Alameda Alliance for Health

Medi-Cal Program

Combined Evidence of Coverage and Disclosure Form
Updated Calendar Year 2017

This document is available in alternative formats (Braille, audio, electronic text file, or large print). Call Alliance Member Services at 510-747-4567 or CRS/TTY 711 / 1-800-735-2929.

Traducción al español: Este documento está disponible en español. Llame a Servicios al Cliente de Alliance al 510-747-4567 ó al CRS/TTY 711 / 1-800-735-2929.

中文譯文：本文件以中文提供。致電 「聯會會員服務部」：510-747-4567 或 CRS/TTY 711 / 1-800-735-2929.

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Introduction

Welcome to Alameda Alliance for Health

Thank you for choosing Alameda Alliance for Health (Alliance) as your Medi-Cal managed care plan. The Alliance contracts with doctors who have their own office. We also have clinics, hospitals, and other health workers to provide care to our members. Our plan gives you access to all the services you need. These include routine care with your own doctor, inpatient care, lab tests, pharmacy, and other items listed in the "Benefits" section of this booklet. Our friendly staff will help you access the care you need. We also offer health education programs to you and your enrolled family members. These programs can help you protect and improve your health.

This Combined Evidence of Coverage (EOC) and Disclosure Form

We refer to this Combined Evidence of Coverage (EOC) and Disclosure Form as a “booklet.” This booklet tells you about health care coverage you get through the Alliance. It talks about the providers, benefits, and rules of the plan. It also lists your rights and responsibilities as a member.

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. You may see a copy of the health plan contract between the Alliance and the Department of Health Care Services if you ask for it. You should read this booklet fully and with care so you will know who or what groups can provide health care services to you. The Alliance Provider Directory lists all of the providers with the Alliance who care for our members. If you do not have a copy of this listing, call Alliance Member Services and we will mail you a copy. If you have special health care needs, please read the parts of this booklet that apply to you (see Contact List for phone number).

Definitions

Some terms have special meaning in this booklet. A complete list of these words is in the “Definitions” section. In this booklet, we use the terms listed below:

- “You” or “your” means a member (the person covered under the Alliance’s Medi-Cal plan).
- “We,” “us,” or “our” means Alameda Alliance for Health.
- “Alliance provider” refers to a licensed doctor, hospital, medical group, pharmacy, or other health care provider who has a contract with the Alliance to provide medically necessary covered services to members. These Alliance providers are the “Alliance network.”
- “Benefits” are the package of medically necessary covered services (such as office visits, lab tests, and surgery), supplies (such as prescription drugs and durable medical equipment), and facilities (such as hospital rooms) that the Alliance gives its members access to and pays for. Exclusions, limitations, and reductions apply.
Introduction

- A “covered service” is a medically necessary health care service that a provider gives an Alameda Alliance for Health (Alliance) member, which is paid for (partially or fully) by the Alliance when conditions and requirements are met (see "Benefits" section, subject to the "Exclusions, Limitations, and Reductions" section).
- An “exclusion” is a service we do not cover.
### Contact List

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<th>Entity</th>
<th>Phone Number</th>
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<tr>
<td>Alameda Alliance for Health (Alliance) – Member Services</td>
<td>Monday - Friday 8 am – 5 p m Phone: 510-747-4567 Toll-Free: 1-877-932-2738</td>
<td>Main Office: 1240 South Loop Road Alameda, CA 94502 Mailing: Alliance Member Services P.O. Box 2818 Alameda, CA 94501-0818</td>
<td><a href="http://www.alamedaalliance.org">www.alamedaalliance.org</a></td>
</tr>
<tr>
<td>Alliance – Community Outreach Center, Ed Roberts Campus, a Center for People with Disabilities</td>
<td>510-747-6100</td>
<td>3075 Adeline Street, Suite 160 Berkeley, CA 94703</td>
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<tr>
<td>Alliance – Grievance and Appeal</td>
<td>Phone: 510-747-4567 Fax: 1-855-891-7258</td>
<td>1240 South Loop Road Alameda, CA 94502</td>
<td>To file a Grievance on-line, members must log into the member portal. Go to: <a href="http://www.alamedaalliance.org">www.alamedaalliance.org</a> and see log in information.</td>
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<tr>
<td>Alliance – Health Education</td>
<td>510-747-4577</td>
<td>1240 South Loop Road Alameda, CA 94502</td>
<td><a href="http://www.alamedaalliance.org/live-healthy">www.alamedaalliance.org/live-healthy</a></td>
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<td>Alliance – Interpreter Scheduling</td>
<td>Phone: 510-747-4567</td>
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<td>(to schedule face-to-face interpreters)</td>
<td>Toll-Free: 1-877-932-2738</td>
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<td>CRS/TTY: 711/1-800-735-2929</td>
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<td>Alliance – Nurse Advice Line</td>
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<td>24-Hour Interpreter Hotline (for interpreters by phone)</td>
<td>510-809-3986</td>
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<td>Alameda County Behavioral Health Care Services – ACCESS Program</td>
<td>1-800-491-9099</td>
<td>2000 Embarcadero Cove, Suite 400, Oakland, CA 94606</td>
<td><a href="http://www.acbhcs.org">www.acbhcs.org</a></td>
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<td>Alameda County Targeted Case Management</td>
<td>510-267-8000</td>
<td>1000 Broadway, Suite 500, Oakland, CA 94607</td>
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<td>Beacon Health Strategies (Also known as College Health IPA; Subcontracted Behavioral Health Provider for Outpatient Mental Health Services)</td>
<td>1-855-856-0577</td>
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<td><a href="http://www.beaconhealthstrategies.com">www.beaconhealthstrategies.com</a></td>
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<td>California Children's Services (CCS)</td>
<td>510-208-5970</td>
<td>1000 Broadway, Suite 500 Oakland, CA 94607</td>
<td><a href="http://www.dhcs.ca.gov/services/ccs">www.dhcs.ca.gov/services/ccs</a></td>
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<td>California Department of Health Care Services (DHCS)</td>
<td>1-916-445-4171</td>
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<td>California Department of Health Care Services (DHCS) – Genetically Handicapped Persons Program (GHPP)</td>
<td>1-800-639-0597</td>
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<td><a href="http://www.dhcs.ca.gov/services/ghpp">www.dhcs.ca.gov/services/ghpp</a></td>
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<td>California Department of Health Care Services (DHCS) – Medi-Cal</td>
<td>1-916-636-1980</td>
<td></td>
<td><a href="http://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx">www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx</a></td>
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<td>California Department of Health Care Services (DHCS) – Office of Family Planning Family PACT</td>
<td>1-800-541-5555</td>
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<td><a href="http://www.familypact.org">www.familypact.org</a></td>
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<td>California Department of Health Care Services (DHCS) – Recovery/Third Party Liability/Other Coverage</td>
<td>1-800-952-5294</td>
<td>Department of Health Care Services Recovery Section</td>
<td><a href="http://www.dhcs.ca.gov/services/PagesThirdPartyLiability.aspx">www.dhcs.ca.gov/services/PagesThirdPartyLiability.aspx</a></td>
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<td>Sacramento, CA 95899-7425</td>
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<td>California Department of Public Health Prenatal Screening Branch</td>
<td>1-866-718-7915</td>
<td>Genetic Disease Screening Program</td>
<td><a href="http://www.cdpca.gov/programs/pns">www.cdpca.gov/programs/pns</a></td>
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<td>850 Marina Bay Parkway, Suite 175, MS 8200</td>
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<td>Richmond, CA 94804</td>
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<td>California Department of Social Services</td>
<td>Phone: 1-800-952-5253</td>
<td>TTY: 1-800-952-8349</td>
<td><a href="http://www.cdss.ca.gov">www.cdss.ca.gov</a></td>
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<td>P.O. Box 944243, Mail Station 19-37</td>
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<td>Sacramento, CA 94244-2430</td>
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<td>California Home Medical Equipment (CHME)</td>
<td>1-800-906-0626</td>
<td>289 Foster City Blvd, Foster City, CA 94404</td>
<td><a href="http://www.chme.org">www.chme.org</a></td>
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<td>California Relay Service (for the hearing impaired)</td>
<td>CRS/TTY: 711/1-800-735-2929</td>
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<td>Children First Medical Group (CFMG)</td>
<td>510-428-3154</td>
<td>6425 Christie Avenue, Suite 110 Emeryville, CA 94608</td>
<td><a href="http://www.children-first-medical-group.com">www.children-first-medical-group.com</a></td>
</tr>
<tr>
<td>City of Berkeley Public Health Division</td>
<td>510-981-5300</td>
<td>1947 Center Street, 2nd Floor Berkeley, CA 94704</td>
<td><a href="http://www.cityofberkeley.info/publichealth">www.cityofberkeley.info/publichealth</a></td>
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<td>Community Health Center Network (CHCN)</td>
<td>510-297-0200</td>
<td>101 Callan Avenue, 3rd Floor San Leandro, CA 94577</td>
<td><a href="http://www.chcnetwork.org">www.chcnetwork.org</a></td>
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<td>Denti-Cal</td>
<td>Phone: 1-800-322-6384 TTY: 1-800-735-2922</td>
<td>P.O. Box 15539 Sacramento, CA 95852-1539</td>
<td><a href="http://www.denti-cal.ca.gov">www.denti-cal.ca.gov</a></td>
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<td>Department of Managed Health Care (DMHC) – California HMO Help Center</td>
<td>Phone: 1-888-466-2219 TDD: 1-877-688-9891</td>
<td>980 9th Street, Suite 500 Sacramento, CA 95814</td>
<td><a href="http://www.dmhc.ca.gov">www.dmhc.ca.gov</a></td>
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<tr>
<td>Department of Managed Health Care (DMHC) – Office of the Patient Advocate</td>
<td>Phone: 1-866-466-8900 TTY: 1-866-499-0858</td>
<td>980 9th Street, Suite 500 Sacramento, CA 95814</td>
<td><a href="http://www.opa.ca.gov">www.opa.ca.gov</a></td>
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<td>Department of Social Services Public Inquiry and Response Unit</td>
<td>1-800-952-5253</td>
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<td><a href="http://www.dss.cahwnet.gov/cdssweb/PG">www.dss.cahwnet.gov/cdssweb/PG</a> 49.htm</td>
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<tr>
<td>EviCore</td>
<td>1-800-420-3471</td>
<td>Option 2</td>
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<tr>
<td>(Formerly known as CareCore National (Radiology Benefit Manager for radiology services requiring authorization))</td>
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<tr>
<td>Health Care Options</td>
<td>Phone: 1-800-430-4263 TTY: 1-800-430-7077</td>
<td>CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850</td>
<td><a href="http://www.healthcareoptions.dhcs.ca.gov">www.healthcareoptions.dhcs.ca.gov</a></td>
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<tr>
<td>March Vision Care</td>
<td>1-844-336-2724</td>
<td>6701 Center Drive West, Suite 790 Los Angeles, CA 90045</td>
<td><a href="http://www.marchvisioncare.com">www.marchvisioncare.com</a></td>
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<tr>
<td>Native American Health Center – Indian Health Service Facility in Alameda County</td>
<td>510-535-4400</td>
<td>3124 International Blvd. Oakland, CA 94601</td>
<td><a href="http://www.nativehealth.org">www.nativehealth.org</a></td>
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<tr>
<td>Entity</td>
<td>Phone Number</td>
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<td>Organ Donation: Donate Life California</td>
<td>1-866-797-2366</td>
<td>California Transplant Donor Network</td>
<td><a href="http://www.donatelifecalifornia.org">www.donatelifecalifornia.org</a></td>
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<td></td>
<td></td>
<td>1000 Broadway, Suite 600</td>
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<tr>
<td>Regional Center of the East Bay</td>
<td>510-618-6100</td>
<td>500 Davis Street, Suite 100</td>
<td><a href="http://www.rceb.org">www.rceb.org</a></td>
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<tr>
<td>(Developmental Disabilities)</td>
<td></td>
<td>San Leandro, CA 94577</td>
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<td>Women, Infants and Children (WIC)</td>
<td>1-888-942-9675</td>
<td></td>
<td><a href="http://www.cdph.ca.gov/programs/wicworks">www.cdph.ca.gov/programs/wicworks</a></td>
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Service Area
How to Get Help
We want you to be happy with the health care you get from our providers. If you have any questions or concerns about your care, talk with your Primary Care Provider (PCP) or other providers who see you. They want to help you with your questions.

Member Services
Alameda Alliance for Health (Alliance) Member Services staff is here to assist you with benefits and covered services. We can:

- Answer questions about the health plan.
- Help you choose a PCP.
- Tell you where to get the care you need.
- Provide you with interpreter services if English is not your primary language.

You can call Alliance Member Services to ask for help Monday through Friday, 8:00 am to 5:00 pm (see Contact List for phone number).

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

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

The Alliance provides translation of written Member materials in its threshold languages: Spanish, Cantonese, and Vietnamese. Member materials can be translated into other languages as needed, upon request.

To schedule face-to-face interpreter services:
- Call Alliance Member Services Monday through Friday, 8:00 am to 5:00 pm (see Contact List for phone number). Please call 72 hours in advance to schedule face-to-face interpreter services.

To get after hours telephonic interpreter services:
- Call our 24-hour Interpreter Hotline (see Contact List for phone number).

If your linguistic needs are not met, you can file a grievance (see “How to Solve Problems” section).
If you need these services, contact Alameda Alliance for Health (Alliance) Member Services:

- Monday – Friday, 8:00 am - 5:00 pm
- Tel: 510-747-4567
- Toll-Free: 1-877-932-2738
- CRS/TTY: 711/1-800-735-2929

If you believe that the Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Alliance. You can file a grievance in person or by telephone, mail, fax, or email. If you need help filing a grievance, the Alliance is available to help you.

1240 South Loop Road
Alameda CA 94502
Tel: 510-747-4531
CRS/TTY: 711/1-800-735-2929
Fax Number: 1-855-891-7258
Email: grievances@alamedaalliance.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by mail, phone, or electronically through the Office for Civil Rights Complaint Portal:

- U.S. Department of Health and Human Services
- 200 Independence Avenue, SW
- Room 509F, HHH Building
- Washington, D.C. 20201
- Toll-Free: 1-800-368-1019
- TDD: 1-800-537-7697
- Website: ocrportal.hhs.gov/ocr/portal/lobby.jsf

**Disability Access**

**Physical Access**

We have made every effort to ensure that our offices and the offices of our providers are easy for people with a disability to enter. If you cannot find an office that meets your needs, please contact Alliance Member Services. We can help you find a provider who meets your needs.

**Access for the Hearing Impaired**

You may contact the California Relay Service (CRS) for assistance at 711 or TTY at 1-800-735-2929. At your request, we can help to arrange a sign language interpreter to be present at your next health care visit.
Access for the Vision Impaired

For help in reading this booklet, please contact Alameda Alliance for Health (Alliance) Member Services. You can also request a copy of this booklet in an alternative format (Braille, audio, electronic text file, or large print) (see Contact List for phone number).

Disability Access Grievances

If you believe the Alliance or our providers have not taken action about your disability access needs, you may file a grievance with the plan (see “How to Solve Problems” section).

The American with Disabilities Act of 1990

Section 506 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, based on disability, be excluded from participation in, be denied the benefits of or otherwise be subjected to discrimination under any program or activity that receives or benefits from federal financial assistance.

Program Transitions to Medi-Cal

If your child has moved to Medi-Cal as a result of a program change, and you would like information about your child’s Medi-Cal services and benefits, call Alliance Member Services (see Contact List for phone number). They can tell you who your child’s doctor is or help you find a new doctor. They can also answer your questions about the Alliance.

If you have been told you have to pay a premium, you may visit your county office or call 1-800-880-5305 for more information.

If you have questions about your child’s Medi-Cal eligibility or about when your child has to renew his or her eligibility, please call the Medi-Cal office in your area.

Medi-Cal Center
Social Services Agency Enterprise Office
8477 Enterprise Way
Oakland, CA 94621
Monday – Friday, 8:30 am – 12 pm, 1 pm – 5 pm
Tel: 510-777-2300
Toll-Free: 1-800-698-1118

Your Rights and Responsibilities

Your Rights

As an Alliance member, you have the right to:

1. Receive information about your rights and responsibilities.
2. Get information about the Alliance, its programs, and its doctors and the health care network.
3. Be treated with respect at all times. Alameda Alliance for Health (Alliance) values your dignity and right to privacy.
4. Keep your health information private.
5. Help make choices about your health care with your doctor. This includes the right to refuse treatment.
6. Talk freely with your doctors about treatment options for your health problem, in spite of cost or benefit coverage.
7. Voice complaints or appeals, either in words or in writing, about the Alliance, its doctors, or the care we provide.
8. Ask for a State Medi-Cal Fair Hearing.
9. Advise on the Alliance’s member rights and responsibilities policy.
10. Choose a doctor [Primary Care Provider (PCP)] within the Alliance’s network.
11. Get oral interpretation in the language that you speak at no cost to you. This includes interpretation to assist in the receipt of care outside of business hours.
12. Have access to:
   - Federally Qualified Health Centers
   - Indian Health Programs (for those Medi-Cal enrollees that are eligible to access these services)
   - Treatment for sexually transmitted disease
   - Emergency care outside the Alliance’s network as detailed in Federal law
   - Family planning from any qualified provider of family planning service under the Medi-Cal program, including service outside the Alliance’s network
   - Minor Consent Services
14. Review, request changes to, and receive a copy of your health records.
15. Leave the Alliance upon request at any time, subject to any restricted disenrollment period.
16. Refuse, if you are an American Indian, to enroll in the Alliance’s plan or any other Medi-Cal managed care plan.
17. Get member information in other formats. This includes Braille, large size print, and audio.
18. Be free from any form of control or limits used as a means of pressure, reproof or revenge. Neither your doctor nor the Alliance may restrict your health care access in order to ease our own workloads.
19. Get information about your health condition and treatment plan options in a way that is easy for you to understand.
20. Use these rights freely without changing how you are treated by the Alliance, doctors and the health care network, or the State.

Your Responsibilities

As an Alliance member, your responsibilities are to:

1. Tell the Alliance and your doctors what we need to know (to the extent possible) so we can provide care.
2. Follow care plans and advice for care that you have agreed to with your doctors.
3. Learn about your health problems and help to set treatment goals that you agree with, to the degree possible.
4. Work with your doctor.
5. Always present your Alameda Alliance for Health (Alliance) Member ID Card when getting services.
6. Ask questions about any medical condition and make certain you understand your doctor’s explanations and instructions.
7. Give your doctors and the Alliance correct information.
8. Help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
9. Make and keep medical appointments and inform your doctor at least 24 hours in advance when an appointment must be cancelled.
10. Treat all the Alliance staff and health care staff with respect and courtesy.
11. Use the emergency room only in case of an emergency or as directed by your doctor.

Who Can Enroll

Who Can Enroll in This Plan

You can join the Alliance if you get Medi-Cal benefits, are eligible to be in a managed care health plan, and live in Alameda County. To learn more about eligibility, enrollment, disenrollment, and changing health plans, call Health Care Options (see Contact List for phone number).

Health Care Options works for the State’s Medi-Cal program to help you choose a managed care health plan. They can help you fill out the Medi-Cal Choice Form to enroll or disenroll from a health plan.

How to Know When Your Coverage Starts

Health Care Options will send you a letter to let you know when you are a member of the Alliance. Sometimes it takes 15-45 days after you fill out the Medi-Cal Choice Form for you to become a member of the Alliance.

The Alliance will tell you in writing within seven (7) days from the date that your coverage starts and once every year after that. Your coverage will always start on the first day of the month. Once you become an Alliance member, we will pay for your health care as described in this booklet.

How to Enroll a New Baby

If the mother is a member of the Alliance, we cover a new baby for the month of birth plus the next month. If you have your baby the month before you become a member, we cover the baby for one (1) month. After that, your baby must have his or her own coverage.
To continue your baby’s health care coverage, you must apply to enroll the baby in Medi-Cal as soon as he or she is born. Contact your Medi-Cal eligibility worker at your Alameda County Social Services Agency or the California Department of Social Services for help (see Contact List for phone number).

If you are a member while you are pregnant, you can pick a Primary Care Provider (PCP) for your baby from our Provider Directory. As soon as your baby is born, make sure you schedule a visit with your baby’s PCP, usually within two (2) weeks.

**Completion of Services for New Members**

If you are being required to enroll in Medi-Cal managed care and were previously enrolled in Covered California or received care from Medi-Cal Fee-For-Service, you may be able to continue getting care from a non-Alliance PCP or specialist for up to twelve (12) months after you enroll with Alameda Alliance for Health (Alliance). The Alliance may allow you to continue seeing a non-Alliance primary care provider or specialist if we decide that: 1) the treatment with the non-Alliance provider is medically appropriate; 2) you or the non-Alliance provider give us proof that you received care from your provider in the last twelve (12) months before enrolling with the Alliance; and 3) the non-Alliance provider is willing to accept the same payment rate as similar Alliance providers for Medi-Cal services.

In addition, the Alliance may allow all new members, including those members described above, getting care from a non-Alliance provider upon enrollment, to complete covered services. This will happen if the Alliance decides that the treatment with the non-Alliance provider is medically appropriate and you have one of the following:

- **Acute condition** – You will be allowed to complete covered services for as long as the acute condition lasts.
- **Newborn care** – The care of a newborn child between birth and age 36 months. This shall not be more than twelve (12) months from the time you enroll with the Alliance.
- **Pregnancy** (including postpartum care) – Completion of covered services shall be for the period of the pregnancy.
- **Serious chronic condition** – Completion of covered service shall be provided for the period of time needed to complete a course of treatment and arrange for a safe transfer to another provider. This will be done when the Alliance consults with the member and the non-Alliance provider. Completion of covered services shall not be more than twelve (12) months from the time you enroll with the Alliance.
- **Surgeries and/or procedures** – Surgeries and/or procedures that the member’s previous plan authorized as part of a documented course of treatment. This must have been recommended and documented by the non-Alliance provider. Covered services shall be within 180 days from the time the member enrolled with the Alliance.
- Terminal illness – Completion of covered services shall be provided for the duration of the terminal illness and may be more than twelve (12) months from the time you enroll with Alameda Alliance for Health (Alliance).

To continue to see your previous provider, the non-Alliance provider must agree to continue to provide your care. He or she must also agree to the same contract terms, services, payment rates, and conditions as Alliance providers. If the non-Alliance provider does not accept the terms and conditions, the Alliance is not required to continue that provider’s services. The Alliance is not required to provide completion of covered services as outlined in this section to a newly covered member who was covered under an individual subscriber agreement and being treated on the effective date of his or her Alliance coverage. A member may not receive completion of services for benefits not otherwise covered in this booklet.

Please contact Alliance Member Services to get a copy of our policy on completion of services for new members. If you have further questions, you may contact the Department of Managed Health Care or the Department of Health Care Services (see Contact List for phone number).

**How to Get Care**

The section talks about the appropriate way to get and use health care services in a managed care system. The Alliance provides covered services and care to members through doctors who have their own office, clinics, hospitals, and other types of health care providers. Our plan gives you access to all the services you need. This includes routine care with your own plan doctor, hospital inpatient care, lab tests, pharmacy, and other covered services (see "Benefits" section).

When you choose the Alliance as your health care plan, you must get most services that we cover from Alliance providers in Alameda County, except the following as described in this booklet:

- Covered emergency ambulance service
- Covered emergency care and post-stabilization care
- Covered out-of-area urgent care
- Care at a Federally Qualified Health Center (FQHC)
- Care at an Indian Health Service Facility
- Covered family planning services
- Diagnosis and treatment of sexually transmitted disease
- HIV counseling and testing service

Some hospitals and other providers may not perform some services because of their own religious or ethical point of view. These contracted services may include the following: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. If your provider will not perform these services, call the Alliance Member Services.
Provider and Facilities Locations
You received an Alameda Alliance for Health (Alliance) Provider Directory in your Medi-Cal Welcome Packet. It lists all of the providers who contract with the Alliance to provide care for Alliance members. The name, address and phone number of Primary Care Providers (PCPs), specialist doctors, non-doctor health care practitioners, clinics, skilled nursing facilities, and hospitals are in this listing. If you do not have a copy of the directory, please call Alliance Member Services to get a copy (see Contact List for phone number).

Our Providers’ Training Background
We work with qualified PCPs and specialist doctors. If you have questions about the background of one of our doctors in our network, such as their education or medical training, please call the Alliance Member Services.

Choosing or Changing Your Primary Care Provider (PCP)
Choosing a PCP
You should choose a PCP as soon as you join the Alliance. A PCP is your Alliance doctor who provides well care and care when you are sick or hurt. Your PCP also helps coordinate care for chronic problems like asthma or diabetes; referrals, and hospital stays.

You can find a list of PCPs in your Alliance Provider Directory or online at www.alamedaalliance.org. You can choose any PCP who is taking new patients from the list of internal medicine, general practice, family practice, and pediatrics, and OB-GYNs (you can choose an OB-GYN as your PCP). After you pick a PCP, call Alliance Member Services and tell them the name of the PCP you picked. Alliance Member Services staff can also help you find a PCP who knows your language or culture, or who is close to where you work or live.

You may also choose a county or community clinic that is part of the Alliance network as your PCP. All Federally Qualified Health Centers (FQHCs) in Alameda County are part of our network.

If you are a Senior or Person with a Disability, you may choose a specialist or clinic as your PCP if the specialist or clinic agrees to be your PCP and is qualified to care for your medical needs.

We will assign you to a PCP if:
- You do not choose a PCP within 30 days of when you join
- You and your PCP cannot get along
- Your PCP’s contract with the Alliance ends
You can choose a new Primary Care Provider (PCP) at any time for any reason. The PCP you choose must be taking new patients. We will let your PCP know within 10 days of when you choose or are assigned.

### Choosing a PCP

It is best to stay with the same PCP over time so she or he can get to know your needs. If you need to change your PCP, you can switch at any time for any reason by calling Alameda Alliance for Health (Alliance) Member Services. The change will usually take effect by the first day of the next month.

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

We may require that you change your PCP if he or she reports that you:

- Behave in a rude or abusive way, or disrupt his or her office in other ways. Repeated rude, harassing, abusive, or threatening behavior may also be grounds for disenrollment from the Alliance.
- Continue to refuse recommended procedures and treatments that prevent our provider from giving you proper medical care.
- Keep making appointments and not showing up for them.

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

### Health Exam for New Members

If you or your child is a new Alliance member, please call your PCP to make an appointment as soon as you can.

- Adults and children should have an exam within four (4) months (120 days) of joining the Alliance.

These exams are called “well exams” because you go when you feel well. During a well exam, your PCP can get to know you and your family history without the stress of illness. This is the time to screen for problems to avoid major illness and plan for any needed preventive services.

If you have recently been an Alliance member, you might not need this exam. To find out, talk to your PCP.

### Making or Changing an Appointment

**Making an Appointment**

Call your PCP to make an appointment for routine check-ups or visits when you are sick. When you call, tell them you are an Alliance member. The name and phone number of your PCP are on your Alliance Member ID Card (see “ID” section).
When you call, you may not be able to see your provider right away. Alameda Alliance for Health (Alliance) providers are required to meet at least the following standards for scheduling an appointment. The wait times listed below apply to Alliance provider types that are: Primary Care Providers (PCPs), Ancillary, Specialty, and Mental Health.

**Urgent Care**

Services that do not require a Prior Authorization – **Within 48 hours** of request for appointment

Services that require a Prior Authorization – **Within 96 hours** of request for appointment

**Non-urgent Care**

For the diagnosis or treatment of injury, illness, or other health problem – **Within 10 business days** of request for appointment

**Non-urgent Specialist Care**

Appointments with specialist physicians – **Within 15 business days** of the request for appointment *

**Non-urgent Mental Health Care**

Non-urgent appointments with a non-physician mental health care provider – **Within 10 business days** of the request for appointment *

**Non-urgent appointments for ancillary services**

For the diagnosis or treatment of injury, illness, or other health condition – **Within 15 business days** of the request for appointment *

**Preventive and Follow-up Care such as:**

- Follow-up
- Standing referrals for chronic problems
- Pregnancy
- Cardiac problems
- Mental health problems
- Lab and radiology services

Preventive and Follow-up Care may be scheduled in advance in line with medical standards of practice and expert advice of your provider.

**Telephone Triage or Screening** – Call your PCP for telephone triage or screening. This screening will prioritize medical treatment based on how urgent the problem is. You can call your PCP 24 hours a day, 7 days a week. Wait time does not exceed 30 minutes.
During the “triage” or “screening,” the member will discuss their health concerns and symptoms with a doctor, nurse or other health care provider. The goal of the call is to find out the urgency of the health problem and how soon the member will need to receive care.

*Exceptions:

The above wait times for an appointment may be longer. This can happen if the doctor, nurse, or health care provider, within their area of expertise, uses standards of care to decide that care can be postponed. The result must be noted in the member record, and the longer wait time must not harm the member’s health.

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

- Ask questions if you are not clear about what you need to know.
- Bring a list of health problems and questions.
- Bring the medicines you are using. Include any herbs, vitamins, or supplements you take.
- Bring your Alameda Alliance for Health (Alliance) Member ID Card and Medi-Cal Benefits Identification Card (BIC).
- Tell your PCP what you have already done to treat any health problems you have and any ideas you have for treatment.
- Tell your PCP what you think the problem is, even if you do not think it is important.

**Changing an Appointment**

Call your PCP’s office right away if:

- You are going to be late for your appointment, or
- You will not be able to go to your appointment.

This will help your PCP reduce the wait time for others in the waiting room. You can also reschedule for another day if needed.

If you miss quite a few appointments with your PCP and do not call to cancel them in advance, your PCP can decide not to see you as a patient. In such a case, we would contact you so that you could choose a new PCP.

**How to get care when your PCP office is closed**

If you need care when your PCP’s office is closed (such as after normal business hours, on the weekends or holidays), call your PCP’s office. Your PCP’s office will have a message or service to tell you how to get care after normal office hours. You can also call Alliance’s Free Nurse Advice (see Contact List for phone number).
Your ID Cards
You will get an Alameda Alliance for Health (Alliance) Member ID Card from us and a Medi-Cal Benefits Identification Card (BIC) from the California Department of Health Care Services. Bring both of these cards when you get care or a service. Do not let others use your Alliance Member ID Card or BIC. This is fraud and it may result in disenrollment and legal action.

Your Alliance Member ID Card looks like this:

The card has your name and Member ID number on it. We use this number to track your records. You should always have the same Member ID number. Your Alliance Member ID Card also has the name and phone number of your Primary Care Provider (PCP). You should call your PCP to make an appointment for routine check-ups or if you are sick.

If what is printed on your card is not correct or if you need to replace your Alliance Member ID Card, call Alliance Member Services (see Contact List for phone number). Always bring your Alliance Member ID Card when you get care.

Your Medi-Cal ID Card
Your Medi-Cal BIC has your Medi-Cal number on it. We use this card to check if you have Medi-Cal coverage. You will also need this card to get Medi-Cal services we do not cover (see “Other Programs and Services for People with Medi-Cal” section).
Getting Prescription Drugs

An Alameda Alliance for Health (Alliance) provider must write your prescriptions. You must also get the drugs from an Alliance pharmacy, except in an emergency or for urgent care. Be sure to bring your Alliance Member ID Card and Medi-Cal Benefits Identification Card to get your drugs. To see if your pharmacy is in the Alliance network, contact Alliance Member Services (see Contact List for phone number and website).

Referrals and Authorizations for Services

Referrals

Your Primary Care Provider (PCP) will refer you to a specialist in the same medical group, or in the Alliance network if there is not a specialist in the same medical group, when you need medically necessary covered services that your PCP cannot provide. Your PCP will refer you to a specialist as soon as she or he can, given your medical needs. You will be referred to a specialist within 24 hours if your needs are urgent. For non-urgent and preventive needs, your PCP will refer you to a specialist within 15 business days and within one week if you are told you are pregnant.

If your PCP is a provider with the Children First Medical Group (CFMG) or Community Health Center Network (CHCN), this information will be on your Alliance Member ID Card. If you see either of them listed on your Alliance Member ID Card, it means that you will need to see specialists within their network. If you have any questions, please call Alliance Member Services (see Contact List for phone number).

Services That Require a Referral From Your PCP

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

- Specialty care by Alliance specialists, including consultations and in-office procedures
- Diagnostic X-rays, including mammograms
- Laboratory services

Services That Do Not Require a Referral

If you see an Alliance provider, you do not need a referral from your PCP for:

- Services your PCP provides
- OB-GYN care
- Prenatal care
- Routine and preventive women’s health care by a women’s health specialist
- Therapeutic abortion
- Diagnosis and treatment of sexually transmitted diseases
- Family planning
- HIV testing and counseling
- Urgent and emergency care
You can see any Medi-Cal provider, including non-Alliance providers, for sexually transmitted disease care, family planning services, HIV testing and counseling, and urgent and emergency services.

**Standing Referrals**

You may have a condition or disease that requires specialized medical care over a long period of time. If this happens, you may need a standing referral to a specialist to receive continuing specialized care. If you get a standing referral to a specialist, you will not need to get a referral every time you see that specialist. Also, if your condition or disease is life threatening, degenerative, or disabling, you may need to receive a standing referral to a specialist or specialty care center. These must have expertise in treating your condition or disease. They will also coordinate your health care. To get a standing referral, call your Primary Care Provider (PCP).

**Authorizations**

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

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

1. We check if a service is medically needed and covered by the Alliance before making a UM decision. When the Alliance gets an Authorization Request from a provider, our medical staff (doctors, nurses, and pharmacists) will review it. They review each case to make sure you are getting the most appropriate quality treatment for your medical condition according to clinical guidelines.

2. We do not reward anyone who makes a UM decision, which includes doctors, when they deny coverage for a service to a member.

3. We do not give anyone extra money to keep you from getting the care you need or for getting less care.

We will usually decide whether or not to authorize the services after getting all the facts (including exams and test results) within five (5) business days but no later than 14 calendar days from the receipt of the request and all necessary information if the service is not urgent. We will decide no later than 72 hours for an urgent service. If the Alliance cannot meet these timeframes, we will let you and your provider know that more time is needed. We will respond to your medication authorization request within 24 hours or one (1) business day.

Once the Alliance approves the Authorization Request, your provider can give you the service(s), medical equipment, or medication(s). If an Authorization Request is
denied, we will notify your provider by telephone or fax. You and your provider will get a letter from us. The letter will let you and your provider know whether the Authorization Request was denied and why. It will also tell you and your provider about your right to appeal a denial, and tell you how to do that.

Services described in this booklet that require an authorization include, but are not limited to:

- Durable medical equipment, orthotics, and prosthetics
- Home health care
- Hospice care
- In-office injectables
- Inpatient hospital services
- Outpatient therapies, including outpatient surgery
- Services from non-Alliance providers
- Skilled nursing facility care
- Some prescriptions (such as non-formulary medications)
- Some high-tech radiology (such as CT, MRI, and PET scans and nuclear medicine)
- Specialty procedures

If you have questions about Utilization Management (UM) or authorizations, please call Alameda Alliance for Health (Alliance) Member Services (see Contact List for phone number). You can also call this number if you need help talking to someone about UM or authorizations in your language. Business hours are Monday-Friday, 8 am to 5 pm. For calls made after hours, you can leave a message, and your call will be returned the next business day.

**Second Opinions**

If you have questions about a treatment or surgery that your provider says you need, you may want a second opinion. A second opinion is at no cost to you. Reasons you may ask for a second opinion include:

- You question the wisdom of, or need for, a recommended surgical procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial impairment.
- Your provider is unable to diagnose your condition or your diagnosis is in doubt due to test results that conflict with each other.
- You have tried to follow your treatment plan and it has not worked.
- You talked with your initial provider about your concerns about the diagnosis or the treatment plan.

You should speak to your Primary Care Provider (PCP) if you want a second opinion. Your PCP can refer you to an Alliance provider for a second opinion.

A prior authorization from the Alliance is needed to get a second opinion from a non-Alliance provider.
If Your Provider Stops Working With Alameda Alliance for Health (Alliance)

If your PCP or other Alliance provider stops working with the Alliance, we will let you know by mail thirty (30) days before the contract ends, when this is impossible.

You may call Alliance Member Services to request completion of covered services for an ongoing course of treatment if your provider stops working with the Alliance (see Contact List for phone number). The Alliance will authorize completion of covered services for you by your provider who stops working with us, if you were getting this care from him or her before the end of the contract and you have one of the conditions below:

- **Acute condition** – Completion of covered services shall be provided for as long as the acute condition lasts.
- **Newborn care** – The care of a newborn child between birth and age 36 months. Covered services shall be completed within twelve (12) months from your provider’s contract termination date.
- **Pregnancy (including postpartum care)** – Completion of covered services shall be for the duration of the pregnancy.
- **Serious chronic condition** – Completion of covered services shall be for a period of time needed to complete a course of treatment, and to arrange for a safe transfer to another provider. This will be done when the Alliance consults with the member and the non-Alliance provider. Completion of covered services shall not exceed twelve (12) months from your provider’s contract termination date.
- **Surgeries or Procedures** – Surgeries and/or procedures that the Alliance had authorized as part of a documented course of treatment. This must have been recommended and documented by the non-Alliance provider to occur within 180 days of the end of provider’s contract.
- **Terminal illness** – Completion of covered services shall be for the duration of the terminal illness. Covered services may exceed twelve (12) months from the time the end of your provider’s contract with the Alliance.

The Alliance will not provide for completion of covered services from providers who no longer work with us due to medical disciplinary cause or reason, fraud, or other criminal activity.

The terminated provider must agree in writing to provide service to you as described in the terms and conditions, reimbursement rates, of his or her agreement with the Alliance prior to termination. If your provider does not agree with these terms, conditions, and reimbursement rates, we are not required to continue your provider’s services beyond the contract termination date. A member may not receive completion of services for benefits not otherwise covered in this booklet.

Please contact Alliance Member Services to learn more about what happens when your provider stops working with the Alliance (see Contact List for phone number). Normally, eligibility to receive completion of covered services is based on your medical condition.
It is not based strictly on the name of your condition. If you have further questions, you may contact the Department of Managed Health Care, HMO Help Center (see Contact List for phone number).

**Emergency Care, Urgent Care, and Routine Care**

This section explains how to get covered emergency care, urgent care, and routine care. Members may access interpreter services at no cost to the member or provider on a 24-hour basis. This also applies to emergency and/or urgent care. You can get the service by calling Alameda Alliance for Health (Alliance) Member Services (see Contact List for phone number). Alliance providers and hospitals are also required to offer a qualified interpreter for you, either in-person or over the phone. Care discussed in this section is not covered unless it meets coverage requirements (see "Benefits" section, subject to the "Exclusions, Limitations, and Reductions" section).

**Emergency Care**

If you have an emergency medical condition or psychiatric emergency, call 911 or go to the nearest hospital with an emergency room. Show the staff your Alliance Member ID Card and your Medi-Cal Benefits Identification Card (BIC). You do not need prior authorization to receive emergency care when you have an emergency medical condition.

An emergency is a medical or psychiatric condition of a sufficient severity (including severe pain), that if you did not get immediate medical attention you could reasonably expect one of the following to result:

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

Active labor associated with pregnancy is an emergency condition.

Emergency care is covered both inside and outside of the Alliance’s service area, the United States, Canada, and Mexico, and in contracted and non-contracted facilities. Prescribed medications given during an emergency visit will be provided in an amount sufficient enough to last you until you can reasonably have the prescription filled.

**Post-Stabilization Care**

Post-stabilization care happens after emergency care. Once the problem is under control (or stabilized), then you will get post-stabilization care. This means that your health problem is not an emergency anymore but you require further care. You may be seen by other doctors or other kinds of health care workers. The Alliance will approve requests for medically necessary covered post-stabilization care until you are discharged or other plans have been made for your care. The Alliance pays for both the emergency care and medically necessary covered post-stabilization care. You may be
transferred to a hospital or facility in the Alameda Alliance for Health (Alliance) network to get medically necessary post-stabilization care. The Alliance will not continue to cover your inpatient stay if you refuse post-stabilization care after your emergency inpatient stay is no longer deemed medically necessary.

Follow-Up Care

After you get emergency services, you will need to call your Primary Care Provider (PCP) for follow-up care that you may need (see “Definitions” section).

Urgent Care

An urgent medical condition is not an emergency. Even so, it may require prompt medical attention.

"Urgently needed services" are those services necessary to prevent serious deterioration of the health of a member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the Alliance Service Area (Alameda County).

"Urgently needed services” includes maternity services necessary to prevent serious deterioration of the health of the member or the member’s fetus, based on the member’s reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until she returns to Alameda County.

Medical services received in an urgent care setting for conditions that are not urgent are not covered services. The Alliance covers urgent care, both in and outside of Alameda County. The way to get urgent care services depends on where you are.

In Alameda County (also known as the Service Area)

For urgent services within Alameda County, call your PCP. Your PCP’s phone number is on your Alliance Member ID Card. You can call your PCP 24 hours a day, 7 days a week.

Outside of Alameda County

If you need a health care service while you are outside of the Alameda County, you should call your PCP. However, if you have an urgent care need due to a sudden illness, injury, or complication of an existing condition (including pregnancy), we cover out-of-area urgent care or medically necessary services to keep your health (or your unborn child’s health) from seriously worsening if:

- You get the services from non-Alliance providers while you are outside of Alameda County; and
- You reasonably believed that you (or your unborn child’s) health would seriously worsen if you delayed treatment until you got back to Alameda County.
Benefits

Routine Care

Routine care is a medically necessary service that is not urgent. The routine care helps keep you healthy. It includes check-ups, well exams, and services to keep you from getting sick.

Periodic health exams may include diagnostic testing and laboratory services that are appropriate and consistent with the current recommendations for preventive adult and pediatric health care by the United States Preventive Services Task Force (USPSTF) and the American Academy of Pediatrics.

Your PCP will provide routine care and periodic health exams. You should schedule well exams on a regular basis for you and/or your child. Your PCP will tell you how often these exams should occur.

Periodic health exams include:

- Well Child visits
- Well Adolescent visits
- Well Woman visits (including mammograms and pelvic exams)
- All care for pregnant women

You may choose to have an OB-GYN as your PCP.

Benefits

This section tells you about benefits and services that we cover and pay for. These are covered only if they are medically necessary or be preventive care services. Some services listed in this section require referral from your PCP, and authorization by the Alliance. Medically necessary services must meet all other terms, conditions, limitations, and exclusions of this booklet, including those listed in the “Exclusions, Limitations, and Reductions” (see “Exclusions, Limitations, and Reductions” section). All exclusions and limitations that apply to the Medi-Cal Program apply to these benefits.

Most medically necessary services are covered only if:

- An Alliance doctor provides, prescribes, directs, or authorizes the service, and
- You get the service from Alliance providers in Alameda County
You must be sure that the doctor you see is in the Alameda Alliance for Health (Alliance) network. If you do not know if a doctor is within the Alliance network, call Alliance Member Services for help (see Contact List for phone number).

As described in this booklet, the only services we cover that you can get from non-Alliance providers are:

- Abortion service and covered family planning services
- Covered emergency ambulance service
- Covered emergency care and post-stabilization care
- Covered out-of-area urgent care
- Care at a Federally Qualified Health Center (FQHC)
- Care at an Indian Health Service Facility
- Diagnosis and treatment of sexually transmitted diseases
- HIV counseling and testing service

**Medically Necessary**

All covered services that members receive from the Alliance must be medically necessary or be preventive care services. You cannot get any medical service that is not deemed medically necessary. This means that your health care is needed to protect life, prevent illness or disability, or relieve severe pain through the diagnosis and treatment of disease, illness, or injury.

**Hospital Inpatient Services**

Hospital inpatient care is service you get when you are admitted to an Alliance hospital. To get treatment at a hospital, your Primary Care Provider (PCP) must get an approval from the Alliance. The services need to be medically necessary to get approved.

We cover the following hospital services when you get them at a participating Alliance hospital within our network, as referred by your Alliance provider and authorized in accordance with Alliance rules. Hospital services are not covered if they are received from a provider whose services have not been authorized by the Alliance.

Benefits include:

- Administration of blood and blood products
- Alcohol and substance abuse admissions are covered only for medically necessary detoxification
- Drugs, medications, IV fluids, biologicals, and oxygen administered in the hospital
- Inpatient hospital services, including semi-private room, meals (including special diets when medically necessary), and general nursing care
- Inpatient physical, occupational, and speech therapy services are covered as medically necessary
- Medically necessary ancillary services such as diagnostic laboratory and X-ray services
Benefits

- Operating room, special treatment rooms, delivery room, newborn nursery room, and related facilities
- Radiation therapy, chemotherapy, and renal dialysis
- Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses (not including surgically implanted hearing aids), other medical supplies, medical appliances, and equipment administered in the hospital
- Prosthetic devices for a member having a mastectomy (to restore and achieve symmetry), or a member having a laryngectomy (to restore speech)

Exclusions

- Convenience items such as telephones, televisions, guest trays, and personal hygiene items
- Private rooms
- All medical and hospital costs when the member is admitted to a hospital by a non-Alliance provider without prior authorization by Alameda Alliance for Health (Alliance), except in emergencies as described in this booklet, are not benefits

Outpatient Care

Outpatient care is medically necessary service that you get from an Alliance provider in a medical office or hospital when you have not been admitted to the hospital.

Benefits include:

- Blood and blood products
- Diagnostic, surgical, and therapeutic services (including radiation and chemotherapy) in an outpatient setting for ambulatory surgery center
- Emergency department visits (see “Emergency Care, Urgent Care, and Routine Care” section)
- General anesthesia and facility charges
- Outpatient surgery
- Physical, occupational, and speech therapy as needed, and those hospital services that can be provided on an ambulatory basis
- Primary care and specialty care visits
- Services and supplies that relate to outpatient care. This includes operating room, treatment room, ancillary services, and medications supplied by the hospital or facility for use during the member’s stay at the facility

Exclusions

- Hospital outpatient psychiatric care/alcohol and drug abuse treatment are not covered under this benefit. Contact the Alameda County Behavioral Health Plan (ACCESS) for assistance. (See Contact List for phone number).
- Dental services are provided by Denti-Cal for some members (See Contact List for phone number).
**Acupuncture**

We cover outpatient acupuncture services that are medically necessary and must be:

- Prescribed by a Medi-Cal provider (licensed physician, dentist, podiatrist, or certified acupuncturist); and
- Used to treat a condition that follows the member’s Plan-approved treatment plan

Outpatient acupuncture services (with or without electric stimulation of the needles) are limited to two visits per calendar month. Additional services can be provided based on medical necessity through the Alameda Alliance for Health (Alliance) prior approval process.

**Cancer Clinical Trials**

The Alliance covers services that are related to a cancer clinical trial if:

- You have been diagnosed with cancer; and
- You are accepted into phase I, phase II, phase III, or phase IV of a clinical trial for cancer; and
- Your treating doctor, who is providing covered services, agrees that being part of the trial will benefit you; and
- The clinical trial:
  - Has a therapeutic intent with documentation the treating doctor provides; and
  - The treatment offered either:
    - Is approved by one of the following: the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or
    - Involves a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs linked to routine patient care. This includes drugs, items, devices, and services that would be covered if they were not linked to an approved clinical trial program. Routine patient costs for cancer clinical trials include health care services:

- Needed for the provision of the investigational drug, item, device, or service.
- Needed to monitor the investigational drug, item, device, or service.
- Needed to prevent complications that may occur from the investigational drug, item, device, or service.
- Needed to care for a health problem caused by the investigational drug, item, device, or service, which includes diagnosis or treatment of complications.

**Exclusions**

- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Coverage for clinical trials is restricted to participating hospitals and doctors in California, unless the protocol for the trial does not take place in California.
- Health care services that are supplied by the research sponsors free of charge for any member in the trial.
- Health care services that are not a benefit (other than those excluded on the basis that they are investigational or experimental).
- Provision of non-FDA-approved drugs or devices.
- Services other than health care services, such as travel, housing, and other non-clinical expenses that a member may incur because he or she is in the trial.

**Cataract Spectacles and Lenses**
We cover external lenses (contacts or glasses) and intraocular lenses that are medically necessary after cataract surgery.

**Chiropractic Services**
Alameda Alliance for Health (Alliance) covers chiropractic services only when medically necessary and only when these services are provided by a federally qualified health center.

**Community Based Adult Services (CBAS)**
CBAS (which used to be Adult Day Health Care or ADHC) is now a program of the Alliance. The CBAS program is for members who find it hard to take care of their health problems by themselves and want extra help. It is a day program. If you qualify for CBAS, the Alliance helps you find a center that best meets your needs. There are many types of services at CBAS. The kinds of services include:

- Skilled nursing care
- Social services
- Meals
- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Training and support to your family and/or caregiver

You may qualify for CBAS if you:

- Used to get these services from an Adult Day Health Care (ADHC) center and you were approved to get CBAS
- Get a referral from your primary care doctor and you are approved to get CBAS by the Alliance
- Are referred for CBAS by a hospital, skilled nursing facility or community agency and you are approved to get CBAS by the Alliance

Members or authorized representatives who want to find out more about CBAS should call Alliance Member Services (see Contact List for phone number).
Dental Care

Except for services mentioned in this section, dental care is not a benefit through Alameda Alliance for Health (Alliance). These services are available to Medi-Cal members through Denti-Cal (see Contact List for phone number).

Topical Fluoride Varnish

For members younger than six (6) years of age, we cover topical fluoride varnish up to three (3) times in a twelve (12) month period. Children can get this service at an office visit with their Primary Care Provider (PCP).

Drugs Prescribed by a Dentist

Most drugs prescribed by a dentist are covered by the Alliance. This must be based on medical need. The Alliance authorizes these drugs (see “How to Get Care” section, and “Outpatient Pharmacy Services” section).

Dental Services for Radiation Treatment

If you have cancer in your jaw or neck and must have radiation treatment, we cover dental evaluation, X-rays, fluoride treatment, and extractions needed to prepare your jaw for radiation therapy. This is covered when an Alliance doctor provides the services or if we authorize a referral to a dentist.

Dental Anesthesia

Dental anesthesia is available if medically necessary, or medically or clinically indicated for a dental procedure in a dental office, hospital or surgery center. The Alliance requires prior authorization for general anesthesia for dental procedures.

At least one of the following conditions must be met in order for dental anesthesia to be covered:

- Member is under seven (7) years of age
- Member has a developmental disability
- Member has an underlying clinical or medical condition for which general anesthesia is medically necessary

Diabetes Management and Treatment

We cover medically necessary services, supplies, and equipment for the treatment of diabetes. We cover these even if you can get the items without a prescription. We do this only if you get the service or supplies from an Alliance provider.

Benefits include:

- Blood glucose monitors and blood glucose testing strips, which includes blood glucose monitors designed to assist the visually impaired
Benefits

- Glucagon
- Insulin pumps and all related necessary supplies (such as insulin and insulin syringes)
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Outpatient self-management training, education, and medical nutrition therapy to enable a member to use the equipment, supplies, and medications as prescribed by the member’s Alameda Alliance for Health (Alliance) provider
- Pen delivery systems for the administration of insulin
- Podiatric devices to prevent or treat diabetes complications
- Prescribed medications for the treatment of diabetes
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

Dialysis Care
We cover medically necessary dialysis services. You must get the covered services from an Alliance provider.

Drug and Alcohol Abuse Services
We cover inpatient hospitalization in an Alliance facility as medically necessary for the management of withdrawal symptoms and to remove toxic substances from the system. All other drug and alcohol abuse services are obtained through the Alameda County Behavioral Health Plan (ACCESS) (see Contact List for phone number).

If you are 12 or over, your parent does not have to approve for you to get these services.

Durable Medical Equipment
Durable Medical Equipment (DME) is medically necessary equipment that is:
- For repeated use
- Used for a medical purpose
- Generally not useful to someone who is not ill or hurt
- Safe for use in the home

The Alliance contracts with California Home Medical Equipment (CHME) to perform prior authorization reviews for these services. We cover DME for use in your home if it is prescribed by an Alliance provider in Alameda County and authorized in advance. It is only covered when it agrees with Medi-Cal or nationally recognized clinical guidelines. We may require added evaluation to decide whether the DME is medically necessary.

Benefits may include:
- Breast pumps
- Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
Benefits

- Ostomy bags and urinary catheters and supplies
- Oxygen and oxygen equipment
- Pulmoaides and related supplies
- Wheelchairs
- Incontinence medical supplies when prescribed by licensed practitioners within the scope of their practice for members five (5) years or older. These supplies are reimbursable for use only in chronic pathologic conditions that cause the members incontinence.

Alameda Alliance for Health (Alliance) will decide whether to rent or buy the Durable Medical Equipment (DME), and from whom we will rent or buy it. Repairs or replacements are covered, unless needed due to misuse or loss. California Home Medical Equipment (CHME) is our exclusive vendor for the majority of DME items and will provide your DME supplies if the request is authorized. For the remaining items not available through CHME, we have a list of preferred vendors for you to use. Please refer to the Alliance’s website for a complete list of covered DME items.

Exclusions

- Comfort or convenience items, including incontinence creams and washes for members 21 years of age and older
- Deluxe equipment
- Devices not medical in nature. This includes sauna baths and elevators, and changes to the home or automobile.
- Exercise and hygiene equipment; experimental or research equipment
- More than one (1) piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment, within the last five (5) years
- DME repairs needed due to neglect or improper use are not covered

Eye Exams

Eye exams once every two years are available to all Medi-Cal beneficiaries. Members who are under the age of 21, pregnant, or living in a skilled nursing facility may receive additional vision care (see Contact List for phone number).

Family Planning Services

Family planning services are medically necessary services that prevent or delay pregnancy.

Benefits include:

- Counseling on birth control options
- Contraceptive drugs and items, including Emergency Contraceptive (see “Definitions” section)
- Surgical birth control for men or women
- Pregnancy tests and counseling
- Care for medical problems related to birth control methods
Benefits

- Limited history and physical exam
- Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods

If you are age 12 or over, your parent does not have to give approval for you to get family planning services. These services include all methods of birth control that are approved by the government. As a member, you pick a Primary Care Provider (PCP) or OB-GYN specialist who is located near you and will give you the covered services you need. Your PCP does not have to authorize these services. You can get family planning services from an Alameda Alliance for Health (Alliance) provider. You can also get family planning services from a non-Alliance provider that accepts Medi-Cal without having to get permission from the Alliance. We will pay the non-Alliance provider for the covered services that you get. You can call the California Department of Public Health Office of Family Planning “Family PACT” if you want help finding a provider outside of the Alliance network (see Contact List for phone number).

Gender Identity Disorder Services
The Alliance covers treatment for Gender Identity Disorders, when medically necessary. Benefits may include hormone therapy, pubertal suppression, or surgical treatments. If you want to learn more about gender identity disorder services, please contact Beacon Health Strategies (see Contact List for phone number).

Genetic Testing and Counseling Services
If you want to learn more about genetic testing and counseling, see your PCP.

HIV Testing and Counseling Services
You may get confidential HIV counseling and testing from your PCP and clinics listed in the “Confidential HIV Testing Sites” section of the Provider Directory. You may also get these services anywhere that will accept Medi-Cal. You may contact the Office of AIDS Administration for a list of anonymous and confidential test sites (see Contact List for phone number).

You do not need your PCP’s approval for these covered services. If you go to a site outside of our plan, you may be asked to sign a release of information to allow the non-Alliance provider to bill us.

Health Education
Our health education programs can help you learn how to protect and improve your health. There is no cost to you. We can assist you to stop smoking or learn how to reduce or manage stress. We can also help you live better with a chronic disease like asthma, diabetes, or heart disease. You can get books, flyers, pamphlets or videos/DVDs about parenting, how to be healthy while pregnant, what to do when your child gets sick, weight control and how to be active. These materials are free.
If you have a question about health education, please ask your provider or call Alameda Alliance for Health (Alliance) Health Programs (see Contact List for phone number). We have tools to help you take charge of your health. These can improve your health and help you stay healthy.

**Hearing Visits and Aids**

**Hearing Visits**

We cover the following hearing visits for members who are under the age of 21, pregnant, or living in a skilled nursing facility:

- Visits and tests to find out if you need a hearing aid and which hearing aid will be appropriate for you
- Visits to make sure that the aid is working right
- Visits for fitting and cleaning

The Alliance may still pay for hearing visits for other members. Contact Medi-Cal for more information (see Contact List for phone number).

**Hearing Aids**

We cover a new hearing aid if:

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

Coverage is limited to the lowest-cost aid that meets your medical needs.

**Exclusions**

- Extra batteries or other extra equipment, or replacement parts for hearing aids
- Replacement of a hearing aid more than once in a 36-month period
- Aids that are implanted

**Home Health Care Services**

Home health care services provide skilled medical services by licensed Alliance providers to a homebound member. You are homebound if you are confined to your home or a friend’s or family member’s home.

Home health care services are designed to transition the member from inpatient care or to prevent hospitalization. These covered services are furnished under the direction of a home health treatment plan and only when medically necessary and authorized.

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

- Part-time skilled nursing care
- Part-time home health aide as required for skilled medical services only
Benefits

- Medical social services
- Physical, occupational, and speech therapy
- Medical supplies, other than drugs and biologicals

Exclusions

- Services that are non-skilled, custodial care, as defined by Alameda Alliance for Health (Alliance). Custodial care primarily assists you in meeting personal care or housekeeping needs;
- Care that a family member or other layperson could reasonably provide in a safe and effective way in the home setting after getting training.

Hospice Care

Members who are dying can choose to get hospice care for their terminal illness. Hospice care helps both the patient and the family/caregiver(s) through the death process. Patients get care to relieve pain and other symptoms, but not to cure a terminal illness. You can change your choice to get hospice care at any time. Your choice to start or stop hospice care must be in writing and follow Medi-Cal rules. We cover hospice care only if:

- The services are requested by an Alliance provider who finds that you have a terminal illness and you are expected to live twelve (12) months or less; and
- The services are preauthorized; and
- The services are provided by a contracted hospice agency in the Alliance network; and
- The services are needed for pain relief and to manage your terminal illness and related problems.

If the above is true, we cover these hospice services as needed for your hospice care:

- Doctor services
- Skilled nursing care, such as evaluation and case management of nursing needs, treatment for pain and symptom control, emotional support for you and your family, and instructions for caregivers
- Physical therapy, occupational therapy, or speech therapy for symptom control or to help you maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aid
- Drugs for pain control and to help with other symptoms of your terminal illness
- Durable medical equipment
- Respite care when needed to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five (5) days in a row at one time.
- Counseling to help with loss
- Advice about diet
- Short-term inpatient care during periods of crisis when you need care for pain control and symptom management
California Children’s Services (CCS) will work with families whose child has a terminal CCS condition and choose hospice care for their child.

**Medical Transportation Services**

### Emergency Medical Transportation

Emergency medical transportation is when you are taken by ambulance to a hospital for an emergency health problem. If you think you have an emergency, call 911 or go to the nearest hospital.

Alameda Alliance for Health (Alliance) covers emergency transport for a medical problem that causes severe pain, a serious illness or injury, or a psychiatric emergency. And, a prudent layperson (a careful and cautious non-medical person), would believe it to be an emergency that requires ambulance transport. Health problems that meet this standard will be treated as an emergency even if later it is found that an emergency did not exist. If you are unsure whether your medical problem is an emergency, call your Primary Care Provider (PCP) or the Nurse Advice Line (see Contact List for phone number).

Emergency medical transportation does not have to be approved in advance by the Alliance.

### Non-Emergency Medical Transportation

You can use Non-Emergency Medical Transportation (NEMT) when you cannot get to your health care appointment by car, bus, train, or taxi, and the plan pays for your health care visit.

NEMT is an ambulance, litter van or wheelchair van. NEMT is not a car, bus, or taxi. Alameda Alliance for Health allows the lowest cost NEMT for your medical needs when you need a ride to your appointment. That means, for example, if a wheelchair van is able to transport you, the Alliance will not pay for an ambulance.

NEMT can be used when:

- Medically needed;
- You can’t use a bus, taxi, car or van to get to your appointment;
- An Alliance provider requests the transportation; and
- Approved in advance by the Alliance.

To ask for NEMT call Alliance Member Services, at least five (5) business days (Monday – Friday) before your appointment (see Contact List for phone number). Or, call as soon as you can when you have an urgent appointment. Please have your member ID card ready when you call. There is no cost when the Alliance approves the transportation.

There are no limits to the number of rides if you meet the terms above. Rides by car, bus, taxi, or plane are not covered. We do not provide transportation to services not covered by the Alliance (see “Benefits” section for a list of covered services).
Non-Medical Transportation

You can use Non-Medical Transportation (NMT) to get to and from a health care appointment for a screening and/or needed treatment service covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Alameda Alliance for Health (Alliance) allows you to use a car, taxi, bus, or other public/private way of getting to your medical appointment for plan-covered medical services from those who are not Medi-Cal providers. The Alliance allows the lowest cost NMT type for your medical needs that is available at the time of your appointment.

To ask for NMT services, call Alliance Member Services, see Contact List for number at least five (5) business days (Monday – Friday) before your appointment. Please have your member ID card ready when you call.

There are no limits for getting a ride to or from medical appointments covered under the EPSDT program. There is no cost when transportation is approved by the Alliance.

What Doesn’t Apply?

NMT does not apply if:

1) An ambulance, litter van, wheelchair van, or other form of Non-Emergency Medical Transportation (NEMT) is medically needed to get to a covered service.

2) The Alliance does not cover the service (see “Benefits” section).

Mental Health Services

Outpatient Mental Health Services

When medically necessary, the following outpatient mental health services are offered for the treatment of mild to moderate mental health conditions:

- Psychotherapy
- Psychological testing, when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs and supplies
- Psychiatric consultation

Behavioral Health Treatment

The Alliance now covers behavioral health treatment (BHT) for autism spectrum disorder (ASD). This treatment includes applied behavior analysis (ABA) and other evidence-based services. This means the services have been reviewed and have been shown to work. The services should develop or restore, as much as possible, the daily functioning of a Member with ASD.
Behavioral Health Treatment (BHT) services must be:

- Medically necessary
- Prescribed by a licensed doctor or a licensed psychologist
- Approved by Alameda Alliance for Health’s (Alliance)
- Given in a way that follows your Plan-approved treatment plan

You may qualify for BHT services if:

- You are under 21 years of age
- Have a diagnosis of ASD
- Have behaviors that interfere with home or community life. Some examples include anger, violence, self-injury, running away, or difficulty with living skills, play and/or communication skills.

You do not qualify for BHT services if you:

- Are not medically stable; and
- Need 24-hour medical or nursing services
- Have an intellectual disability (ICF/ID) and need procedures done in a hospital or an intermediate care facility.

You can call the Alliance mental health subcontractor, Beacon Health Strategies, if you have any questions or ask your Primary Care Provider (PCP) for screening, diagnosis and treatment of ASD (see Contact List for phone number).

**Specialty Mental Health Services**

You can still get specialty mental health services from Alameda County Behavioral Health Plan (ACCESS) (see Contact List for phone number).

The specialty mental health services provided by the County (ACCESS) are:

1. Outpatient specialty mental health services:
   - Outpatient specialty Mental Health Services including:
     - Assessment
     - Plan development
     - Therapy
     - Rehabilitation
     - Collateral

1 Members under 21 years may be able to get more services through a national program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This includes doctor, nurse practitioner and hospital services. It also includes physical, speech/language, occupational therapies and home health services. Other services it covers are medical equipment, supplies, and devices; treatment for mental health and drug use, and treatment for eye, ear and mouth problems. If you have questions about the EPSDT program, please call Alliance Member Services.
- Medication Support Services
- Day Treatment Intensive
- Day Rehabilitation
- Crisis and Adult Crisis Residential
- Crisis Intervention and Crisis Stabilization
- Targeted Case Management

2. Inpatient specialty mental health services:
- Acute psychiatric inpatient hospital services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Professional Services if the beneficiary is in Fee-For-Service hospital

Exclusions

Mental health services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems*.

Minor Consent Services

Children under the age of 18 may get certain confidential services without parent approval. Minor consent services are services related to:

- Medical care after a sexual assault
- Pregnancy
- Diagnosis and treatment of sexually transmitted diseases

Children must be 12 years of age or older to receive the following services without parent approval:

- Drug and alcohol abuse services
- Outpatient mental health care services
- Family planning services

Ask your doctor or call Alameda Alliance for Health (Alliance) Member Services to find out how to get minor consent services from an Alliance provider. You can also get minor consent services from a non-Alliance provider that accepts Medi-Cal. Your Primary Care Provider (PCP) does not have to authorize these services. We will pay the non-Alliance provider for the covered services that you get. You can call the Alameda County Public Health Clearinghouse if you want help finding a booklet about minor consent services (see Contact List for phone number).

New Technology

The Alliance wants to provide our members with quality care. We have a process for reviewing new technology such as medical or behavioral procedures, drugs, and

* As defined by the current Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV)
devices. We review reports from medical experts to decide if we should cover the new technology as a benefit for our members.

**Nurse Line**

Alameda Alliance for Health (Alliance) Nurse Line gets you 24/7 answers to your health questions in regards to common illnesses and conditions, healthy lifestyle tips, health screenings and shots. The Nurse Line links you to a Registered Nurse who will discuss your health and well-being. The Registered Nurse will also help you decide what kind of care to seek, including: if your health problem can be treated at home, if you should see a doctor, or if you might need to get urgent or immediate care (see Contact List for phone number).

**Organ Transplants**

The Alliance covers medically necessary kidney and corneal transplants for members over the age of 21. For other potential major organ transplant candidates, we cover medically necessary pre-transplantation services until the member has been referred and accepted as a candidate by a transplant facility, and the major organ transplant has been authorized by the California Department of Health Care Services. Transplants for members under the age of 21 may be covered by the California Children’s Services (CCS) program if the member is found to be eligible.

The benefit for kidney and corneal transplants includes:

- Coverage for medically necessary transplants that is not experimental or investigational.
- Costs for obtaining donor organs through a recognized Donor Transplant Bank are covered if the costs have a direct link to the transplant for the member.
- Medically necessary medical and hospital costs of a donor or a person who is the prospective donor, if the costs have a direct link to the transplant for a member.

**Exclusions**

- All other organ transplants, such as heart, heart/lung, bone marrow, liver, lung, combined liver/kidney, and combined liver/small bowel, will be covered by Fee-For-Service Medi-Cal.
- For all transplants other than kidney and corneal, once you are accepted on the transplant list, you will need to switch to Fee-For-Service Medi-Cal (see “Staying a Member” section).
- For members under 21 years old, organ transplant services will be covered and paid for by California Children's Services (CCS) if the member is eligible. The Alliance will coordinate these services with CCS for the member (see “Other Programs and Services for People with Medi-Cal” section).
Organ Donation
Donating organs and tissues can save or enhance the lives of others. If you want to become an organ and/or tissue donor, talk to your doctor. You can also call Donate Life California to get a donor card and to obtain more information about organ and tissue donation (see Contact List for phone number).

Ostomy and Urological Supplies
Ostomy supplies are medically necessary supplies that take waste out of the body. Urological supplies are medically necessary supplies that capture urine outside the body.

We cover ostomy supplies and urological supplies that are prescribed within Medi-Cal guidelines. Coverage is limited to the lowest-cost item that meets your medical needs.

California Home Medical Equipment (CHME) is our exclusive vendor for ostomy and urological supplies. CHME will provide your Durable Medical Equipment (DME) supplies if the request is authorized.

Out-of-State Coverage
We cover out-of-state care for the following reasons:

- An emergency caused by an accident, injury or illness
- When postponed care would cause severe health problems
- When travel back to California would cause severe health problems
- In areas that border another state and use of the other state’s services is the custom of the area.
- When the Department of Health Care Services has authorized a treatment plan for services that cannot be obtained in California.

Alameda Alliance for Health (Alliance) must authorize all out-of-state health care except for emergencies and medically necessary urgent care. No health care service is covered outside of the United States, except for emergency services in Canada and/or Mexico.

Outpatient Imaging, Lab Tests, and Special Procedures
We cover imaging, lab tests, and other special procedures that are medically necessary. Such services must be prescribed by an Alliance provider and you must get the service in Alameda County. Services for MRIs, CT scans, PET scans, and nuclear medicine require prior approval. EviCore, the Alliance’s radiology benefit manager, is available to answer any of your radiology related questions (see Contact List for phone number).
Benefits include:

- Imaging to help find out what is wrong and for treatment:
  - X-rays
  - Mammograms
  - Ultrasound
  - MRIs (magnetic resonance imaging)
  - CT scans (computed tomography)
  - PET scans (positron emission tomography)
  - Nuclear Medicine
- Special procedures, including:
  - Those that check the heart (EKGs) or brain (EEGs)
  - Nuclear medicine
  - Radiation therapy
  - UV (ultraviolet) light treatment
- Tests for the management of diabetes, cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (glycohemoglobin).
- Covered cancer screening tests include: mammography, prostate cancer screening, cytology exams on a periodic basis, including PAP tests, and the option of any other cervical cancer screening test approved by the Food and Drug Administration (FDA) upon referral by the member’s health care provider. Tests and procedures must conform to accepted guidelines.

Exclusions

- Alameda Alliance for Health (Alliance) does not cover all the services that Medi-Cal covers. If we do not cover a service that Medi-Cal covers, you must get the service through Fee-For-Service Medi-Cal or other programs.

Outpatient Pharmacy Services

An Alliance provider must write your prescriptions except in an emergency or for urgent care. You must get the drugs from a pharmacy in the Alliance Pharmacy Network, except in cases of an emergency or for urgent care. Be sure to bring your Alliance Member ID card with you to the pharmacy.

We cover medically necessary drugs and items when prescribed by an Alliance provider and dispensed at an Alliance pharmacy. You should not be asked to pay for covered prescription drugs.

Formulary/Non-Formulary Drugs

Our drug formulary is a list of drugs that have been reviewed with care and approved by our Pharmacy and Therapeutics (P&T) Committee for our members. The P & T Committee is made of Alliance doctors and pharmacists who review drugs to add or remove from the formulary every three (3) months. They choose drugs for the list using
factors like how safe the drug is and how well it works. To find out if a drug is on the formulary, or to request a current copy of the formulary, contact Alameda Alliance for Health (Alliance) Member Services or visit our website (see Contact List for phone number and website). The fact that a drug is on the list does not mean that your doctor will prescribe that drug.

We sometimes can approve a drug that is not on the formulary (known as a non-formulary drug). You must first have tried formulary drugs and they did not work for you. Or your doctor can give the Alliance a medical reason why the non-formulary drug is needed. Your provider must request approval in advance for any non-formulary drug.

There are reasons some drugs on the formulary also require advance approval:

- Your provider requests an amount over the current limit;
- Your provider requests the drug for a use that is not approved by the U.S. Food & Drug Administration;
- The P&T Committee has agreed that requests for the drug must receive prior approval.

Your provider can request a prior approval. They can use a “Prior Authorization” form available on the Alliance website (see Contact List for website address). Along with the form, they should submit clinical notes. Alliance pharmacy staff will review the request. After review, we will send you and your provider a letter with our response.

If the request is approved, the letter will list the drug name along with quantity and the valid date range for the approval. If the request is delayed, changed or denied, the reasons will be stated in the letter. You and your provider have the right to appeal. The decision letter includes details on how to make an appeal.

Your doctor may also prescribe a drug for a use that is other than the use for which that drug has been approved (off-label use). But, your doctor must have a medical reason and request approval in advance.

**Injectable and Other Special Drugs**

The Alliance has a management program for certain injectable drugs and other special medications. Some injectable drugs may require prior approval. The Alliance website, www.alamedaalliance.org, has a complete list. These drugs are dispensed by a special pharmacy or given at your doctor’s office. Call Alliance Member Services to learn more (see Contact List for phone number).

**Brand Name/Generic Drugs**

A generic drug has the same active ingredient as the brand name version of the drug. Generic drugs usually cost less than brand name drugs. The U.S. Food & Drug Administration (FDA) ensures that generic drugs work just as well as the brand drugs. It also ensures that they have the same high quality, strength, purity and stability.
Alameda Alliance for Health (Alliance) has a mandatory generic program. This program promotes the use of generic options over brand when medically appropriate. When your doctor writes you a prescription for a brand name drug and not a generic because of medical need, your doctor must request approval and give the Alliance a reason for why you need the brand drug. Your doctor must write down the reason on a MedWatch form. MedWatch is an FDA form and can be found on the FDA’s website at www.fda.gov.

**Quantity Limits/Day Supply Limit**

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

**Step Therapy**

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

**Tobacco Cessation Drugs**

Tobacco cessation drugs help control the urge to smoke. These drugs are available on the Alliance drug formulary and most do not require prior approval. While not required, the Alliance recommends that the member for whom the treatment is prescribed attend a tobacco cessation program. To obtain a current listing of tobacco cessation programs/classes, please call Alliance Member Services (see Contact List for phone number).

**Drugs Not Covered (Exclusions)**

- Dietary supplements (except for formulas or special food products, when medically necessary), appetite control, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity
- Drugs or medications for solely cosmetic purposes
- Experimental or investigational drugs
- Drugs to treat infertility
- Drugs to treat erectile dysfunction

**Drugs Covered by Fee-For-Service Medi-Cal**

Some drugs are not covered by the Alliance but are covered by Fee-For-Service Medi-Cal. You may still get these drugs as an Alliance Member. These drugs are for HIV/AIDS treatment, some mental health and substance abuse conditions, and...
hemophilia blood factor. Fee-For-Service Medi-Cal pays for these drugs, not Alameda Alliance for Health (Alliance). The pharmacy filling prescriptions for these drugs must be a Medi-Cal provider. The pharmacy must use Medi-Cal's authorization procedures and bill Medi-Cal instead of the Alliance.

**Phenylketonuria (PKU)**

The testing and treatment of PKU are covered. This includes formulas and special food products that are part of a prescribed diet.

A “special food product” is defined as a food product that is:

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

**Podiatry**

For members under the age of 21, the Alliance covers podiatry services only when medically necessary with no limitations on care setting.

For members 21 years and older, the Alliance covers podiatry services only when medically necessary and only when these services are provided by a federally qualified health center.

**Pregnancy and Maternity Care**

Once you think you are pregnant, schedule a prenatal exam. This care is vital for both the health of you and your baby.

**Prenatal and Postnatal Doctor Office Visits and Delivery**

We cover medically necessary professional and hospital services. This includes prenatal and postnatal care, care for complications of labor and delivery, exams of the newborn, and nursery care while the mother is in the hospital. First Trimester and Second Trimester Tests offered by the California Department of Public Health’s California Prenatal Screening (PNS) Program to detect birth defects are also covered (see Contact List for website address).

**Certified Nurse Midwife and Nurse Practitioner Services**

You may get care from Alliance providers who are Certified Nurse Midwives or Nurse Practitioners. A list of these providers is located in the Alliance Provider Directory. You may also get services from Certified Nurse Midwives who are not in the Alliance network. Call Alliance Member Services if you need help choosing an Alliance provider.
Inpatient Hospital Services
Alameda Alliance for Health (Alliance) covers hospital stays for the purpose of a normal delivery, cesarean section, complications, or medical problems that may arise from pregnancy or childbirth. The length of inpatient hospital stay is based upon the unique health and care needs of each member and her newborn child.

The Alliance will not restrict its inpatient hospital care to less than 48 hours following a normal vaginal delivery and not less than 96 hours following a Cesarean section delivery. However, the inpatient hospital care may be for less than 48 to 96 hours if the following two (2) conditions are met:
1. The discharge decision is made by the treating doctor, after consult with the mother; and
2. The treating doctor schedules a follow-up visit for the member and her newborn within 48 hours of discharge.

Exclusions
- Amniocentesis, except when medically necessary, is not a benefit.

Prosthetic and Orthotic Devices
Prosthetic devices are medically necessary items that replace all or part of an organ or limb. Orthotic devices are medically necessary items that support or correct a body part.

We cover prosthetic devices and orthotic devices if they are:
- For repeated use
- Used for a medical purpose

You may only receive a prosthetic or orthotic device from a select group of vendors. Your PCP can assist you in selecting a preferred vendor.

Internally Implanted Devices
We cover items implanted during a covered surgery. The item must be approved by the Food and Drug Administration (FDA) for the indicated condition.

External Devices
We cover the following items when medically necessary:
- Prosthetic devices to restore a way of speaking after all or part of the larynx has been removed
- Breast prostheses after removal of a breast, which includes custom-made items and up to three (3) bras required to hold a prosthesis each year
- Footwear to prevent or treat problems related to diabetes
- Burn wraps and wraps for swelling after lymph nodes have been removed
• Prosthetic devices needed to replace an organ or limb, but only if the device replaces the function of the organ or limb
• Orthotic devices needed to support or correct a body part
• Braces and special shoes if they are attached to the brace
• Special footwear for foot disfigurement due to disease, injury, or developmental disability

Please refer to the Alameda Alliance for Health (Alliance) website for a complete list of covered Prosthetic and Orthotic devices (see Contact List for website address).

We do not cover:
• Dental appliances
• Luxury items
• Most shoe inserts

Reconstructive Surgery

Exclusions
The Alliance covers medically necessary reconstructive surgical services performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease when performed to improve function or to create a normal appearance to the extent possible.

After a mastectomy, we cover reconstructive surgery of the breast and reconstructive surgery of the other breast for a more similar look. We also cover services for swelling after lymph nodes have been removed.

We also cover medically necessary dental or orthodontic services and surgery needed to correct a cleft palate.

Sexually Transmitted Disease Care

You may get confidential testing and treatment for sexually transmitted diseases (STDs), like syphilis, gonorrhea, and chlamydia. We have the following types of providers in our plan that may provide treatment:

• Family planning sites
• Certified midwives, certified nurse practitioners, and clinics
• Primary care providers (PCPs)
• STD testing and treatment sites
• Teen specialists or pediatricians
• Women’s specialists (such as OB-GYNs)

Your PCP does not have to refer you to this care. Federal law states that you may go to any qualified Medi-Cal agency, clinic, or provider for STD services even if we do not have a contract with a site. You may only go to a non-contracted site for a
limited number of times for each sexually transmitted diseases (STD) episode. Please talk with your Primary Care Provider (PCP) about getting follow-up care. If you go to a site outside of the Alameda Alliance for Health’s (Alliance) network, you may be asked to sign a release of information to allow the non-contracted site to bill us.

**Skilled Nursing / Intermediate / Subacute Facility Care**

A skilled nursing / intermediate / subacute facility is a place that contracts with the Alliance, provides continuous skilled nursing services, and is licensed by the state of California. Such places must be contracted with the Alliance for members to receive care.

We cover medically necessary skilled nursing, intermediate, and subacute nursing care for the month of admission plus the next month. The services must be prescribed by an Alliance doctor and authorized by the Alliance. If you need skilled nursing, intermediate, or subacute nursing care for more than the month of admission plus the next month, you will be disenrolled and get this care through Fee-For-Service Medi-Cal. You will not be disenrolled if you are getting covered hospice care.

Benefits include:

- Doctor services
- Nursing services
- Room and meals
- Medications
- Durable medical equipment (DME)
- Imaging, lab services, and special procedures that skilled nursing facilities normally provide
- Medical social services
- Blood and blood products
- Medical supplies
- Physical therapy, occupational therapy, and speech therapy
- Respiratory therapy

**Exclusions**

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

**Substance Use Disorder Preventive Services**

Alcohol misuse screening services are covered by Alliance for all members ages 18 and older. The services for alcohol misuse, also known as Screening, Brief Intervention, and Referral to Treatment (SBIRT), cover:

- One (1) expanded screening for risky alcohol use per year
- Three (3) 15-minute brief intervention sessions to address risky alcohol use per year
Not Covered:
- Alameda Alliance for Health (Alliance) does not cover services for alcohol and drug problems, but you may be referred to the County Alcohol and Drug Program.

Therapeutic Abortion
We cover therapeutic abortions performed by providers who accept Medi-Cal. Your PCP does not need to refer you to this service, nor does the Alliance need to authorize this service. You can get abortion services from an Alliance provider. You can also get abortion services from a non-Alliance provider that accepts Medi-Cal, without having to get permission from the Alliance. We will pay the non-Alliance provider for the covered services that you get.

Therapeutic Enteral Formula
We cover medically necessary therapeutic enteral formulas for members who have medical conditions that do not allow them to eat regular food.

Vaccines
Vaccines are part of routine care covered by the Alliance. Child members are entitled to receive all vaccines in keeping with the most recent childhood vaccine schedule and recommendations from the Advisory Committee on Immunization Practices (ACIP). Adult members are also covered for all necessary vaccines listed in the most current California Adult Immunization recommendations.
- Vaccines for infants and children may include MMR, DTap, Tdap, polio, PCV, IPV, Rota, Varicella, influenza, hemophilus influenza type b (Hib), Hep A, Hep B, HPV MCV4, and PPV.

Exclusions
Vaccines requested for travel purposes are not covered and not payable by your health plan.

Vision Care
We cover vision care, including eye exams once every two years, for all Medi-Cal beneficiaries. Members who are under the age of 21, pregnant, or living in a skilled nursing facility may receive additional vision care (see Contact List for phone number and website address, see Attachment A for more information).
Benefits Chart

Please note that the table below is only a summary. More details about benefits can be found in the “Benefits” section of this booklet.

All health care is arranged through your doctor. In order for your health care to be paid for by Alameda Alliance for Health (Alliance), your doctor and the Alliance have to say you need it. For most care, your doctor or provider has to be a part of the Alliance network. If you choose to receive services from outside of our network for routine care, these services are not covered. If you get care from outside of our network or outside of our service area, you may be billed by your provider and you may have to pay, except for emergency care, urgent care, and family planning.

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<td>Kidney and corneal transplants for members over the age of 21. For other kinds of transplants, the Alliance covers some types of care.</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>38</td>
<td>All medically necessary care that you get in a doctor’s office or clinic.</td>
</tr>
<tr>
<td>Outpatient Imaging, Lab Tests, and Special Procedures</td>
<td>52</td>
<td>We cover imaging, lab tests, and special procedures to help find out what is wrong, and for treatment. This includes X-rays and MRIs.</td>
</tr>
<tr>
<td>Outpatient Pharmacy Services</td>
<td>53</td>
<td>We cover drugs that are on the Alliance formulary and other items when prescribed by an Alliance doctor and dispensed at an Alliance network pharmacy. More details about special types of drugs and limits on certain drugs are in the “Benefits” section of this booklet.</td>
</tr>
<tr>
<td>Phenylketonuria (PKU)</td>
<td>56</td>
<td>Testing and treatment of PKU are covered. This includes formulas and special food products that are part of a PKU diet.</td>
</tr>
<tr>
<td>Podiatry</td>
<td>56</td>
<td>We cover podiatry services only when medically necessary with no limitations on care setting for members under the age of 21. We cover podiatry services only when medically necessary and only when these services are provided by a federally qualified health center for members 21 years and older.</td>
</tr>
<tr>
<td>Pregnancy and Maternity Care</td>
<td>56</td>
<td>We cover all health care before the birth of a baby, during the birth of a baby and after the birth of a baby. Newborn coverage stops at the end of the month after the month of birth.</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>57</td>
<td>We cover the prosthetic and orthotic devices that are dispensed by an Alliance provider in Alameda County.</td>
</tr>
<tr>
<td>Internally Implanted Devices</td>
<td>57</td>
<td>We cover items implanted during a covered surgery. These items must be approved by the FDA.</td>
</tr>
<tr>
<td>External Devices</td>
<td>57</td>
<td>We cover prosthetic devices to restore normal function under certain conditions.</td>
</tr>
<tr>
<td>Benefit</td>
<td>PG</td>
<td>Covered Services</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>58</td>
<td>We cover reconstructive surgical service performed to correct or repair abnormal structures of the body caused by certain conditions in order to improve function or to create</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases</td>
<td>58</td>
<td>You may get private testing and treatment for sexually transmitted diseases (STDs).</td>
</tr>
<tr>
<td>Skilled nursing / Intermediate / Subacute Facility Care</td>
<td>58</td>
<td>We cover skilled nursing, intermediate, and subacute nursing care for the month of admission plus the next month in a place that we contract with. If you need the above types of care for more than the month of admission plus the next month, you will be moved to Fee-For-Service Medi-Cal.</td>
</tr>
<tr>
<td>Therapeutic Abortion</td>
<td>60</td>
<td>Therapeutic abortions performed by providers who accept Medi-Cal.</td>
</tr>
<tr>
<td>Therapeutic Enteral Formula</td>
<td>60</td>
<td>We cover therapeutic enteral formulas for members who have specific health problems.</td>
</tr>
<tr>
<td>Vaccines</td>
<td>60</td>
<td>All approved vaccines are covered for children and adults. This includes the HPV vaccine.</td>
</tr>
<tr>
<td>Vision Care</td>
<td>60</td>
<td>We cover vision care through a separate vision plan. See Attachment A and the &quot;Benefits&quot; section of this booklet for more information.</td>
</tr>
</tbody>
</table>
Other Programs and Services for People with Medi-Cal

Some health care services are not benefits under your coverage with the Alameda Alliance for Health (Alliance), but you may still qualify for them while you are an Alliance member. These services are part of Fee-For-Service Medi-Cal or other programs.

California Children’s Services (CCS)

Alliance members up to 21 years old who need special health care for serious or chronic conditions may qualify for the CCS Program (see Contact List for phone number).

CCS is a State medical program that treats children with certain diseases, physical limitations, or chronic health problems who need special medical care. This program is open to all children in California whose families meet certain medical, financial, and residential eligibility requirements. All services through CCS are coordinated by the Alameda County CCS Office.

If you or your child is under 21 years old, and a doctor thinks you have an eligible condition, you will be referred to CCS. CCS will evaluate your condition and decide if you are eligible to get services. If CCS decides that you are eligible:

- You must get services related to that condition from CCS providers.
- CCS will let you know the doctor and facility that is authorized to treat your CCS-eligible condition.
- You will get all covered services not related to that condition from the Alliance.

If CCS determines that you are not eligible, the Alliance will continue to provide covered services.

To learn more about services that CCS covers and how to get services from CCS providers that are not in the Alliance network, talk to your doctor or call your local CCS office (see Contact List for phone number).

Certain Management Services

The following are case management services:

- Lead poisoning case management services. You must get these services from the local health department. This exclusion does not apply to covered treatment for lead poisoning, which is provided by the Alliance (see Contact List for phone number).
- Targeted case management services. You must get these services from the local health department (see Contact List for phone number).

If you live in Berkeley, call the City of Berkeley Public Health Division for these services (see Contact List for phone number).
Exclusions, Limitation, and Reductions

Certain Lab Tests
Lab tests (such as serum alpha-fetoprotein [AFP] testing) that you get through a State program for pregnant women. These services are paid for by the California Department of Public Health Prenatal Screening Branch (see Contact List for phone number).

Certain Services for Tuberculosis (TB)
Some TB services such as directly observed therapy. You must get these services through the local health department. If you live in Berkeley, call the City of Berkeley Public Health Division for these services (see Contact List for phone number).

Dental Care
These are services that are performed by a dentist, orthodontist, or oral surgeon, and include dental appliances. You must get dental services through Denti-Cal (see Contact List for phone number).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
The EPSDT program is a benefit for individuals under the age of 21. This benefit allows for periodic screenings to determine health care needs. Your doctor is responsible for identifying and referring members who are eligible for the EPSDT program and its supplemental services during regular health assessment screenings or visits.

EPSDT provides the following medically necessary services for qualified individuals under the age of 21 years:
- Routine well child checks
- Diagnosis and treatment for persons with specific physical and mental illnesses or conditions
- Physical, occupational and speech therapies
- Pediatric day health care facilities
- Case management

Long-Term Care (Skilled or Intermediate Nursing Facility)
If you need skilled or intermediate nursing care for longer than the month of admission and the full month after, you will need to switch to Fee-For-Service Medi-Cal. We will help you disenroll from Alameda Alliance for Health (Alliance) to get care for extended long-term care services.

Prayer Healing
Services of Christian Science providers. You must get these services through Fee-For-Service Medi-Cal.
Regional Center of the East Bay

Developmental Disabilities – Support Services

Adults and children who have developmental disabilities may receive counseling, support, and other non-medical services, such as respite care, out-of-home placement, and arrange for supportive living from the Regional Center of the East Bay (see Contact List for phone number).

Examples of developmental disabilities are:

- Autism
- Cerebral palsy
- Epilepsy
- Mental retardation
- Significant delays in development

Early Start Program Services

The Early Start Program is available through the Regional Center of the East Bay (see Contact List for phone number). Early Start is for infants and toddlers from birth to three (3) years who have problems that may result in developmental delays, or who show signs of developmental delay.

Some risk conditions are:

- Asphyxia
- Central nervous system infection
- Prematurity

Home and Community-Based Service Waiver Programs

The California Department of Health Care Services (DHCS) has a number of Medi-Cal waiver programs that provide home and community-based services to specific groups of eligible individuals. If you are accepted by one of the programs, you may need to change to Fee-For-Service Medi-Cal. We will help you disenroll from Alameda Alliance for Health (Alliance) so that you can receive these services.

To learn more about Medi-Cal Waivers, visit the DHCS – Medi-Cal Waivers website (see Contact List for website address). Or call the Alameda County Social Services Agency – Medi-Cal Center (see Contact List for phone number).

Indian Health Services

The Native American Health Center is part of our network and is the Indian Health Service Facility in Alameda County (see Contact List for phone number).

If you are Native American, you have the right to disenroll from Medi-Cal managed care
at any time for any reason. You can also get health care at an Indian Health Service Facility that is not part of the Alameda Alliance for Health (Alliance) network. If you want to get your health care from one of these clinics on a regular basis, you will need to disenroll from the Alliance. To disenroll, you must fill out a medical exemption form. Contact Health Care Options (see Contact List for phone number).

**Fee-For-Service Medi-Cal**

The following services and drugs are not covered by the Alliance. You can get these services through Fee-For-Service Medi-Cal by going to any provider who takes Medi-Cal:

- Alcohol and drug treatment
- Chiropractic care, if you are under the age of 21, pregnant, or living in a skilled nursing facility, unless provided by a federally qualified health center. Other members may also be able to get these services. Contact Medi-Cal for more information (see Contact List for phone number and website address).
- Major organ transplants (the Alliance covers only kidney and corneal transplants) (see “Benefits” and “Exclusions, Limitations, and Reductions” sections).
- Dental services, if you are under the age of 21, pregnant, or living in a skilled nursing facility. Members may be able to get these services through Denti-Cal (see Contact List for phone number and website address).
- Direct Observed Therapy (DOT) for tuberculosis (TB)
- HIV, AIDS, and certain psychiatric drugs
- Hemophilia blood factors
- Long-term Care (the Alliance covers only skilled or intermediate nursing care for the month of admission and the full month after (see “Benefits” and “Exclusions, Limitations, and Reductions” sections).
- Prayer or spiritual healers
- Serum alpha-fetoprotein (AFP) testing during pregnancy
- Specialty mental health services (provided through Alameda County Behavioral Health Services ACCESS Program).

To learn more about how to get services that are covered by Fee-For-Service Medi-Cal, call your Medi-Cal eligibility worker at your Alameda County Social Services Agency (see Contact List for phone number).

**Special Care Services for Adults with Genetic Diseases**

You or your child may be able to get special services, which include some benefits not covered by the Alliance, from the Genetically Handicapped Persons Program (GHPP). People 21 years or older may apply. GHPP eligible medical conditions include:

- Certain diseases of the blood, brain, nerves, protein metabolism, carbohydrates metabolism, or copper metabolism
- Cystic fibrosis
- Von Hippel-Lindau Disease (VHL)
Go to the GHPP website to learn more about this program (see Contact List for website address). Talk to your Primary Care Provider (PCP) if you are interested in obtaining these services.

**Women, Infants, and Children Services**

The Women, Infants, and Children (WIC) nutrition program may help you and your children. WIC offers nutrition information, food vouchers, breastfeeding support, and certain types of baby food.

If you are pregnant, breastfeeding, or have a child under five (5) years old, you may be able to get WIC service (see Contact List for phone number).

**Exclusions, Limitations, and Reductions**

Alameda Alliance for Health (Alliance) does not cover all the services that Medi-Cal covers. If we do not cover a service that Medi-Cal covers, you must get the service through Fee-For-Service Medi-Cal or other programs. In most cases, like California Children's Services, your Alliance provider will refer you to a non-Alliance provider. In some cases, like dental care, you can go directly to a non-Alliance provider.

**Exclusions**

The services listed in this "Exclusions" section are not covered by the Alliance. Other exclusions that apply only to one service are listed in the description of that service in the "Benefits" section.

**Exclusions Due to Medi-Cal Law Change**

Due to a change in California law, Medi-Cal benefits have been reduced, with some exceptions. This affects Medi-Cal Members age 21 years and older. Medi-Cal no longer pays for the following benefits and Services for most adults:

- Speech Therapy Services
- Podiatric Services
- Audiology Services
- Chiropractic Services
- Optician Services (eyeglasses and frames)
- Incontinence creams and washes

**Exceptions**

Chiropractic Services and Podiatric Services are available to members who receive the services through a federally qualified health center.

The above benefits and services will NOT change for Medi-Cal Members who are:

- Under the age of 21 years; or
Living in a Skilled Nursing Facility; or
Pregnant. If you are pregnant you can continue to receive pregnancy-related benefits and Services. You can also receive other benefits and Services listed above to treat conditions that, if left untreated might cause difficulties in the pregnancy. This includes dental exams, cleanings and gum treatment. Dental and other benefits and Services may also be available up to 60 days after the baby is born; or
Receiving benefits through the California Children’s Services Program (CCS).

For further information on the Medi-Cal reduction of benefits, please call Alameda Alliance for Health (Alliance) Member Services (see Contact List for phone number).

**Certain Exams and Services**

Services needed:
- To get or keep a job
- To get insurance
- To get any kind of license
- By order of a court, or for parole or probation

**Comfort or Convenience Items**

Items that are solely for the comfort or convenience of a member, a member's family, or a member's health care provider.

**Cosmetic Services**

This exclusion does not apply to:
- Services covered under "Reconstructive Surgery" in the "Benefits" section
- Services covered under "Prosthetic and Orthotic Devices" in the "Benefits" section

**Drug and Alcohol Abuse Services**

Inpatient drug and alcohol abuse detoxification services covered directly by the Alliance are described in the "Benefits" section. All other drug and alcohol abuse services may be gotten through the Alameda County Behavioral Health Plan (ACCESS) (see Contact List for phone number).

**Disposable Supplies**

Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages.

**Experimental or Investigational Services**

A service of which we find that one of the following is true:
- It is not seen as safe and effective by accepted medical standards to treat a condition (even if it has been authorized by law for use in testing or other studies on human patients); or
Exclusions, Limitation, and Reductions

- It has not been approved by the government to treat a condition.

This exclusion does not apply to services covered under "Cancer Clinical Trials" in the "Benefits" section.

See "Independent Medical Review" in the "How to Solve Problems" section to learn about independent medical review of requests for experimental or investigational services.

Hair Loss or Growth Treatment

Services to make hair grow or for hair loss.

Local Education Agency Assessment Services

Services that you get through schools. Call your local school district for services.

Major Organ Transplants

Alameda Alliance for Health (Alliance) covers kidney and corneal transplants (see “Organ Transplants” in the “Benefits” section). All other organ transplants, which include, but are not limited to, heart, heart/lung, bone marrow, liver, lung, combined liver/kidney, and combined liver/small bowel may be covered by Fee-For-Service Medi-Cal. We will help you disenroll from the Alliance to get care for these transplant services.

Personal Care Services

These are services that are not medically necessary, such as help with activities of daily living (bathing, cleaning, and cooking). These services can be done by people who do not have a medical license or need to be supervised by a nurse.

This exclusion does not apply to services covered under "Skilled Nursing/Intermediate/Subacute Facility Care" or "Hospice Care" in the "Benefits" section.

Reversal of Sterilization

Services to reverse voluntary surgical birth control.

Services Related to a Non-Covered Service

When a service is not covered, all services related to the non-covered service are excluded. This exclusion does not apply to services we would cover to treat complications of the non-covered service.

Services Not Covered by Medi-Cal

We do not cover any services that are not covered by the Medi-Cal program.
Exclusions, Limitation, and Reductions

Speech Therapy
Speech therapy services to treat social, behavioral, or cognitive delays in speech or language development unless medically necessary. This exclusion does not apply to members eligible for CBAS.

Service that Helps Someone Get a Child
Services that help a woman conceive or obtain a baby. Other terms include artificial insemination, infertility services, and surrogacy.

Travel and Lodging Costs
Care in a facility where you stay overnight, except that this exclusion does not apply to:
- Overnight stays as part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care, a licensed facility providing crisis residential services, or a licensed facility providing transitional residential recovery services.
- Situations in which you are referred to a non-Alliance provider and we authorize the costs ahead of time.
- Services covered under "Medical Transportation Services" in the "Benefits" section.

Waiver Programs
Waiver programs provide care at home for people who would otherwise be in an institution. The California Department of Health Care Services (DHCS) has a number of Medi-Cal waiver programs that provide home and community-based services to specific groups of eligible individuals. If you are accepted by one of the programs, you may need to change to Fee-For-Service Medi-Cal. We will help you disenroll from the Alameda Alliance for Health (Alliance) so that you can receive these services. To learn more about Medi-Cal Waivers, visit DHCS – Medi-Cal Waivers website (see Contact List for website address). Or call the Alameda County Social Services Agency – Medi-Cal Center (see Contact List for phone number).

Limitations
If something happens that is out of our control, like a disaster, we will strive to provide you with the care that you need. If you have an emergency medical condition, go to the nearest hospital. You have coverage for emergency care (see "Emergency Care, Urgent Care, and Routine Care" section).

Reductions
The cost of services listed below is paid by some other source (a third party). In some cases, DHCS has a right to recover money from the third party. If DHCS does not recover these costs, the Alliance can do so. DHCS can ask a third party to pay for services that you get from Alliance if:
- You are hurt on the job (workers’ compensation)
- You are sick or hurt due to someone else, such as a car accident (third party liability)
- There is money owed through your estate (estate recovery)
However, in cases when DHCS can ask a third party to pay for services, we will provide any services when medically necessary. We will let DHCS know about the third party's action if we know about it. If the third party pays you money, you may have to pay DHCS for services that we paid for or gave to you.

**Services Covered by an Employer**

We will not pay for services that your employer must provide to you by law. When we provide any of these services, we may ask your employer to pay us back for the cost of these services.

**Services Covered by Government Agencies**

We will not pay for services that a government agency must provide by law. When we provide any of these services, we may ask the agency to pay us back for the cost of these services.

**Services Covered by Medicare**

If you are eligible for Medicare, you must let us know. The Medicare program may have to pay for certain services that you get from us. Medi-Cal always pays last.

**Services Covered by the U.S. Department of Veterans Affairs**

Alameda Alliance for Health (Alliance) will not pay for services needed due to military service that the Department of Veterans Affairs (VA) must provide by law. When we provide any of these services, we may ask the VA to pay us back for the cost of these services.

**Services Covered by Any Other Insurer**

We will not pay for medically necessary covered services or benefits that a member is entitled to from any other state, federal, or local health care program including but not limited to any insurer, health care service plan, or union health care trust fund.

**Services Provided Free of Charge**

We will not pay for covered services given free of charge or without expectation of payment.

**Member Responsibilities - Other Insurance**

1. Apply for and keep up other insurance where there is no cost to you.
2. Provide the state of California with the most current information regarding your other insurance coverage. You can call the California Department of Health Care Services (DHCS) Recovery / Third-Party Liability / Other Coverage Branch to report or resolve issues about your other insurance. (Sometimes the State agencies have outdated information that may affect your eligibility for the Alliance (see Contact List for phone number).
3. Provide us with information about any other insurance that you may have. You must use your other insurance before using Alliance benefits.
4. Report to us whether your need for health care services is because of another person’s fault or negligence (like a car accident).
5. Tell us if you get any payment from other insurance for services provided through Alameda Alliance for Health (Alliance).

We may request disenrollment from DHCS for fraud or intentional misrepresentation or other grounds permitted under Medi-Cal rules (including but not limited to moving out of the Service Area (Alameda County) and loss of Medi-Cal coverage.

How to Solve Problems

Complaints and Problems/Grievance and Appeals

We want you to be happy with the health care we offer you! If you have a problem with the Alliance, you have the right to make a complaint. This is also called a grievance (see “Definitions” section). An appeal is when you ask for review of an “action.”

Actions are:

- You receive a “Notice of Action” letter about a denial or limited approval of a requested service.
- You receive a “Notice of Action” about a reduction, suspension, or termination of a service that had been approved in the past.
- A failure to provide services in a timely way. (This may also be a reason for a grievance).
- A failure of the Alliance or the State to act within the timeframes for grievances and appeals. (This may also be a reason for a grievance).

If you have a problem with your health care services, please call Alliance Member Services (see Contact List for phone number). If you have a grievance or an appeal, you may file it by phone or fill out a form. You can appeal a “Notice of Action” by phone. Your provider may file an appeal for you.

For help, you can call us at:

Phone: 510-747-4567  
Toll-Free: 1-877-932-2738  
CRS/TTY: 711 or 1-800-735-2929

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

G&A Coordinator  
Alameda Alliance for Health  
1240 South Loop  
Road Alameda, CA 94502  
Fax: 1-855-891-7258

You will be treated with respect during the grievance or appeal process. You have the right to give your views, provide papers that support your views, or propose a solution. You may speak for yourself or have someone else speak for you, including a lawyer. Using this grievance process does not rule out any legal rights or remedies that you may have.

You may ask to look at or get a copy of our records that relate to your case. You or your provider may get a copy of the benefit provision, guideline protocol, or criteria used to

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510-747-4567 or toll-free 1-877-932-2738 • www.alamedalliance.org
make a denial decision by calling Alameda Alliance for Health (Alliance) Member Services (see Contact List for phone number).

Timeframes
If you have a problem, you must file a grievance with the Alliance within 180 calendar days of the event that caused your grievance. You must file an appeal of a Notice of Action within 90 calendar days of the date the service or benefit was denied, delayed or changed.

The Alliance will review your grievance or appeal and send you a letter within 5 days to confirm we received your grievance or appeal. We will respond to your grievance or appeal within 30 calendar days, or sooner, based on your health. If you think waiting 30 days will harm your health, be sure to explain why when you file your grievance or appeal. Then you might get an answer within 3 calendar days. At the time you file your appeal, you can ask the Alliance to give you the same service until the grievance or appeal process is complete.

If you need help with:
1. A grievance about an emergency; or
2. A grievance that has not been acceptably resolved by the health plan; or
3. A grievance that has not been resolved for more than 30 days, you may call DMHC for help (see “California Department of Managed Health Care” section).

You do not need to go through the Alliance grievance process before asking DMHC to review an urgent grievance.

Independent Medical Review (IMR)
An IMR is a review of your case by doctors who are not part of the Alliance. You can ask for an IMR from the HMO Help Center at the Department of Managed Health Care (DMHC).

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

You can ask for an IMR if the Alliance:
- Denies, changes, or delays a service or treatment because it has been determined as not medically necessary.
- Will not cover an experimental or investigational treatment for a serious medical problem.
- Will not pay for emergency or urgent medical services that you have already received.

The Alliance must give you a decision within 30 days or within three (3) days if your problem is an urgent and serious threat to your health.

If the Alliance denied your treatment because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an Independent
Medical Review (IMR). You can ask for the IMR right after you receive a “Notice of Action” but no longer than six (6) months after you receive the Notice of Action.

To ask for an IMR, contact:

- HMO Help Center at the Department of Managed Health Care (DMHC)
  - Phone: 1-888-466-2219
  - TDD: 1-877-688-9891
  - CRS/TTY: 711/1-800-735-2929
  - IP-Relay service: www.IP-relay.com

You can find DMHC forms and a guide at: www.hmohelp.ca.gov

If you qualify for an IMR, the HMO Help Center will review your request and send you a letter within 7 days that says if you qualify for an IMR. After all your information is received, such as medical records, the IMR decision will be made within 30 days or within 3 to 7 days if your case is urgent. Doctors will review your case and you will receive notice of the decision. If they decide the IMR in your favor, Alameda Alliance for Health (Alliance) must give you the service or treatment you asked for.

If you do not qualify for an IMR, your issue will be reviewed through DMHC’s standard complaint process. You will receive a written notice of the decision within 30 days. If you decide not to use the IMR process, you may be giving up your rights to pursue legal action against the Alliance about the service or treatment you are asking for.

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

**Experimental or Investigational Denials**

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

The letter will tell you about your right to ask for an IMR through the Department of Managed Health Care (DMHC) (see “Independent Medical Review” section). To complete an application for an IMR of an experimental or investigational therapy, you need one of the following:

- The doctor who is treating you gave us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be right for you, or that there is no more beneficial standard therapy we cover than the therapy being asked for.
  - "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.
  - "Seriously debilitating" means diseases or conditions that cause major damage that cannot be reversed.
Exclusions, Limitation, and Reductions

- If the doctor who is treating you is an Alameda Alliance for Health (Alliance) doctor, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the therapy being asked for is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Alliance doctor in certifying his or her recommendation.

- You (or your Alliance doctor who is a licensed, and either board-certified or board-eligible, doctor qualified in the area of practice appropriate to treat your condition) requested a therapy that is 1) based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), and is 2) likely to be more beneficial for you than any available standard therapy. The doctor's certification included a statement of evidence relied upon by the doctor in certifying his or her recommendation. We do not cover the services of a non-Alliance provider.

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

State Fair Hearings

If you receive a “Notice of Action”, you may file an appeal with us or ask for a State Fair Hearing.

You can file an appeal with your health plan and ask for a State Hearing at the same time. If you want a State Fair Hearing, you must ask for it within 90 days of the action you complain about. Or if you and your treating provider want to keep treatment going that is being stopped or reduced, you must ask for a State Fair Hearing within 10 days of the date of the appeal response letter you get from the Alliance. Please tell us that you want to keep getting your treatment during the hearing process and have the treatments paid for by the Alliance. If you ask for a State Fair Hearing within the 90 day timeframe, all services authorized in the past by the Alliance will carry on while the Hearing is being resolved.

You may ask for a State Fair Hearing by filling out the Form to File a State Fair Hearing, by sending a letter, or call:

California Department of Social Services, State Hearing Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
Toll-Free: 1-800-952-5253
TTD: 1-800-952-8349

This number can be very busy, so you may get a message to call back later.

If you are writing a letter to ask for a State Fair Hearing, please include your name, address, phone number, Social Security Number, and the reason you want a State Fair Hearing. If someone is helping you ask for a State Fair Hearing, add their name, address and phone number to the letter. If you need a free interpreter, tell us what language you speak.
After you ask for a hearing, it could take up to 90 days for your case to be decided and for an answer to be sent to you. If you believe waiting that long will cause danger to your life or health or ability to attain, maintain, or regain maximum function, ask your doctor for a letter. The letter must explain how waiting for up to 90 days for your case to be decided will cause danger to your life or health or ability to attain, maintain, or regain maximum function. Then ask for an expedited hearing and provide the letter with your request for a hearing. Expedited cases are decided within three (3) working days.

Requests for an expedited hearing can be faxed to 916-229-4267 or mailed to:

   Expedited Hearing Unit State Hearings Division
   744P Street, MS 19-65
   Sacramento, CA 95814

If you have questions or would like to learn more about expedited state hearings, you may contact the Department of Health Care Services, Medi-Cal Managed Care Division, Office of the Ombudsman (see Contact List for phone number).

LEGAL HELP: You may speak for yourself at the State Fair Hearing or have someone else speak for you, such as a family member, friend or lawyer. You must get the other person to help you. You may be able to get free legal help through Alameda County or a legal service agency. Call Bay Area Legal Aid at 1-800-551-5554 or go to www.baylegal.org.

Medi-Cal Managed Care Office of the Ombudsman

The Medi-Cal Managed Care Office of the Ombudsman can look into and solve problems. The Ombudsman can help members with urgent enrollment and disenrollment problems. The Ombudsman can also offer information and referrals.

California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Alameda Alliance for Health (Alliance), you should first telephone Alliance Member Services and use our grievance process before contacting the department (see Contact List for phone number). 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-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.
Office of the Patient Advocate

- You can also call the Office of the Patient Advocate if you have any problems and need help to solve them (see Contact List for phone number).

Medi-Cal Fraud

To report Medi-Cal fraud, call the California Department of Health Care Services (DHCS) (see Contact List for phone number). You do not have to give your name.

Some examples of fraud are:

- Someone says that you will lose your Medi-Cal coverage if you do not transfer to a different Medi-Cal provider
- A Medi-Cal provider charges you a copay for covered services
- Someone takes your Medi-Cal Benefits ID Card (BIC) and uses it to get services

(See “Definitions” section).

How Your Coverage Can End (Termination of Benefits)
You Can Disenroll

Your benefits are ongoing, unless you decide to disenroll (leave the Alameda Alliance for Health (Alliance)). You may request to disenroll from the Alliance at any time without a reason. Please call Alliance Member Services (see Contact List for phone number) to discuss the reason for your disenrollment. We would like to help with any problems you may have.

After talking with us, you will need to call Health Care Options at 1-800-430-4263 to get a disenrollment form. You will be notified by Health Care Options when you are disenrolled from the Alliance. You may still get the care you need through the Alliance until the effective date of your disenrollment. Please call Alliance Member Services if you want to re-enroll or want information about other health care programs we may offer (see Contact List for phone number).

You Must Disenroll

In some cases, the state of California stops paying us for your care. If this happens, you will no longer be our member or receive our services. These situations include:

- If you move out of our health plan service area (Alameda County).
- If you are absent from the state for more than 60 days, unless you write to us (our address is in the Contact List) stating:
  - You intend to return to California, and
  - You are out-of-state for one of these reasons:
    - You have an illness or an emergency
    - You live with family members in California who are present in the state at the time of your absence
    - You maintain your California housing
Exclusions, Limitation, and Reductions

- If you leave California and take any of these actions in another state:
  - Purchase, lease, or rent housing
  - Become employed
  - Get an out-of-state driver’s license
  - Apply for aid
- If you are in jail
- If you lose your Medi-Cal eligibility. The state of California, not Alameda Alliance for Health (Alliance), determines your Medi-Cal eligibility.
- If your Medi-Cal aid code category changes to one that is not eligible for Medi-Cal managed care. You can contact the Alameda County Social Services Agency for more information on Fee-For-Service Medi-Cal (see Contact List for phone number).
- If you need certain services that the Alliance does not cover such as certain waiver program services; services in a skilled nursing facility, intermediate care facility, or subacute care facility after the month of admission plus the next month; or transplant services, except corneal transplants and kidney transplants that California Children’s Services does not cover.
- If you have a medical exemption from Medi-Cal managed care enrollment.
- If your enrollment is based on a mistake made by us or the State.
- If you are enrolled in violation of State regulations.
- If the contract between the California Department of Health Care Services (DHCS) and the Alliance is ended.

In rare cases, and with approval from DHCS, we may ask a member to leave our health plan. This is called an “involuntary” or “plan-initiated disenrollment.”

A plan-initiated disenrollment could happen for any of the following reasons:
- You let someone else use your Alliance Member ID Card or Medi-Cal ID Card (BIC).
- You obtain or attempt to obtain services or benefits fraudulently.
- You physically assault an Alliance staff person, doctor, office/clinic/hospital staff, patient, or other member.
- You threaten another individual with a weapon or your behavior threatens the safety of Alliance staff or of any person or property at a facility in the Alliance network.
- The Alliance is not able to, in good cause, give health care services to you. The Alliance will strive to provide the needed services.

Your health status or your use of services are not reasons for disenrollment from the Alliance unless you are getting home or community-based services or long-term care.

If you think you were made to leave our health plan because of your health status or requests for services, you may:
1. File a grievance with Alliance Member Services (see Contact List for phone number)
2. Request a State Fair Hearing. You can call the Department of Social Services Public Inquiry and Response Unit (see Contact List for phone number)
3. Contact the Department of Health Services Office of the Ombudsman (see Contact List for phone number)

(See “Alliance Grievance and Appeal Process” section.)
Faster (Expedited) Disenrollment

You may be able to disenroll Alameda Alliance for Health (Alliance) cannot provide you with medical services due to your medical condition or situation. The Alliance will submit your disenrollment request to the California Department of Health Care Services (DHCS). DHCS will make a decision within 3 business days.

This faster (expedited) disenrollment process happens if:

- You receive services under Foster Care or Adoption Assistance Programs; or
- You need a major organ transplant or other special Medi-Cal services that are not offered by the Alliance; or
- You are already in another Medi-Cal, Medicare, or commercial health plan; or
- You move out of Alameda County.

Health Care Options will process your request. If DHCS approves the disenrollment, your coverage with the Alliance will end no later than midnight on the last day of the first calendar month after your disenrollment request and all required supporting documentation are received by DHCS. If you disenroll because you need a major organ transplant, your coverage will end on the first day of the month in which you are approved as an organ transplant candidate. Please call Alliance Member Services for help (see Contact List for phone number).

Review by the Department of Managed Health Care (DMHC)

DMHC is responsible for regulating health care service plans, including the plan’s enrollment and disenrollment decisions. An applicant or member who alleges that an enrollment has been cancelled or not renewed because of the member’s health status or their requirements for health services may request a review by DMHC. Online forms and instructions are on the DMHC website at www.hmohelp.ca.gov. You can call the DMHC Toll Free Help Line at 1-888-466-2219 or TDD 1-877-688-9891 if you have questions about how to request a review.

Staying a Member

Transitional Medi-Cal (TMC)

TMC is for families who lose cash aid and Medi-Cal (or who would have been eligible for cash under old rules), but are no longer eligible because of higher earnings from work.

If you are the principal earner or caretaker and get a job or your job pays more money, you may get no-cost Medi-Cal for 12 months or more under the following circumstances:

- To get the first six (6) months of TMC, you must have a child in the home.
- To get the second six (6) months of TMC, you must also continue to work and earn under a certain amount.

Be sure to let your eligibility worker know if you get a job or have increased earnings from your job. You can also contact the Alameda County Social Services Agency (see Contact List for phone number).
If you lose Medi-Cal, but are eligible for health care coverage through your or your spouse’s work or another group, you must apply for the work or group coverage within 60 days after your Medi-Cal coverage ends.

**Other Coverage through Alameda Alliance for Health (Alliance)**

When your membership under this Combined Evidence of Coverage and Disclosure Form ends, you may be eligible for other health insurance coverage offered by the Alliance. Please call Alliance Member Services to learn more (see Contact List for phone number).

**Other Facts About This Plan**

**Administration of Your Benefits**

You must fill out any forms that we ask for in our normal course of business. Also, we may create standards (policies and procedures) in order to better provide your services. You may see a copy of our policies and procedures if you ask for it.

If we make an exception to the terms of this booklet for you or someone else, we do not have to do the same for you or someone else in the future.

If we do not enforce part of this booklet, this does not mean that we waive the terms of this booklet. We have the right to enforce the terms of this booklet at any time.

**Advance Directives**

State law gives you two ways to let people know what kind of care you will get if you are very sick or unconscious:

1. A Power of Attorney for Health Care: This means naming someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other kinds of care.

2. Individual Health Care Instructions: This means telling people if you want to have life support and other care. You can tell your doctor what you want and your doctor will write this in your chart. Or, you can write down what you want and have this included in your chart.

We will let you know if there are any changes to this law as soon as possible but no later than 90 days after the change. To learn more about advance directives or to get the forms, contact Alliance Member Services (see Contact List for phone number).

**Assignment**

You may not give someone the right to use your benefits or claims related to your coverage.

**Changes to This Combined Evidence of Coverage and Disclosure Form (Booklet)**

We can make changes to this booklet at any time. We will let you know in writing of any changes 30 days before they happen.
Combined Evidence of Coverage and Disclosure Form (Booklet)

Binding on Members

The terms of this booklet are binding on you when you choose to enroll in Alameda Alliance for Health (Alliance).

Copayments and Deductibles

Members will not be charged a copayment or deductible for covered services provided through our health plan. We will tell you in writing if this policy changes. If a member is billed for services that are covered by the Alliance, the member should call Alliance Member Services (see Contact List for phone number).

Governing Law

The terms of this booklet must conform to California State law, except when federal law takes precedence. If a law says that we must add something to this booklet, we and you must comply with the law even if that provision is not part of this booklet.

Independent Contractors

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

Member Satisfaction

The Alliance conducts surveys of member experience to help find ways to improve the care you receive. The Alliance asks your opinion on the care you receive. Your opinion counts and is needed for us to make things better for all members. You may be asked to rate how good it is and how easy it is to get care. The results of these surveys will be reported to Alliance committees. A member who shares their views will not be known by name or any other means. Helping us with these surveys will not affect the benefits you receive.

Notice of Privacy Practices

How the Alliance is required to protect your health information

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

We (Alameda Alliance for Health or 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
1240 South Loop Road
Alameda, CA 94502
Tel: (510) 747-4567
CRS/TTY: 711/1-800-735-2929

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

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

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

B. How We May Use or Share Your Information
1. Treatment. We may use or share your information to help your doctors or hospitals provide health care to you. For example, if you are in the hospital, we may give them your health records sent to us by your doctor. Or we may share this information with a pharmacist who needs it for a prescription for you, or a lab that performs a test for you.
2. Payment. We may use or share your information to pay for your health care-related bills. For example, your doctor will give us information we need before we pay them. We may also share information with other health care providers so they can be paid.
3. Health care operations. We may use or share your information to operate this health plan.
   • For example, we may use or share your information to review and improve the quality of care you receive. It can also be used to review the skills and qualifications of our providers.
Exclusions, Limitation, and Reductions

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

4. Appointment reminders. We may use or share your information to remind you about doctor or health care visits. If you are not home, we may leave this information on your answering machine or leave a message with the person who answers the phone.

5. Notification and communication with family. We may share your information to let a family member, your personal representative or a person responsible for your care know about where you are, your general condition or your death. In case of a disaster, we may share information with a group like the Red Cross so they can contact you. We may also share information with someone who helps you with your care or helps pay for your care. If you are able to decide, we will let you decide before we share the information. But we may share this information in a disaster even if you do not want us to, so we can respond to the emergency. If you are not able to decide because of your health or you cannot be found, our professional staff will use their best judgment in sharing information with your family and others.

6. Required by law. As required by law, we will use or share your information, but we will limit our use or sharing to only what we are allowed to use or share by the law.

7. Provider peer review. We may use or share your information to review the skills of your provider or the quality of care you receive.

8. Group health plans. If you are a member of a group health plan, we may share information with the sponsor of your group health plan. For instance, if your employer provides your health coverage, we may let your employer know if you are still a member of the plan.

9. Research. We may share your information without your written consent if the research meets certain rules.

10. Marketing. We may contact you to give you information about products or a service. We will not use or share your information for this purpose without your written permission.

11. Court and administrative proceedings. We may, and sometimes need to by law, share your information for an administrative or judicial proceeding as we are told to by a court or administrative order, if you were told of the request and you did not object or the court or administrative judge did not agree with your objection.

12. Health monitoring activities. We may, and sometimes need to by law, share
your information with health monitoring agencies for audits, investigations, inspections, 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 their lawful custody.

17. Insurers. We may use or share your information with insurers when we review a health plan application.

18. Employers. We may use or share your information with your employer to find out about an illness or injury from work, or for workplace medical surveillance, to the extent that you consent to that use. We may use or share your information with your employer if you consent and/or if permitted by law when there is an employee claim or lawsuit about a medical condition, or if the information is about doing a particular job.

19. Other ways the Alliance may use or share your information:
   - We may, as needed by law, share your information to coroners when they investigate deaths.
   - We may share information with funeral directors, as they need it to carry out duties, to the extent permitted by law.
   - We may share your information with organizations that provide services for organ and tissue transplants.
   - We may use or share your information with the FDA when it is about the quality, safety, or effectiveness of an FDA-related product or activity.
   - We may use or share your information with Conservators/Guardians under certain circumstances.
   - We may share your information as we need to for worker's compensation.
   - If the Alliance is sold or merged with another organization, your information/record will be owned by the new owner. But you will be able to change enrollment to another health plan.
   - We may use or share your information in order to protect it when we send it over the Internet.
C. 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 Alameda Alliance for Health (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.

D. 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.

E. Your Privacy Rights

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

2. Right to Request Confidential Communications. You have the right to ask that you receive your information in a specific way or at a specific location if the usual way may put you in danger. For example, you may ask that we send information to your work address. Please write us and tell us how you would like to receive your information and why you would be in danger if we did not follow your request. If your request has a cost that you will have to pay for, we will let you know.

3. Right to See and Copy. You have the right to see and copy your information, with limited exceptions. To see your information, you must send a written request and tell us what information you want to see. Also let us know if you want to see it, copy it, or get a copy of it. California law allows us to charge a fair fee to copy records. We may deny your request under limited circumstances.

***IMPORTANT***

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

4. Right to Change or Supplement. You have a right to ask that we change your information that you believe is incorrect or incomplete. You must ask us in writing to change your record. Tell us the reasons you believe the information is not correct. We do not have to change your information, and if we deny your request, we will let you know why. We will also tell you how you can disagree with our denial. We may deny your request if we do not have the information. We may also deny your request if we did not create the information (unless the person that created the information is no longer available to make the amendment). We may also deny your request if you would not be permitted to inspect or copy the information, or the information is correct and complete.
5. Right to an Accounting of How We Shared Your Information. You have a right to receive a list of how we shared certain information during the six years prior to your request. Please note that a fee may apply.

6. 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 Personal Health Information.

7. 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 our Member Services department.

F. Changes to This Notice of Privacy Practices

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

G. Complaints

Let us know if you have any complaints about this Notice of Privacy Practices or how Alameda Alliance for Health (Alliance) handles your information:

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

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

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

Department of Health Care Services
Office of HIPAA Compliance
P.O. Box 997413, MS 4721
Sacramento, CA 95899-7413
Tel: 916-255-5259
Toll-Free: 1-866-866-0602
TTY/TDD: 1-877-735-2929

You may also notify the Alliance Privacy Officer at:

Alameda Alliance for Health
Attn: Compliance
1240 South Loop Road
Alameda, CA 94502
Tel: 510-747-4500
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.

Notices
We may send you updates about your health care coverage. We will send this to the most recent address we have for you. If you move or have a new address, let us know your new address as soon as you can by calling Alameda Alliance for Health (Alliance) Member Services (see Contact List for phone number).

Payment of Providers
The Alliance contracts with a network of local doctors and medical groups, as well as pharmacies, hospitals, and allied health workers to provide services to its members. Payment to Alliance providers is based on their contract with us. Each contract includes specific rates of payment for each service provided.

The Alliance pays “capitation” to its PCPs and for laboratory, transportation services, and certain other providers. A “capitation” is a fixed rate of payment per month for each member for whom your provider is responsible. The amount of the capitation will vary depending upon the predefined services provided by each type of provider. For non-capitated services, the Alliance generally pays on a Fee-For-Service basis. There are no financial penalties designed to limit health care. In fact, there are incentives for many of our providers to offer the appropriate levels and types of health care to our members. Providers may receive incentives and bonuses. Please call us, your Alliance provider, or your provider’s network if you would like to know more about this.

Our contracts with Alliance providers say that you will not have to pay any money that we owe. But, if you get services that are not covered by Medi-Cal, from Alliance providers or non-Alliance providers, you may have to pay for the cost of services.

Public Policy Participation
The Alliance has a Member Committee to help our Board of Governors. This group makes sure that plan policies meet members' needs and concerns. The Committee is made up of members of our health plan, a community provider, and a member of our Board of Governors.

If you would like more information about our Member Committee or would like to be considered for membership, please contact Alliance Member Services (See Contact List for phone number).

The Alliance is a publicly sponsored health plan. Meetings of its Governing Board are open to the public.

Reimbursement Provisions
Under the Medi-Cal program, you do not have to pay for covered services. Sometimes
Exclusions, Limitation, and Reductions

non-Alliance doctors, pharmacies, and hospitals make you pay for services. For example, you may pay a bill (claim) or have to pay when treated for an emergency outside of Alameda County.

If you have an urgent or emergency care visit outside of Alameda County and you do not see an Alameda Alliance for Health (Alliance) provider, pharmacy, or hospital, the Alliance will pay the non-Alliance provider(s) directly or reimburse you for the amount you had to pay for the care.

If you receive a bill (claim) or have to pay a bill, you should let us know by sending a copy of the bill to the Alliance. If you have paid the bill, also send a copy of your cancelled check or any receipts to the Alliance.

When you send us a bill, include all of the following information:

- Your name, address, phone number, and Alliance Member ID number
- Name, address, and phone number of the service provider (if not stated on the bill)
- Date of each service and reason for the service (if not stated on the bill)
- Copy of the prescription receipt and cash register receipt for any pharmacy claim reimbursement request and reasons for paying out of pocket.

Send this information and a copy of the bill within 90 days of the date of service to:

Alameda Alliance for Health
Attention: Member Bills
P.O. Box 2818
Alameda, CA 94501-0818

When we get a request for payment from you or a non-Alliance provider for out-of-area urgent or emergency services, unless we do not have all the facts we need, we will let the non-Alliance provider know whether we will pay the claim within 45 days. If we need more facts from you or the non-Alliance provider, we may follow-up with you or the non-Alliance provider to get more facts. We may ask you for travel documents or original travel tickets to validate your claim. We will let your provider know that more time is needed to pay the claim (up to 45 more days).

If you send us bills for a service other than out-of-area urgent care or emergency care, we will let you know in writing within 30 days whether we will pay the claim, unless we let you know within those 30 days that we need more facts from you or the non-Alliance provider. If you got services that are not covered by the Alliance or Medi-Cal you may have to pay for the cost of services.

If you are asking us to pay you back for services that you paid for, and we deny the request, we will let you know in writing. The letter will say why we denied your request. Call Alliance Member Services if you have questions about your medical bills (See Contact List for phone number).
Definitions
Here are some of the terms used in this booklet:

**Acute** – A health condition that is sudden and lasts a limited time.

**Active Labor** – Describes a period of time when a woman is in the three stages of giving birth.

**Alameda Alliance for Health (the Alliance)** – A public entity and licensed health plan. In this booklet, “we,” “us,” or “our” means Alameda Alliance for Health.

**Alliance Doctor** – A California-licensed doctor of medicine or osteopathy, who at the time care is rendered to a member, has a contract in effect with the Alliance to provide covered services to members. An Alliance doctor is part of the Alliance network.

**Alliance Facility** – A clinic, hospital, skilled nursing facility, or other licensed health facility or home health agency that, at the time care is rendered to a member, has a contract in effect with the Alliance to provide covered services to members. An Alliance facility is part of the Alliance network.

**Alliance Hospital** – A hospital that, at the time care is rendered to a member, has a contract in effect with the Alliance to provide covered services to members. An Alliance hospital is part of the Alliance network.

**Alliance Network** – All Alliance providers. The providers with contracts in effect with the Alliance to provide covered services to members make up the Alliance network.

**Alliance Pharmacy** – A pharmacy that, at the time care is rendered to a member, has a contract in effect with the Alliance Pharmacy Benefit Manager to provide covered services to members.

**Alliance Provider** – A doctor, clinic, hospital, pharmacy, skilled nursing facility, or other licensed health professional, licensed facility, or licensed home health agency who, or that, at the time care is rendered to a member, has a contract in effect with the Alliance to provide covered services to members. An Alliance provider is part of the Alliance network.

**Authorization** – The requirement that certain medically necessary covered services be approved by the Alliance or your medical group before you get them.

**Basic Health Care Services** – Means all of the following:

- Physician services, including consultation and referral;
- Hospital inpatient services and ambulatory care services;
- Diagnostic laboratory and diagnostic and therapeutic radiologic services;
- Home health services;
- Preventive health services;
- Emergency health care services, including ambulance and ambulance transportation services provided through the “911” emergency response system;
- Hospice care pursuant to Section 1368.2 of the California Health and Safety Code.

**Benefits** – The package of covered services (such as office visits, lab tests, and surgery), supplies (such as prescription drugs and durable medical equipment), and
facilities (such as hospital rooms) that Alameda Alliance for Health (Alliance) gives its members access to and pays for. Exclusions, limitations, and reductions apply.

**Booklet** – The document between the Alliance and the member that is represented by this Combined Evidence of Coverage and Disclosure Form.

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

**Clinically Stable** – When the doctor who is treating you believes you are safe for discharge or transfer and your condition is not expected to get worse during, or as a result of, discharge or transfer.

**Complaint** – see “Grievance”

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

**Covered Service** – Medically necessary services, supplies, and drugs that a member is entitled to receive under the terms of the Alliance’s contract with DHCS and covered in this Combined Evidence of Coverage and Disclosure Form. Exclusions, limitations, and reductions apply.

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

**Disenroll** – To stop using the health plan services and health care because you lost eligibility or quit the health plan.

**Durable Medical Equipment** – Certain medically necessary equipment that is:
- For repeated use
- Used for a medical purpose
- Generally not useful to someone who is not ill or hurt

**Emergency Care** –
- An exam performed by a doctor (or other appropriate staff under the 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 ambulance services covered under "Medical Transportation Services" in the “Benefits” section.

**Emergency Contraceptive** – A drug that may keep you from getting pregnant if your regular contraceptive fails or if you had unprotected sex.

**Emergency Medical Condition** – A medical or psychiatric condition marked by acute symptoms severe enough (including severe pain) that a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the person (or in the case of a pregnant woman, the health of the woman and her unborn child) in serious danger, or
- Serious impairment to body functions, or
- Serious dysfunction of any body part or organ.
- Active labor associated with pregnancy is an emergency condition.
Exclusions, Limitation, and Reductions

(See “Definition” for “Psychiatric Emergency Medical Condition”.)

**Enrollee** – A person who is enrolled in a plan and who is a recipient of services from the plan.

**Evidence of Coverage** – Also known as “Combined Evidence of Coverage and Disclosure Form.” Any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

**Exclusion** – A service we do not cover. A non-covered service.

**Experimental or Investigational** – A service that:

- Is not seen as safe and effective by nationally recognized medical guidelines to treat a problem (even if it has been authorized by law for use in testing or other studies on human patients); or
- Has not been approved by the government to treat a health problem.

**Family Planning Services** – Services that prevent or delay pregnancy.

**Federally Qualified Health Center (FQHC)** – A clinic that gets direct federal funds to provide health care.

**Fee-For-Service Medi-Cal** – Refers to a health care system for Medi-Cal recipients. This is not a “managed care” system. With “Fee-For-Service” Medi-Cal, recipients may go to any provider or clinic that takes Medi-Cal patients.

**Follow-Up Care** – A process of regular doctor visits to check a patient’s progress after a hospitalization or during a course of treatment. Follow-up care consists of appointments with a PCP or specialist to check the results of treatment, monitor new or ongoing problems, perform preventive exams, and/or prepare for upcoming clinical visits.

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

**Fraud** – An intentional act to deceive or misrepresent made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under the applicable federal or state law.

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

**Group Contract** – A contract, which by its terms limits the eligibility of subscribers and enrollees to a specified group.

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

1. Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the
Exclusions, Limitation, and Reductions

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

Hospital – A health care facility licensed by the state of California, and accredited by The Joint Commission, as either:
1. An acute care hospital; 2) a psychiatric hospital; or
2. A hospital operated primarily for the treatment of alcoholism and/or substance abuse. A facility that is primarily a rest home, nursing home, or home for the aged, or a distinct part of a skilled nursing facility portion of a hospital, is not included.

Hospital Inpatient Care – Medically necessary covered services that you get when you are admitted to an Alliance hospital.

Interpreter – Someone who conveys the meaning of spoken or signed language between people who speak different languages. An interpreter does not add, omit, or distort meaning or offer an opinion.

License or licensed – as used in the definition of “Alameda Alliance for Health” only, “licensed” refers to a license as a plan pursuant to Section 1353 of the California Health and Safety Code.

Life-Threatening Condition – A disease or condition where the likelihood of death is high unless the course of the disease is broken and/or a disease or condition that is fatal and where the goal of clinical care is survival.

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

Medically Necessary – Services that are reasonable and needed to protect life, to prevent illness or disability, or to relieve severe pain, through the diagnosis or treatment of disease, illness, or injury.

Member – A person who joins the Alliance to receive his or her health care. In this booklet, a member is also referred to as “you.”

Mental Health Services – Psychoanalysis, psychotherapy, counseling, medical management, or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage, family and child counselor, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition.
- Outpatient Mental Health Services – benefit provided by the Alliance through our subcontractor Beacon Health Strategies. These services are for the treatment of mild to moderate mental health conditions, which include:
  - Individual and group mental health testing and treatment (psychotherapy);
  - Psychological testing to evaluate a mental health condition;
  - Outpatient services that include lab work, drugs, and supplies;
  - Outpatient services to monitor drug therapy; and
  - Psychiatric consultation.
Exclusions, Limitation, and Reductions

- Specialty Mental Health Services – benefit provided by the Alameda County Behavioral Health Services (ACCESS Program).

**Nationally Recognized Clinical Guidelines** – One of the following publicly available guidelines such as Milliman Care Guidelines or coverage guidelines professionally recognized and accepted from DHCS or DMHC.

**Non-Alliance Provider** – A provider who does not have a contract with the Alliance. A non-Alliance provider is not part of the Alliance network.

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

**OB-GYN** – The short name for “obstetrician-gynecologist.” OB-GYN also stands for obstetrics and gynecology, which are the two surgical specialties dealing with the female reproductive organs.

**Occupational Therapy** – Medically necessary services to help someone who is injured or disabled keep doing, or get better at, activities of daily living.

**Orthotic Devices** – Medically necessary items that support or correct a body part.

**Ostomy Supplies** – Medically necessary supplies that take waste out of the body.

**Out-of-Area Urgent Care** – Medically necessary services to prevent serious deterioration of the health of a member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the plan’s Service Area (Alameda County).

This includes maternity services necessary to prevent serious deterioration of the health of the member or the member’s fetus, based on the member’s reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the member returns to the plan’s service area.

**Outpatient Care** – Medically necessary services that you get from an Alliance provider in a medical office. Outpatient care can occur in a hospital.

**Primary Care Provider (PCP)** – A provider who is licensed to practice medicine and includes pediatricians, general practitioners, family practitioners, internists, obstetricians/gynecologists (OB-GYNs), nurse practitioners and physician assistants. All PCPs must be contracted with the Alliance or work for a clinic/office that is contracted with the Alliance. It is the job of the PCP to provide primary care to members and to refer, authorize, supervise, and coordinate all medical benefits to members in accordance with their contract.

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

**Phenylketonuria (PKU)** – A genetic problem in which a baby lacks or has very low levels of a certain enzyme. This enzyme is vital to a healthy nervous system and brain. A lack of or low levels of the enzyme leads to mental retardation and other problems with the central nervous system. The baby must be tested for PKU soon after birth so steps can be taken to avoid serious problems.
Physical Therapy – Medically necessary services that use exercises and hands-on care to help someone, who is sick or hurt, keep or improve function.

Plan – Unless the context indicates otherwise, “plan” refers to health care service plans and specialized health care service plans.

Plan Contract – A contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes group contracts.

Post-Stabilization Care – Medically necessary services that you get after the doctor who is treating you finds that your emergency medical condition is clinically stable.

Prior Authorization – Refers to a situation where both the Alliance and your health care provider agree that the service or care you are requesting is medically necessary and therefore covered. Also referred to as prior approval in this document.

Prosthetic Devices – Medically necessary items that replace all or part of an organ or limb.

Protected Health Information (PHI) – This is also known as PHI. PHI is health information such as your medical record or claims history. For example, your medical record is PHI because it includes your name and other information that reveals who your identity.

Provider – Any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

Provider Directory – A listing of all the contracted providers with the Alliance to provide covered services to members.

Privacy Breach – An unauthorized acquisition, access, use, or disclosure of Protected Health Information.

Psychiatric Emergency Medical Condition – A mental problem where there are acute symptoms severe enough to cause either a danger to yourself or others, or you are unable to provide or use food, shelter, or clothing due to the mental problem.

Reconstructive Surgery – Medically necessary reconstructive surgical services performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following (A) To improve function; (B) To create a normal appearance, to the extent possible.

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

Referral – The process used by an Alliance doctor to arrange for services by a specialist or other provider.

Respiratory Therapy – Medically necessary services that help with breathing.

Routine Care – Medically necessary services that are not urgent and help keep you
healthy, such as check-ups, Well Child visits, and services to keep you from getting sick. The goal of routine care is to prevent health problems.

**Senior(s) or Person(s) with a Disability** – A Medi-Cal beneficiary who falls under specific Aged and Disabled aid codes, as defined by the Department of Health Care Services.

**Seriously Debilitating Condition** – A disease or condition that causes major damage that cannot be reversed.

**Service Area** – A geographical area designated by the plan within which a plan shall provide health care services. Alameda County is the service area for Alliance Members.

**Services** – Health care services or items.

**Skilled Nursing Facility** – A place we contract with that provides 24-hour a day skilled nursing care. The facility must provide inpatient skilled nursing care, rehabilitation services, or other related health services and be licensed by the California Department of Public Health and meet Medi-Cal and Medicare standards.

**Specialist Doctor** – A contracted Alliance doctor who is specialty board certified or specialty board-eligible. A specialist provides services upon referral from a primary care provider. Specialists provide care within the range of their specialty area only.

**Speech Therapy** – Medically necessary services to help someone speak or swallow better.

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

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

**Terminated Provider** – A provider who used to be an Alliance provider, but whose contract to provide health care services ended or was not renewed by the Alliance (See “Alliance Provider” section).

**Urgent Care** or **Urgently needed services** – are those services necessary to prevent serious deterioration of the health of a member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the Alliance’s Service Area (Alameda County). "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the member or the member’s fetus, based on the member’s reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until she returns to the Alliance’s Service Area (Alameda County).

**Urological Supplies** – Medically necessary supplies that capture urine outside the body.
# Attachment A: Vision Benefits

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Vision Benefits

Getting Vision Services

Your eligibility for vision benefits starts on the same day as your medical benefits. Vision benefits are offered through the Alameda Alliance for Health’s (Alliance) vision network provider, March Vision. For help finding a vision provider in the network, call Alliance Member Services or visit March Vision Care website (see Contact List for phone number and website).

When you need vision services, call a network vision provider and let him/her know that you are an Alliance Medi-Cal member and are calling to schedule an exam. Your provider will confirm with the vision plan that you are eligible and will get approval to provide services to you. If you go to an out-of-network provider or get services without approval, you will need to pay in full for those services.

When you go to your exam, be sure to bring your Alliance Member ID Card and your Medi-Cal Benefits Identification Card (BIC). Please be sure to tell the office staff that you are a vision plan member through the Alliance.

Schedule of Vision Benefits

Vision Care for Members Under the Age of 21, Pregnant, or Living in a Skilled Nursing Facility

Eye Exams

The member is eligible for a complete vision exam, which includes a test of visual functions, and includes a prescription for eyewear to correct vision problems.

Exclusions/Limitations

Exams are limited to 1 in each 24 month period, which begins with the date of the last exam.

Frames

The vision plan’s providers will assist in the choice of frames, proper fitting and adjustment of the frames, and provide future adjustments to the frames to maintain comfort and correct fit.

Exclusions/Limitation

Frames are limited to 1 in each 24 month period, from the last date frames were obtained.

Lenses

The vision plan’s providers will order the proper lenses that are needed for your visual welfare. Your provider shall confirm the accuracy of the finished lenses.

Exclusions/Limitations

Lenses are limited to 1 set in each 24 month period, from the last date lenses were obtained. Lenses must meet the minimum prescription requirements for Medi-Cal. Contact lenses must be medically necessary per Medi-Cal standards.
Primary Vision Care

The member is eligible for services that are designed for the detection, medically necessary treatment, and management of ocular conditions and/or systemic conditions which produce ocular or vision problems. This includes monitoring to prevent future vision loss. Examples of conditions which may require management include:

- Ocular hypertension
- Glaucoma
- Cataract
- Pink eye
- Macular degeneration
- Sty

Members may also receive medically necessary treatment and management of urgent and follow-up services when the member has symptoms like:

- Pain in or around the eyes
- Swollen lids
- Red eyes
- Eye muscle dysfunction
- Temporary loss of vision

Vision Care for Members Over the Age of 21

Eye Exams

The member is eligible for a basic eye exam, which includes a test of the member’s eye health and visual acuity.

Exclusions/Limitations

Exams are limited to one (1) in each 24 month period, which begins with the date of the last exam. Frames, lenses, and contact lenses are not covered.

Primary Vision Care

The member is eligible for services that are designed for the detection, medically necessary treatment, and management of ocular conditions and/or systemic conditions which produce ocular or vision problems. This includes monitoring to prevent future vision loss. Examples of conditions which may require management include:

- Ocular hypertension
- Glaucoma
- Cataract
- Pink eye
- Macular degeneration
- Sty

Members may also receive medically necessary treatment and management of urgent and follow-up services when the member has symptoms like:

- Pain in or around the eyes
Swollen lids
- Red eyes
- Eye muscle dysfunction
- Temporary loss of vision

Vision Benefit Exclusions and Limitations

Any cost attached to the items listed below must be paid by the member.

1. Any services not provided as a Medi-Cal benefit.
2. Benefits that are not medically necessary or appropriate.
3. Benefits that are not obtained to comply with benefit limitations described in this “Vision Benefits” section.
4. Costs for services and/or materials above what the plan benefit allows.
5. Eye exams for any corrective eyewear, required as a condition of employment.
6. Laser vision care is not a covered benefit.
7. Lost, broken, or damaged eyewear may not be replaced unless the member or the member’s agent (like a parent or guardian) supplies your provider with a signed statement, which describes how the loss or damage occurred and the steps taken to recover the lost item. The letter must state that the loss, breakage, or damage was beyond the member’s control.
8. Medical or surgical treatment of the eyes is not covered under the Vision program but as a medical benefit through your Primary Care Provider (PCP) (see “Benefits” section).
9. Medication for eye problems is not covered under the Vision program but as a medical benefit through your PCP (see “Benefits” section).
10. Orthoptics or vision training and related extra testing.
11. Services or materials for which you are covered under a Worker’s Compensation Policy. Services or materials will be covered at the time of need. However, the member shall help to ensure that Alameda Alliance for Health (Alliance) is paid for these services.
12. Services or materials covered by any other group benefit for vision care. Services or materials will be covered at the time of need. However, the member shall help to ensure that the Alliance is paid for these services.
13. Services/materials not stated as covered plan benefits.
14. There are no out-of-network benefits, except for emergency services (see “Emergency Care, Urgent Care, and Routine Care” section). There is no benefit for professional services or materials related to elective cosmetic procedures.
15. Two pairs of glasses instead of bifocals, unless medically necessary and confirmed by the plan prior to the order.

Please call Alliance Member Services to get information about your benefits (see Contact List for phone number).

The Vision Plan and Payment

The vision plan pays its providers an agreed upon payment schedule. There are no incentives or financial bonuses paid to providers for services covered under this plan.

If a provider stops being a part of the vision plan network, the vision plan will owe...
your provider for services approved for you before the termination. In most cases, the vision plan will let your provider keep giving you plan benefits until the services are finished or until the vision plan arranges to provide such services through another network provider. In the event the vision plan fails to pay one of its providers, you will not owe your provider for any sums owed by the vision plan other than those charges for services or materials that you received that are not covered by the plan.

**Vision Plan Provisions for Out-of-Network**

There are no out-of-network benefits, except for emergency services (see “Emergency Care, Urgent Care, and Routine Care” section).

**Second Medical Opinions**

Members have the right to a second opinion. All requests for a second medical opinion should be directed to the vision plan.

**Filing a Complaint or Appeal about Vision Services**

Members who have a complaint involving vision care services may contact Alameda Alliance for Health (Alliance) (see “How to Solve Problems” section).

**Claims Appeals**

If a claim for benefits put forward by a member is denied by the vision plan in whole or in part, the vision plan will inform the member in writing of the reason(s) why it is denied within 15 days. Within 180 days after the notice is received, the member may request in writing a full review of the denial by the Alliance. The written request should include the member’s name, date of birth, and the Alliance ID number. The request should also state the reason the member believes that the denial of the claim was a mistake. The member may include any related documents that he/she feels should be reviewed.

The Alliance will review the claim and give the member the chance to review any documents about the claim. The member will have the chance to send and appear in person to present any statements, documents or written support for the claim. The Alliance’s review decision, which includes detailed reasons, will be given to the member in writing within 30 days after the request for review is received.

If the member chooses not to use this process with the Alliance or is not satisfied with the Alliance’s response, the member may request a State Fair Hearing or file a complaint with the California Department of Managed Health Care (DMHC). A member can also file an Independent Medical Review (IMR) if a claim for medically necessary services is denied (see “How to Solve Problems” section).