen, or broken and cannot be fixed, and it was not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken.
- Low vision devices for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine, or surgery that interferes with a person’s ability to perform everyday activities (such as age-related macular degeneration)

- Medically necessary contact lenses. Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (such as missing an eye). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus

Transportation benefits for situations that are not emergencies

You can get medical transportation if you have medical needs that do not allow you to use a car, bus, or taxi to your appointments. You can get medical transportation for covered services and Medi-Cal covered pharmacy appointments. You can request medical transportation by asking your doctor, dentist, podiatrist, or mental health or substance use disorder provider for it. Your provider will decide the correct type of transportation to meet your needs.

If they find that you need medical transportation, they will prescribe it by filling out a form and submitting it to the Alliance. Once approved, the approval is good for up to 12 months, depending on the medical need. Once approved, you can get as many rides as you need. Your doctor will need to reassess your medical need for medical transportation and re-approve it every 12 months.

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

You will get medical transportation if:

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

To ask for medical transportation that your doctor has prescribed for non-urgent (routine) appointments, call the Alliance Case Management Department toll-free at 1-877-251-9612 **or** Alliance Transportation Services toll-free at 1-866-791-4158 at least 3 business days (Monday-Friday) before your appointment. For urgent appointments, call as soon as possible. Have your member ID card ready when you call.

Limits of medical transportation

The Alliance provides the lowest cost medical transportation that meets your medical needs to the closest provider from your home where an appointment is available. You cannot get medical transportation if Medi-Cal does not cover the service you are getting, or it is not a Medi-Cal-covered pharmacy appointment. There is a list of covered services in this Member Handbook.

If Medi-Cal covers the appointment type but not through the health plan, the Alliance will not cover the medical transportation but can help you schedule your transportation with Medi-Cal. Transportation is not covered outside of the network or service area unless pre-authorized by the Alliance. To learn more or to ask for medical transportation, call the Alliance Case Management Department toll-free at 1-877-251-9612 or Alliance Transportation Services toll-free at 1-866-791-4158.

Cost to member

There is no cost when the Alliance arranges transportation.

How to get non-medical transportation

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

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

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

The Alliance allows you to use a car, taxi, bus, or other public or private way of getting to your medical appointment for Medi-Cal-covered services. The Alliance will cover the lowest cost of non-medical transportation type that meets your needs. Sometimes, the Alliance can reimburse you (pay you back) for rides in a private vehicle that you arrange. The Alliance must approve this before you get the ride.

You must tell us why you cannot get a ride any other way, such as by bus. You can call, email, or tell us in person. If you have access to transportation or can drive yourself to the appointment, the Alliance will not reimburse you. This benefit is only for members who do not have access to transportation.

For mileage reimbursement, you must submit copies of the driver's:

- Driver's license,
- Vehicle registration, and
- Proof of car insurance

To request a ride for services that have been authorized, call the Alliance Case Management Department toll-free at 1-877-251-9612 **or** Alliance Transportation Services toll-free at 1-866-791-4158 at least 3 business days (Monday-Friday) before your appointment. Or call as soon as you can when you have an urgent appointment. Have your member ID card ready when you call.

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

Limits of non-medical transportation

The Alliance provides the lowest cost non-medical transportation that meets your needs to the closest provider from your home where an appointment is available. Members cannot drive themselves or be reimbursed directly for non-medical transportation. To learn more, call the Alliance Case Management Department toll-free at 1-877-251-9612 **or** Alliance Transportation Services toll-free at 1-866-791-4158 .

Non-medical transportation does not apply if:

- An ambulance, litter van, wheelchair van, or other form of medical transportation is medically needed to get to a Medi-Cal covered service

- You need help from the driver to and from the residence, vehicle, or place of treatment due to a physical or medical condition
- You are in a wheelchair and are unable to move in and out of the vehicle without help from the driver
- Medi-Cal does not cover the service

Cost to member

There is no cost when the Alliance arranges non-medical transportation.

Travel expenses

In some cases, if you have to travel for doctor's appointments that are not available near your home, the Alliance can cover travel expenses such as meals, hotel stays, and other related expenses such as parking, tolls, etc. They may also be covered for someone who is traveling with you to help you with your appointment or someone who is donating an organ to you for an organ transplant. You need to request pre-approval (prior authorization) for these services by contacting the Alliance Case Management Department toll-free at 1-877-251-9612 **or** Alliance Transportation Services toll-free at 1-866-791-4158 .

Other Alliance covered benefits and programs

Long-term care services and supports

The Alliance covers, for members who qualify, long-term care services and supports in the following types of long-term care facilities or homes:

- Skilled nursing facility services as approved by the Alliance
- Subacute care facility services (including adult and pediatric) as approved by the Alliance
- Intermediate care facility services the Alliance approves, including:
    - Intermediate care facility/developmentally disabled (ICF/DD),
    - Intermediate care facility/developmentally disabled-habilitative (ICF/DD-H), and
    - Intermediate care facility/developmentally disabled-nursing (ICF/DD-N)

Basic Care Management

If you qualify for long-term care services, the Alliance will make sure you are placed in a health care facility or home that gives the level of care most appropriate to your medical needs.

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

Getting care from many different providers or in different health systems is challenging. The Alliance wants to make sure members get all medically necessary services, prescription medicines, and behavioral health services. The Alliance can help coordinate and manage your health needs, at no cost to you. This help is available even when another program covers the services.

It can be hard to figure out how to meet your health care needs after you leave the hospital or if you get care in different systems.

Here are some ways the Alliance can help members:

- If you have trouble getting a follow-up appointment or medicines after you are discharged from the hospital, the Alliance can help you.
- If you need help getting to an in-person appointment, the Alliance can help you get free transportation.

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

Care Coordination

The Alliance Care Coordination Program offers health navigators, nurses, and social workers to provide you short-term help, such as:

- Coordinate with multiple health care providers
- Find providers in the Alliance network
- Guides for self-care to manage health conditions
- Help schedule transportation to appointments

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

- Find community resources

Complex Care Management (CCM)

Members with more complex health needs may qualify for extra services focused on case management. The Alliance offers Complex Care Management (CCM) services to high-risk members which may include members with multiple medical and behavioral health conditions, members with multiple hospital and ER visits, and members with other complex health conditions.

The Alliance CCM team of nurses, social workers, and navigators can help members:

- Schedule doctor appointments – for their physical and mental health
- Understand their medications
- Learn about community services and resources
- Coordinate services and supplies that are needed at home
- Provide tools for better care
- Reach their health goals

Transitional Care Services (TCS)

The Alliance provides Transitional Care Services (TCS) to members who are transferring from one setting or level of care to another such as a hospital discharge, a skilled nursing facility (SNF) discharge, and other transitions. A single point of contact will help members during their transition.

TCS will be offered to members who meet criteria. The Alliance may contact you about TCS if you qualify. You can also call the Alliance or your health care provider to find out when you can receive TCS.

The Alliance TCS single-point-of contact can help members:

- Schedule follow-up doctor appointments
- Understand medications
- Learn about community services and resources
- Coordinate services and supplies that are needed at home

Members who are enrolled in CCM have an Assigned Care Manager at the Alliance. Members who are enrolled in Enhanced Care Management (read below) have an Assigned Care Manager from the community ECM provider. These Assigned Care Managers can help with basic care management as described above and any other complex care needs, including transitional care support if you are discharged from a hospital, skilled nursing facility, psychiatric hospital, or residential treatment.

Enhanced Care Management (ECM)

The Alliance covers ECM services for members with highly complex needs. ECM has extra services to help you get the care you need to stay healthy. It coordinates your care from different doctors and other health care providers. ECM helps coordinate primary and preventive care, acute care, behavioral health, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to community resources.

If you qualify, you may be contacted about ECM services. You can also call the Alliance to find out if and when you can get ECM. Or talk to your health care provider. They can find out if you qualify for ECM or refer you for care management services.

Covered ECM services

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

ECM includes:

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

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

Cost to member

There is no cost to the member for ECM services.

Community Supports

Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members. If you qualify, these services might help you live more independently. They do not replace benefits you already get under Medi-Cal.

If you need help or want to find out what Community Supports might be available for you, and would like to access these services, call the Alliance Case Management Department at 1-510-747-4512 or toll-free at 1-877-251-9612 (TTY 1-800-735-2929 or 711). Or call your health care provider.

Community Supports shall support and not replace services received by the Medi-Cal beneficiary through other state, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Housing Transitions Navigation Services

The Alliance offers Housing Transitions Navigation Services to assist members with getting housing.

Eligibility

Members who are prioritized for a permanent supportive housing unit, or who meet the Housing and Urban Development (HUD) definition of homeless, or if the member has significant barriers to housing stability and meet additional criteria.

Limitations

These services must be identified as reasonable and necessary in the member's individualized housing support plan. Service duration can be as long as necessary.

Housing Deposits

The Alliance offers housing deposits to assist members with identifying, coordinating, securing, or funding one-time services and modifications necessary for them to establish a basic household (that do not constitute room and board).

Eligibility

Members who received Housing Transition Navigation Services, or a member who is prioritized for a permanent supportive housing unit, or who meets the Housing and Urban Development (HUD) definition of homeless.

Limitations

Housing deposits are available once in a member's lifetime. They can only be approved one (1) additional time with documentation as to what conditions have changed to demonstrate why providing housing deposits would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the member's individualized housing support plan.

Persons must also receive housing transition navigation services in conjunction with this service.

Housing Tenancy and Sustaining Services

The Alliance offers housing tenancy and sustaining services to assist members with providing tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Eligibility

Members who received Housing Transition Navigation Services, or a member who is prioritized for a permanent supportive housing unit, or who meets the Housing and Urban Development (HUD) definition of homeless, or if the person has significant barriers to housing stability and meet additional criteria.

Limitations

These services are available from the start of service through the time when the member's housing support plan determines they are no longer needed. They are only available for a single duration in the member's lifetime. Housing tenancy and sustaining services can be approved one (1) additional time with documentation as to what conditions have changed to demonstrate why providing housing tenancy and sustaining services would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the member's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance. Service duration can be as long as necessary.

Many will have also received housing transition navigation services in conjunction with this service, but it is not a prerequisite for eligibility.

Recuperative Care (Medical Respite)

The Alliance offers recuperative care (medical respite) for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable environment. This is also considered short-term residential care.

Eligibility

Members who are at risk of hospitalization or are post-hospitalization, members who live alone with no formal support, members who face housing insecurity or have housing that would jeopardize their health and safety without modification, members who meet the Housing and Urban Development (HUD) definition of homeless, or if the member has significant barriers to housing stability and meet additional criteria.

Limitations

This service is used when it is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health assistance. This service cannot be longer than 90 continuous days and it does not include funding for building modification or building rehabilitation.

Medically Tailored Meals/Medically-Supportive Food

The Alliance offers medically tailored meals/medically-supportive food that can be delivered to the home that meet the unique dietary needs of those with chronic conditions, immediately following discharge from a hospital or nursing home.

Eligibility

Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders; members being discharged from the hospital or skilled nursing facility or at high risk of hospitalization or nursing facility placement; or members with extensive care coordination needs.

Limitations

This service can support up to two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.

These meals that are eligible for or reimbursed by alternative programs are not eligible.

These meals are not covered to respond solely to food insecurity.

Asthma Remediation

The Alliance offers asthma remediation services which are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable to individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Eligibility

Members with poorly controlled asthma (as determined by one (1) ER visit or hospitalization or two (2) sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for who a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, ER visits, or other high-cost services.

Limitations

If another service such as durable medical equipment (DME) is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, that service should be used.

If another service such as durable medical equipment is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

Asthma remediations much be conducted in accordance with applicable State and local building codes.

Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception is if the member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable to the member to function with greater independence in the home and avoid institutionalization or hospitalization.

Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the managed care plan must provide the owner and member with written documentation that the modifications are permanent, and that the state is not responsible for maintenance or repair of any modification nor for removal of any modification if the member ceases to reside at the residence.

Nursing Facility Transition/Diversion to Assisted Living Facilities

The Alliance offers nursing facility transition/diversion to assisted living facilities, such as residential care Facilities for elderly and adult residential facilities to assist individuals to live in the community and/or avoid institutionalization when possible.

Nursing Facility Transition Eligibility

Members who has resided 60+ days in a nursing facility, and willing to live in an assisted living setting as an alternative to a nursing facility, and is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

Nursing Facility Diversion Eligibility

Members interested in remaining in the community, willing and able to reside safely in an assisted living facility with appropriate and cost-effect supports and services, and must be currently receiving medically necessary nursing facility level of care (LOC) or meet the minimum criteria to receive nursing facility LOC and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an assisted living facility.

Limitations

Members are directly responsible for paying their own living expenses.

Community Transition Services/Nursing Facility Transition to a Home

The Alliance offers community transition services/nursing facility transition to a home to help members live in the community and avoid further institutionalization.

Eligibility

Members currently receiving medically necessary nursing facility level of care (LOC) services and, in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services, have lived 60+ days in a nursing home and/or medical respite setting, is interested in moving back to the community, and is able to reside safely in the community with appropriate and cost-effective supports and services.

Limitations

This service does not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

This service is payable up to a total lifetime maximum amount of $7,500. The only exception is if the member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond their control.

This service must be necessary to ensure the health, welfare, and safety of the member, and without the member would be unable to move to the private residence and would then require continued or re-institutionalization.

Personal Care and Homemaker Services

The Alliance offers personal care and homemaker services to members with activities of daily living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Services can also include meal preparation, grocery shopping, and money management.

Eligibility

Members at risk for hospitalization, or institutionalization in a nursing facility, or individuals with functional deficits and no other adequate support system, or individuals approved for In-Home Supportive Services (IHSS). IHSS eligibility can be found at www.CDSS.CA.GOV/In-Home-Supportive-Services.

Limitations

This service cannot be utilized in lieu of referring to the IHSS program. A member must be referred to IHSS when they meet referral criteria.

If a member receiving personal care & homemaker services has any change in their current condition, the member must be referred to IHSS for reassessment and determination for additional hours. Members can continue to receive this service during the reassessment waiting period.

Respite (Caregiver) Services

The Alliance offers respite (caregiver) services to caregivers of members who require short-term, temporary care while their primary care giver is not available.

Eligibility

Members who live in the community and are unable to perform their activities of daily living and depend on a qualified caregiver who provides most of their support and who need relief to avoid the member moving into a facility; children who were previously covered for respite services under the Pediatrics Palliative Care Waiver, foster care beneficiaries, members enrolled in either California Children's Services (CCS) or the Genetically Handicapped Persons Program (GHPP), and members with complex care needs.

Limitations

In the home setting, these services, in combination with any direct care services the member is receiving, cannot exceed 24 hours per day of care.

Service is limited to 336 hours per calendar year. Exceptions can be made with Alliance authorization.

This service is only to avoid placement for which the Alliance would be responsible.

Respite services cannot be provided virtually, or via telehealth.

Environmentally Accessibility Adaptations (Home Modifications)

The Alliance offers environmentally accessibility adaptations (home modifications) to members for physical changes to a home so an individual can stay in their own home and avoid going to a facility.

Eligibility

Members who are at risk for institutionalization in a nursing facility.

Limitations

If another service such as DME is available and would accomplish the same goals of independence and avoid institutional placement, that service should be used.

Environmental accessibility adaptations (EAA) must be conducted in accordance with applicable state and local building codes. EAA are payable up to a total lifetime maximum of $7,500. The only exceptions are if the member's place of residence changes or if the member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

Modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g. to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Major organ transplant

Transplants for children under age 21

In Alameda County, state law requires children who need transplants to be referred to the California Children's Services (CCS) program to decide if the child qualifies for CCS. If the child qualifies for CCS, CCS will cover the costs for the transplant and related services.

If the child does not qualify for CCS, the Alliance will refer the child to a qualified transplant center for evaluation. If the transplant center confirms that the transplant would be needed and safe, the Alliance will cover the transplant and related services.

Transplants for adults ages 21 and older

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

The major organ transplants that the Alliance covers include, but are not limited to:

- Bone marrow
- Heart

- Heart/lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/small bowel
- Lung
- Pancreas
- Small bowel

Street medicine programs

Members experiencing homelessness may receive covered services from Street Medicine Providers within the Alliance provider network. A Street Medicine Provider is a licensed primary care physician or primary care non-physician in-network.

Members experiencing homelessness may be able to select an Alliance Street Medicine Provider to be their primary care provider (PCP), if the Street Medicine Provider meets PCP eligibility criteria and agrees to be the member's PCP. For more information on the Alliance's street medicine program, 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).

Other Medi-Cal programs and services

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

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

Outpatient prescription drugs

Prescription drugs covered by Medi-Cal Rx

Prescription drugs given by a pharmacy are covered by Medi-Cal Rx, which is a Medi-Cal FFS program. The Alliance might cover some drugs a provider gives in an office or clinic. If your provider prescribes drugs given in the doctor's office, infusion center, or by a home infusion provider, these are considered physician-administered drugs.

If a non-pharmacy based medical health care professional administers a drug, it is covered under the medical benefit. Your provider can prescribe you drugs on the Medi-Cal Rx Contract Drugs List.

Sometimes, you need a drug not on the Contract Drugs List. These drugs need approval before you can fill the prescription at the pharmacy. Medi-Cal Rx will review and decide these requests within 24 hours.

- A pharmacist at your outpatient pharmacy may give you a 14-day emergency supply if they think you need it. Medi-Cal Rx will pay for the emergency medicine an outpatient pharmacy gives.
- Medi-Cal Rx may say no to a non-emergency request. If they do, they will send you a letter to tell you why. They will tell you what your choices are. To learn more, read "Complaints" in Chapter 6 of this handbook.

To find out if a drug is on the Contract Drugs List or to get a copy of the Contract Drugs List, call Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711). Or go to the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/.

Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with Medi-Cal Rx. You can find a list of pharmacies that work with Medi-Cal Rx in the Medi-Cal Rx Pharmacy Directory at https://medi-calrx.dhcs.ca.gov/home/. You can also find a pharmacy near you or a pharmacy that can mail your prescription to you by calling Medi-Cal Rx at 1-800-977-2273 (TTY press 7 or dial 711).

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

Members can also get transportation services from the Alliance to get to pharmacies. To learn more about transportation services, read “Transportation benefits for situations that are not emergencies” in Chapter 4 of this handbook.

Specialty mental health services

Some mental health services are provided by county mental health plans instead of the Alliance. These include specialty mental health services (SMHS) for Medi-Cal members who meet rules for SMHS.

SMHS may include these outpatient, residential, and inpatient services:

Outpatient services:

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

Residential services:

- Adult residential treatment services
- Crisis residential treatment services

Inpatient services:

- Psychiatric inpatient hospital services
- Psychiatric health facility services

To learn more about specialty mental health services the county mental health plan provides, you can call your county mental health plan. To find all counties' toll-free telephone numbers online, go to https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx. If the Alliance finds you will need services from the county mental health plan, the Alliance will help you connect with the county mental health plan services.

Substance use disorder treatment services

The Alliance encourages members who want help with alcohol use or other substance use to get care. Services for substance use are available from general care providers such as primary care, inpatient hospitals, and emergency departments and from specialty substance use service providers. County Behavioral Health Plans often provide specialty services.

To learn more about treatment options for substance use disorders, call Alameda County Behavioral Health Care Services - ACCESS Program toll-free at 1-800-491-9099.

The Alliance members can have an assessment to match them to the services that best fit their health needs and preferences. When medically necessary, available services include outpatient treatment, residential treatment, and medicines for substance use disorders (also called Medication Assisted Treatment (MAT)) such as buprenorphine, methadone, and naltrexone.

The county provides substance use disorder services to Medi-Cal members who qualify for these services. Members who are identified for substance use disorder treatment services are referred to their county department for treatment. For a list of all counties' telephone numbers go to https://www.dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx.

The Alliance will provide or arrange for MAT to be given in primary care, inpatient hospital, emergency department, and other medical settings.

Dental services

The Medi-Cal Dental FFS Program is the same as FFS Medi-Cal for your dental services. Before you get dental services, you must show your BIC to the dental provider. Make sure the provider takes FFS Dental and you are not part of a managed care plan that covers dental services.

Medi-Cal covers a broad range of dental services through the Medi-Cal Dental Program, including:

- Diagnostic and preventive dental services such as examinations, X-rays, and teeth cleanings
- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planing
- Complete and partial dentures
- Orthodontics for children who qualify
- Topical fluoride

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

California Children's Services (CCS)

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

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

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

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

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

Examples of CCS-eligible conditions include but are not limited to:

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

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

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

1915(c) waiver Home and Community-Based Services (HCBS)

California's six Medi-Cal 1915(c) waivers allow the state to provide services to persons who would otherwise need care in a nursing facility or hospital in the community-based setting of their choice. Medi-Cal has an agreement with the Federal Government that allows waiver services to be offered in a private home or in a homelike community setting. The services offered under the waivers must not cost more than the alternative institutional level of care. HCBS Waiver recipients must qualify for full-scope Medi-Cal.

The six Medi-Cal 1915(c) waivers are:

- California Assisted Living Waiver (ALW)
- California Self-Determination Program (SDP) Waiver for Individuals with Developmental Disabilities
- HCBS Waiver for Californians with Developmental Disabilities (HCBS-DD)
- Home and Community-Based Alternatives (HCBA) Waiver
- Medi-Cal Waiver Program (MCWP), formerly called the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver
- Multipurpose Senior Services Program (MSSP)

To learn more about the Medi-Cal Waivers, go to https://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx. Or call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

In-Home Supportive Services (IHSS)

The In-Home Supportive Services (IHSS) program provides in-home personal care assistance to qualified aged, blind, and disabled persons as an alternative to out-of-home care. It enables recipients to stay safely in their own homes.

To learn more about IHSS available in your county, go to www.CDSS.CA.GOV/inforesources/ihss. Or call your local county social services agency.

Services you cannot get through the Alliance or Medi-Cal

The Alliance and Medi-Cal will not cover some services. Services that the Alliance or Medi-Cal do not cover include, but are not limited to:

- In vitro fertilization (IVF), including but not limited to infertility studies or procedures to diagnose or treat infertility
- Fertility preservation

- Experimental services
- Home modifications
- Vehicle modifications
- Cosmetic surgery

The Alliance may cover a non-covered service if it is medically necessary. Your provider must submit a pre-approval (prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.

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

Evaluation of new and existing technologies

The Alliance has a process for reviewing new and/or experimental technology as well as new ways to use existing technology. The Alliance's process for reviewing new and/or experimental technology complies with standards set by Title 42, CFR, §422.202(b).

The evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care. The Alliance reviews new technology and new application of existing technology for inclusion in plan benefits.

This review encompasses the following:

- Medical procedures
- Behavioral healthcare procedures
- Pharmaceuticals
- Devices

5. Child and youth well care

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

Pediatric services (Children under age 21)

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

Covered services include, but are not limited to:

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

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

Well-child health check-ups and preventive care

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

Preventive care also includes shots you or your child need. The Alliance must make sure all enrolled children are up to date with all the shots they need when they have their visits with their doctor. Preventive care services and screenings are available at no cost and without pre-approval (prior authorization).

Your child should get check-ups at these ages:

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

Well-child health check-ups include:

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

- Health education
- Vision and hearing screening
- Oral health screening
- Behavioral health assessment

If the doctor finds a problem with your or your child's physical or mental health during a check-up or screening, you or your child might need to get medical care.

The Alliance will cover that care at no cost to you, including:

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

Blood lead poisoning screening

All children enrolled in the Alliance should get blood lead poisoning screening at 12 and 24 months of age or between 36 and 72 months of age if they were not tested earlier. Children should also be screened whenever the doctor believes a life change has put the child at risk.

Help getting child and youth well care services

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

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

An Alliance care coordinator can:

- Tell you about available services
- Help find in-network providers or out-of-network providers, when needed
- Help make appointments
- Arrange medical transportation so children can get to their appointments
- Help coordinate care for services available through fee-for-service (FFS) Medi-Cal, such as:
    - Treatment and rehabilitative services for mental health and substance use disorders
    - Treatment for dental issues, including orthodontics

Other services you can get through fee-for-service (FFS) Medi-Cal or other programs

Dental check-ups

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

These Medi-Cal dental services are free or low-cost services for:

Babies aged 1 to 4

- Baby's first dental visit
- Baby's first dental exam
- Dental exams (every 6 months, and sometimes more)
- X-rays
- Teeth cleaning (every 6 months, and sometimes more)
- Fluoride varnish (every 6 months, and sometimes more)
- Fillings
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Kids aged 5-12

- Dental exams (every 6 months, and sometimes more)
- X-rays
- Fluoride varnish (every 6 months, and sometimes more)
- Teeth cleaning (every 6 months, and sometimes more)
- Molar sealants
- Fillings
- Root canals
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Youth aged 13-20

- Dental exams (every 6 months, and sometimes more)
- X-rays
- Fluoride varnish (every 6 months, and sometimes more)
- Teeth cleaning (every 6 months, and sometimes more)
- Orthodontics (braces) for those who qualify
- Fillings
- Crowns
- Root canals
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

*Providers should consider sedation and general anesthesia when they determine and document a reason local anesthesia is not medically appropriate, and the dental treatment is pre-approved or does not need pre-approval (prior authorization).

These are some of the reasons local anesthesia cannot be used and sedation or general anesthesia might be used instead:

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

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

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

Additional preventive education referral services

If you are worried that your child is not participating and learning well at school, talk to your child's doctor, teachers, or administrators at the school. In addition to your medical benefits covered by the Alliance, there are services the school must provide to help your child learn and not fall behind.

Services that can be provided to help your child learn include:

- Speech and language services
- Psychological services
- Physical therapy
- Occupational therapy
- Assistive technology
- Social Work services
- Counseling services
- School nurse services
- Transportation to and from school

The California Department of Education provides and pays for these services. Together with your child's doctors and teachers, you can make a custom plan that will best help your child.

6. Reporting and solving problems

There are two ways to report and solve problems:

- Use a **complaint** (**grievance**) when you have a problem or are unhappy with the Alliance or a provider or with the health care or treatment you got from a provider.
- Use an **appeal** when you don't agree with the Alliance's decision to change your services or to not cover them.

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

You may contact the Alliance Member Services Department first to let us know about your problem.

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

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

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

If your grievance or appeal is still not resolved after 30 days, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC). Ask them to review your complaint or conduct an Independent Medical Review (IMR). If your matter is urgent, such as those involving a serious threat to your health, you may call DMHC right away without first filing a grievance or appeal with the Alliance. You can call DMHC for free at 1-888-466-2219 (TTY 1-877-688-9891 or 711). Or go to https://www.dmhc.ca.gov.

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

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

To report incorrect information about your health insurance, call Medi-Cal Monday through Friday, 8 am to 5 pm at 1-800-541-5555.

Complaints

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

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

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

Mail the form to:

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

Your doctor's office will have complaint forms.

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

If you need help filing your complaint, we can help you. We can give you no-cost language services. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

If you have an urgent matter involving a serious health concern, we will start an expedited (fast) review. We will give you a decision within 72 hours. To ask for an expedited review, call us at the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

Within 72 hours of getting your complaint, we will decide how we will handle your complaint and whether we will expedite it. If we find that we will not expedite your complaint, we will tell you that we will resolve your complaint within 30 days. You may contact DMHC directly for any reason, including if you believe your concern qualifies for expedited review, or the Alliance does not respond to you within the 72-hour period.

Complaints related to Medi-Cal Rx pharmacy benefits are not subject to the Alliance grievance process or eligible for Independent Medical Review. Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY press 7 or dial 711). Or go to https://medi-calrx.dhcs.ca.gov/home/.

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

Appeals

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

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

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

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

  Mail the form to:

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

Your doctor's office will have appeal forms available.

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

If you need help asking for an appeal or with Aid Paid Pending, we can help you. We can give you no-cost language services. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

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

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

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

- Ask for a **State Hearing** from the California Department of Social Services (CDSS), and a judge will review your case. CDSS' toll-free telephone number is 1-800-743-8525 (TTY 1-800-952-8349). You can also ask for a State Hearing online at www.CDSS.CA.GOV.
- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have the Alliance's decision reviewed. Or ask for an **Independent Medical Review (IMR)** from DMHC. If your complaint qualifies for DMHC's Independent Medical Review (IMR) process, an outside doctor who is not part of the Alliance will review your case and make a decision that the Alliance must follow.

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

- DMHC's toll-free telephone number is 1-888-466-2219 (TTY 1-877-688-9891). You can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: https://www.dmhc.ca.gov.

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

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

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

Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by the Alliance. You can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling 1-800-977-2273 (TTY press 7 or dial 711). Complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review (IMR).

If you do not agree with a decision related to your Medi-Cal Rx pharmacy benefit, you may ask for a State Hearing. You cannot ask DMHC for an IMR for Medi-Cal Rx pharmacy benefit decisions.

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

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

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

If your complaint to DMHC does not qualify for an IMR, DMHC will still review your complaint to make sure the Alliance made the correct decision when you appealed its denial of services.

The 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 **www.dmhc.ca.gov/** has complaint forms, IMR application forms and instructions online.

State Hearings

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

You must ask for a State Hearing within 120 days from the date on our NAR letter. If we gave you Aid Paid Pending during your appeal and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 days of our NAR letter or before the date we said your services will stop, whichever is later.

If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, contact the Alliance between Monday through Friday, 8 am to 5 pm by calling 1-510-747-4567 or toll-free at 1-877-932-2738 . If you cannot hear or speak well, call 1-800-735-2929. Your authorized representative or provider can ask for a State Hearing for you with your written permission.

Sometimes you can ask for a State Hearing without completing our appeal process. For example, if we did not notify you correctly or on time about your services, you can request a State Hearing without having to complete our appeal process. This is called Deemed Exhaustion.

Here are some examples of Deemed Exhaustion:

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

You can ask for a State Hearing in these ways:

- **Online:** Request a hearing online at www.CDSS.CA.GOV
- **Fax:** Fill out the form that came with your appeals resolution notice and Fax it to the State Hearings Division at 1-833-281-0905
- **By phone:** Call the State Hearings Division at 1-800-743-8525 (TTY 1-800-952-8349 or 711)

- **By mail**: Fill out the form provided with your appeals resolution notice and send it to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, MS 09-17-442
  Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you no-cost language services. Call the Alliance Member Services Department at 1-510-747-4567 or toll-free at 1-877-932-2738 (TTY 1-800-735-2929 or 711).

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

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

Fraud, waste, and abuse

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

Provider fraud, waste, and abuse includes:

- Falsifying medical records
- Prescribing more medicine than is medically necessary
- Giving more health care services than medically necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service
- Offering free or discounted items and services to members to influence which provider is selected by the member

- Changing member's primary care provider without the knowledge of the member

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

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

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

Send your report to:

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

Anonymous Compliance Hotline: 1-844-587-0810
Phone Number: 1-510-747-4500
People with hearing and speaking impairments (CRS/TTY): 711/1-800-735-2929

7. Rights and responsibilities

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

Your rights

These are your rights as a member of the Alliance:

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

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

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

Your responsibilities

Alliance members have these responsibilities:

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

Notice of non-discrimination

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

The Alliance provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats)

- No-cost language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

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

How to file a grievance

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

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

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

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

Office of Civil Rights – California Department of Health Care Services

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

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

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

  Complaint forms are available at https://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- **Electronically:** Send an email to CivilRights@dhcs.ca.gov.

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

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

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

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

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

Ways to get involved as a member

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

Alliance Consumer Advisory Committee (CAC)

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

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

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

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

Member Surveys

The Alliance surveys members to ask for feedback on our services and the health care we provide. Your valued input helps make our programs better for all members. Please take time to respond to surveys by mail or phone.

Notice of privacy practices

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

If you are of the age and capacity to consent to sensitive services, you are not required to get any other member's authorization to get sensitive services or to submit a claim for sensitive services. You can read more about sensitive services in the "Sensitive care" section of this handbook.

You can ask the Alliance to send communications about sensitive services to another mailing address, email address, or telephone number that you choose. This is called a "request for confidential communications." If you request confidential communications, the Alliance will not give information on your sensitive care services to anyone else without your written permission. If you do not give a mailing address, email address, or telephone number, the Alliance will send communications in your name to the address or telephone number on file.

The Alliance will honor your requests to get confidential communications in the form and format you asked for. Or we will make sure your communications are easy to put in the form and format you asked for. We will send them to the place you choose. Your request for confidential communications lasts until you cancel it or submit new request for confidential communications.

Members can request confidential communications by writing, email, or through the Alliance Member Portal. Please submit your request and include the address and/or phone number you would like for us to use.

- **In writing:** Please send a letter to:

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

  Fax: 1-877-747-4504

- **By email:** Please email the Alliance Member Services Department at memberservices@alamedaalliance.org

  Please Note: Sending Protected Health Information (PHI) (also called medical or personal information) through email may not be a secure method of communication with the Alliance, third parties may intercept the email and use the information for malicious purposes.
- **Alliance Member Portal:** To upload a document through the Alliance Member Portal please complete the following steps:

  1. Visit the Alliance website at www.alamedaalliance.org
  2. Click ‘Member Portal’ in the top right corner
  3. Sign in to the Member Portal
  4. Click ‘Help & Resources’ in the top navigation toolbar
  5. Click ‘Contact Us’
  6. Under ‘Send a secure message’, select ‘click here’
  7. Write a message in the box and click ‘Submit’ when done.

The Alliance’s statement of its policies and procedures for protecting your medical information (called a “Notice of Privacy Practices”) is included below:

Alliance Notice of Privacy Practices

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

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

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

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

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

Types of information we keep

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

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

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

How we may use or share your information

1. **Treatment –** We may use or share your information to help your doctors or hospitals provide health care to you. For example, if you are in the hospital, we may give them your health records sent to us by your doctor. Or we may share this information with a pharmacist who needs it for a prescription for you, or a lab that performs a test for you.
2. **Payment –** We may use or share your information to pay for your health care-related bills. For example, your doctor will give us information we need before we pay them. We may also share information with other health care providers to 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 also use or share this information so we can approve services and 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. We may share this information in a disaster even if you do not want us to so that 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 law.
7. **Provider peer review –** We may use or share your information to review the skills of your provider or the quality of care you receive.
8. **Group health plans –** If you are a member of a group health plan, we may share information with the sponsor of your group health plan. For instance, if your employer provides your health coverage, we may let your employer know if you are still a member of the plan.
9. **Research –** We may share your information without your written consent if the research meets certain rules.
10. **Marketing –** We may contact you to give you information about products or a service. We will not use or share your information for this purpose without your written permission.
11. **Court and administrative proceedings –** We may, and sometimes need to by law, share your information for an administrative or judicial proceeding as we are told to by a court or administrative order, if you were told of the request and you did not object or the court or administrative judge did not agree with your objection.
12. **Health monitoring activities –** We may, and sometimes need to by law, share your information with health monitoring agencies for audits, investigations, inspections, licensure 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 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 to coroners when they investigate deaths.
    - We may share information with organizations that provide services for organ and tissue transplants.
    - We may use or share your information with the FDA when it is about the quality, safety, or effectiveness of an FDA-related product or activity.
    - We may use or share your information with Conservators/Guardians under certain circumstances.
    - We may share your information as we need to for worker's compensation.
    - If the Alliance is sold or merged with another organization, your information/record will be owned by the new owner, but you will be able to change enrollment to another health plan.

- We may use or share your information in order to protect it when we send it over the internet.

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

When we may not use or share your information

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

The Alliance may contact you

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

Your privacy rights

1. **Right to request special privacy protections –** You have the right to ask for limits on certain uses and sharing of your information. You can do this by a written request that tells us what information you want to limit and what ways you want to limit our use or sharing of that information. We reserve the right to accept or reject your request and will let you know of our decision.

2. **Right to request confidential communications –** You have the right to ask that you receive your information in a specific way or at a specific location if the usual way may put you in danger. For example, you may ask that we send information to your work address. Please write us and tell us how you would like to receive your information and why you would be in danger if we did not follow your request. If your request has a cost that you will have to pay for, we will let you know.
3. **Right to see and copy –** You have the right to see and copy your information, with limited exceptions. To see your information, you must send a written request and tell us what information you want to see. Also let us know if you want to see it, copy it, or get a copy of it. California law allows us to charge a fair fee to copy records. We may deny your request under limited circumstances.
4. **Right to request information through a third-party application –** You have the right to request certain information through a third-party application of your choice as allowed by the “Interoperability Rules”.
5. **Right to change or supplement –** You have a right to ask that we change your information that you believe is incorrect or incomplete. You must ask us in writing to change your record. Tell us the reasons you believe the information is not correct. We do not have to change your information, and if we deny your request, we will let you know why. We will also tell you how you can disagree with our denial. We may deny your request of we do not have the information. We may also deny your request if we did not create the information (unless the person that created the information is no longer available to make the amendment). We may also deny your request if you would not be permitted to inspect or copy the information or the information is correct and complete.
6. **Right to an accounting of how we shared your information –** You have a right to receive a list of how we shared certain information during the **six (6) years** prior to your request. Please note that a fee may apply.
7. **Right to receive notice of privacy breach –** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your Protected Health Information.
8. **Right to a paper copy of this Notice of Privacy Practices –** You have a 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 contact the Alliance Member Services Department at **1-510-747-4567** or toll-free at **1-877-932-2738** (People with hearing and speaking impairments (CRS/TTY)) **711/1-800-735-2929**).

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

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 (HHS) 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.

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

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

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

You may also notify the Alliance Privacy Officer 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.

Notice about laws

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

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

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

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

Federal and state laws require Medi-Cal members to report OHC and any changes to an existing OHC. You may have to repay DHCS for any benefits paid by mistake if you don't report OHC quickly. Submit your OHC online at http://dhcs.ca.gov/OHC.

If you do not have access to the internet, you can report OHC to the Alliance. Or call toll-free 1-800-541-5555 (TTY 1-800-430-7077 or 711) inside California, or 1-916-636-1980 (outside California).

The California Department of Health Care Services (DHCS) has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. For example, if you are injured in a car accident or at work, auto or workers' compensation insurance may have to pay first, or reimburse Medi-Cal.

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

Submit your notification online:

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

To learn more, visit https://dhcs.ca.gov/tplrd or call 1-916-445-9891.

Notice about estate recovery

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

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

Notice of Action

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

Contents in notices

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

- A statement of the action the Alliance intends to take
- A clear and concise explanation of the reasons for the Alliance's decision
- How the Alliance decided, including the rules the Alliance used
- The medical reasons for the decision. The Alliance must clearly state how the member's condition does not meet the rules or guidelines.

Translations

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

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

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

8. Important numbers and words to know

Important phone numbers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medi-Cal Rx
Toll-Free: 1-800-977-2273
People with hearing and speaking impairments (TTY/TDD): 1-800-977-2273, press 7 or dial 711

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

Words to know

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

Acute: A short, sudden medical condition that requires fast medical attention.

American Indian: Individual who meets the definition of “Indian” under federal law at 42 CFR section 438.14, which defines a person as an “Indian” if the person meets any of the following:

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

- Is a member of a federally recognized Indian tribe,
- Lives in an urban center and meets one or more of the following:
    - Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant in the first or second degree of any such member, or
    - Is an Eskimo or Aleut or other Alaska Native, or
    - Is considered by the Secretary of the Interior to be an Indian for any purpose, or
    - Is determined to be an Indian under regulations issued by the Secretary of the Interior, or
- Is considered by the Secretary of the Interior to be an Indian for any purpose, or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native

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

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

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

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

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

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

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

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

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

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

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

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

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

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. You are automatically enrolled in a COHS plan if you meet enrollment rules. Enrolled recipients choose their health care provider from among all COHS providers.

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

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

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

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

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

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

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

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

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

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

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

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

Established patient: A patient who has an existing relationship with a provider and has gone to that provider within a specified amount of time established by the health plan.

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

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

Family planning services: Services to prevent or delay pregnancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Intermediate care facility or home: Care provided in a long-term care facility or home that provides 24-hour residential services. Types of intermediate care facilities or homes include intermediate care facility/developmentally disabled (ICF/DD), intermediate care facility/developmentally disabled-habilitative (ICF/DD-H), and intermediate care facility/developmentally disabled-nursing (ICF/DD-N).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthotic device: A device used as a support or brace attached outside the body to support or correct a badly injured or diseased body part that is medically necessary for the medical recovery of the member.

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

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

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

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

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

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

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

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

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

Plan: Go to "Managed care plan."

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized to keep the member stabilized.

Post-stabilization care services are covered and paid for. Out-of-network hospitals might need pre-approval (prior authorization).

Pre-approval (prior authorization): The process by which you or your provider must request approval from the Alliance for certain services to make sure the Alliance will cover them. A referral is not an approval. A pre-approval is the same as prior authorization.

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

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

Primary care: Go to “Routine care.”

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need.

Your PCP can be a:

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

Prior authorization (pre-approval): The process by which you or your provider must request approval from the Alliance for certain services to ensure the Alliance will cover them. A referral is not an approval. A prior authorization is the same as pre-approval.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subacute care facility (adult or pediatric): A long-term care facility that provides comprehensive care for medically fragile persons that need special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.

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

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

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

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