

Before the Board of Supervisors in and for the County of Monterey, State of California

Agreement No.: A-11489

Approve and authorize the Vice-Chair of the Board of Supervisors to sign an agreement with the Central California Alliance for Health to provide health plan benefits for eligible IHSS providers for the period July 1, 2011 to June 30, 2013, including the non-standard Termination provision in Exhibit A-I, Sections 4.0 through 5.2, and non-standard Mutual Indemnification provisions in Exhibit A-I, Sections 9.14 and 9.15, with the first twelve months funding of \$1,956,480 July 1, 2011 to June 30, 2012.....)

Upon motion of Supervisor Parker, seconded by Supervisor Salinas, and carried by those members present, the Board hereby;

Approved and authorized the Vice-Chair of the Board of Supervisors to sign an agreement with the Central California Alliance for Health to provide health plan benefits for eligible IHSS providers for the period July 1, 2011 to June 30, 2013, including the non-standard Termination provision in Exhibit A-I, Sections 4.0 through 5.2, and non-standard Mutual Indemnification provisions in Exhibit A-I, Sections 9.14 and 9.15, with the first twelve months funding of \$1,956,480 July 1, 2011 to June 30, 2012.

PASSED AND ADOPTED on this 21st day of June, 2011, by the following vote, to wit:

AYES: Supervisors Armenta, Calcagno, Salinas, Parker, and Potter

NOES: None

ABSENT: None

I, Gail T. Borkowski, Clerk of the Board of Supervisors of the County of Monterey, State of California, hereby certify that the foregoing is a true copy of an original order of said Board of Supervisors duly made and entered in the minutes thereof of Minute Book 75 for the meeting on June 21, 2011.

Dated: June 23, 2011

Gail T. Borkowski, Clerk of the Board of Supervisors County of Monterey, State of California

By Clair A. Inel Deputy

DUPLICATE

ORIGINAL

COUNTY OF MONTEREY AGREEMENT FOR PROFESSIONAL SERVICES
(MORE THAN \$100,000)*

This Professional Services Agreement ("Agreement") is made by and between the County of Monterey, a political subdivision of the State of California (hereinafter "County") and:
Central California Alliance for Health
(hereinafter "CONTRACTOR").

In consideration of the mutual covenants and conditions set forth in this Agreement, the parties agree as follows:

1. **SERVICES TO BE PROVIDED.** The County hereby engages CONTRACTOR to perform, and CONTRACTOR hereby agrees to perform, the services described in **Exhibit A** in conformity with the terms of this Agreement. The services are generally described as follows:
Provide health plan benefits for In-Home Supportive Services providers.

2. **PAYMENTS BY COUNTY.** County shall pay the CONTRACTOR in accordance with the payment provisions set forth in **Exhibit A**, subject to the limitations set forth in this Agreement. The total amount payable by County to CONTRACTOR under this Agreement shall not exceed the sum of \$ 1,956,480.00.

3. **TERM OF AGREEMENT.** The term of this Agreement is from July 1, 2011 to June 30, 2013, unless sooner terminated pursuant to the terms of this Agreement. This Agreement is of no force or effect until signed by both CONTRACTOR and County and with County signing last, and CONTRACTOR may not commence work before County signs this Agreement.

4. **ADDITIONAL PROVISIONS/EXHIBITS.** The following attached exhibits are incorporated herein by reference and constitute a part of this Agreement:

Exhibit A Scope of Services/Payment Provisions
See Page 9(a) List of Exhibits

5. **PERFORMANCE STANDARDS.**

5.01. CONTRACTOR warrants that CONTRACTOR and CONTRACTOR's agents, employees, and subcontractors performing services under this Agreement are specially trained, experienced, competent, and appropriately licensed to perform the work and deliver the services required under this Agreement and are not employees of the County, or immediate family of an employee of the County.

5.02. CONTRACTOR, its agents, employees, and subcontractors shall perform all work in a safe and skillful manner and in compliance with all applicable laws and regulations. All work performed under this Agreement that is required by law to be performed or supervised by licensed personnel shall be performed in accordance with such licensing requirements.

*Approved by County Board of Supervisors on _____.

5.03. CONTRACTOR shall furnish, at its own expense, all materials, equipment, and personnel necessary to carry out the terms of this Agreement, except as otherwise specified in this Agreement. CONTRACTOR shall not use County premises, property (including equipment, instruments, or supplies) or personnel for any purpose other than in the performance of its obligations under this Agreement.

6. PAYMENT CONDITIONS.

6.01. CONTRACTOR shall submit to the Contract Administrator an invoice on a form acceptable to County. If not otherwise specified, the CONTRACTOR may submit such invoice periodically or at the completion of services, but in any event, not later than 30 days after completion of services. The invoice shall set forth the amounts claimed by CONTRACTOR for the previous period, together with an itemized basis for the amounts claimed, and such other information pertinent to the invoice as the County may require. The Contract Administrator or his or her designee shall certify the invoice; either in the requested amount or in such other amount as the County approves in conformity with this Agreement, and shall promptly submit such invoice to the County Auditor-Controller for payment. The County Auditor-Controller shall pay the amount certified within 30 days of receiving the certified invoice.

6.02. CONTRACTOR shall not receive reimbursement for travel expenses unless set forth in this Agreement.

7. TERMINATION.

(See Exhibit A-I-A; Sections 4.0 through 5.2)

~~7.01. During the term of this Agreement, the County may terminate the Agreement for any reason by giving written notice of termination to the CONTRACTOR at least thirty (30) days prior to the effective date of termination. Such notice shall set forth the effective date of termination. In the event of such termination, the amount payable under this Agreement shall be reduced in proportion to the services provided prior to the date of termination.~~

~~7.02. The County may cancel and terminate this Agreement for good cause effective immediately upon written notice to CONTRACTOR. "Good cause" includes the failure of CONTRACTOR to perform the required services at the time and in the manner provided under this Agreement. If County terminates this Agreement for good cause, the County may be relieved of the payment of any consideration to CONTRACTOR, and the County may proceed with the work in any manner, which County deems proper. The cost to the County shall be deducted from any sum due the CONTRACTOR under this Agreement.~~

8. INDEMNIFICATION. ~~CONTRACTOR shall indemnify, defend, and hold harmless the County, its officers, agents, and employees, from and against any and all claims, liabilities, and losses whatsoever (including damages to property and injuries to or death of persons, court costs, and reasonable attorneys' fees) occurring or resulting to any and all persons, firms or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims, liabilities, and losses occurring or resulting to any person, firm, or corporation for damage, injury, or death arising out of or connected with the CONTRACTOR's performance of this Agreement, unless such claims, liabilities, or losses arise out of the sole negligence or willful misconduct of the County. "CONTRACTOR's performance" includes CONTRACTOR's action or inaction and the action or inaction of CONTRACTOR's officers, employees, agents and subcontractors.~~ (See Exhibit A-I-A; Sections 9.14 and 9.15)

9.0 INSURANCE.

9.01 Evidence of Coverage:

Prior to commencement of this Agreement, the Contractor shall provide a "Certificate of Insurance" certifying that coverage as required herein has been obtained. Individual endorsements executed by the insurance carrier shall accompany the certificate. In addition the Contractor upon request shall provide a certified copy of the policy or policies.

This verification of coverage shall be sent to the County's, Contracts/Purchasing Department, unless otherwise directed. The Contractor shall not receive a "Notice to Proceed" with the work under this Agreement until it has obtained all insurance required and such, insurance has been approved by the County. This approval of insurance shall neither relieve nor decrease the liability of the Contractor.

9.02 Qualifying Insurers:

All coverage's, except surety, shall be issued by companies which hold a current policy holder's alphabetic and financial size category rating of not less than A- VII, according to the current Best's Key Rating Guide or a company of equal financial stability that is approved by the County's Purchasing Manager.

9.03 Insurance Coverage Requirements:

Without limiting CONTRACTOR's duty to indemnify, CONTRACTOR shall maintain in effect throughout the term of this Agreement a policy or policies of insurance with the following minimum limits of liability:

Commercial general liability insurance, including but not limited to premises and operations, including coverage for Bodily Injury and Property Damage, Personal Injury, Contractual Liability, Broadform Property Damage, Independent Contractors, Products and Completed Operations, with a combined single limit for Bodily Injury and Property Damage of not less than \$1,000,000 per occurrence.

Exemption/Modification (Justification attached; subject to approval).

Business automobile liability insurance, covering all motor vehicles, including owned, leased, non-owned, and hired vehicles, used in providing services under this Agreement, with a combined single limit for Bodily Injury and Property Damage of not less than \$1,000,000 per occurrence.

Exemption/Modification (Justification attached; subject to approval).

Workers' Compensation Insurance, if CONTRACTOR employs others in the performance of this Agreement, in accordance with California Labor Code section 3700 and with Employer's Liability limits not less than \$1,000,000 each person, \$1,000,000 each accident and \$1,000,000 each disease.

Exemption/Modification (Justification attached; subject to approval).

Professional liability insurance, if required for the professional services being provided, (e.g., those persons authorized by a license to engage in a business or profession regulated by the California Business and Professions Code), in the amount of not less than \$1,000,000 per claim and \$2,000,000 in the aggregate, to cover liability for malpractice or errors or omissions made in the course of rendering professional services. If professional liability insurance is written on a "claims-made" basis rather than an occurrence basis, the CONTRACTOR shall, upon the expiration or earlier termination of this Agreement, obtain extended reporting coverage ("tail coverage") with the same liability limits. Any such tail coverage shall continue for at least three years following the expiration or earlier termination of this Agreement.

Exemption/Modification (Justification attached; subject to approval).

9.04 Other Insurance Requirements.

All insurance required by this Agreement shall be with a company acceptable to the County and issued and executed by an admitted insurer authorized to transact Insurance business in the State of California. Unless otherwise specified by this Agreement, all such insurance shall be written on an occurrence basis, or, if the policy is not written on an occurrence basis, such policy with the coverage required herein shall continue in effect for a period of three years following the date CONTRACTOR completes its performance of services under this Agreement.

Each liability policy shall provide that the County shall be given notice in writing at least thirty days in advance of any endorsed reduction in coverage or limit, cancellation, or intended non-renewal thereof. Each policy shall provide coverage for Contractor and additional insureds with respect to claims arising from each subcontractor, if any, performing work under this Agreement, or be accompanied by a certificate of insurance from each subcontractor showing each subcontractor has identical insurance coverage to the above requirements.

Commercial general liability and automobile liability policies shall provide an endorsement naming the County of Monterey, its officers, agents, and employees as Additional Insureds with respect to liability arising out of the CONTRACTOR'S work, including ongoing and completed operations, and shall further provide that such insurance is primary insurance to any insurance or self-insurance maintained by the County and that the insurance of the Additional Insureds shall not be called upon to contribute to a loss covered by the CONTRACTOR'S insurance. The required endorsement form for Commercial General Liability Additional Insured is ISO Form CG 20 10 11-85 or CG 20 10 10 01 in tandem with CG 20 37 10 01 (2000). The required endorsement form for Automobile Additional Insured endorsement is ISO Form CA 20 48 02 99.

Prior to the execution of this Agreement by the County, CONTRACTOR shall file certificates of insurance with the County's contract administrator and County's Contracts/Purchasing Division, showing that the CONTRACTOR has in effect the insurance required by this Agreement. The CONTRACTOR shall file a new or amended certificate of insurance within five calendar days after any change is made in any insurance policy, which would alter the information on the certificate then on file. Acceptance or approval of insurance shall in no way modify or change the indemnification clause in this Agreement, which shall continue in full force and effect.

CONTRACTOR shall at all times during the term of this Agreement maintain in force the insurance coverage required under this Agreement and shall send, without demand by County, annual certificates to County's Contract Administrator and County's Contracts/Purchasing Division. If the certificate is not received by the expiration date, County shall notify CONTRACTOR and CONTRACTOR shall have five calendar days to send in the certificate, evidencing no lapse in coverage during the interim. Failure by CONTRACTOR to maintain such insurance is a default of this Agreement, which entitles County, at its sole discretion, to terminate this Agreement immediately.

10. RECORDS AND CONFIDENTIALITY.

- 10.01 Confidentiality. CONTRACTOR and its officers, employees, agents, and subcontractors shall comply with any and all federal, state, and local laws, which provide for the confidentiality of records and other information. CONTRACTOR shall not disclose any confidential records or other confidential information received from the County or prepared in connection with the performance of this Agreement, unless County specifically permits CONTRACTOR to disclose such records or information. CONTRACTOR shall promptly transmit to County any and all requests for disclosure of any such confidential records or information. CONTRACTOR shall not use any confidential information gained by CONTRACTOR in the performance of this Agreement except for the sole purpose of carrying out CONTRACTOR's obligations under this Agreement.
- 10.02 County Records. When this Agreement expires or terminates, CONTRACTOR shall return to County any County records which CONTRACTOR used or received from County to perform services under this Agreement.
- 10.03 Maintenance of Records. CONTRACTOR shall prepare, maintain, and preserve all reports and records that may be required by federal, state, and County rules and regulations related to services performed under this Agreement. CONTRACTOR shall maintain such records for a period of at least three years after receipt of final payment under this Agreement. If any litigation, claim, negotiation, audit exception, or other action relating to this Agreement is pending at the end of the three year period, then CONTRACTOR shall retain said records until such action is resolved.
- 10.04 Access to and Audit of Records. The County shall have the right to examine, monitor and audit all records, documents, conditions, and activities of the CONTRACTOR and its subcontractors related to services provided under this Agreement. Pursuant to Government Code section 8546.7, if this Agreement involves the expenditure of public funds in excess of \$10,000, the parties to this Agreement may be subject, at the request of the County or as part of any audit of the County, to the examination and audit of the State Auditor pertaining to matters connected with the performance of this Agreement for a period of three years after final payment under the Agreement.
- 10.05 Royalties and Inventions. County shall have a royalty-free, exclusive and irrevocable license to reproduce, publish, and use, and authorize others to do so, all original computer programs, writings, sound recordings, pictorial reproductions, drawings, and other works of similar nature produced in the course of or under this Agreement. CONTRACTOR shall not publish any such material without the prior written approval of County.

11. **NON-DISCRIMINATION.** During the performance of this Agreement, CONTRACTOR, and its subcontractors, shall not unlawfully discriminate against any person because of race, religious creed, color, sex, national origin, ancestry, physical disability, mental disability, medical condition, marital status, age (over 40), or sexual orientation, either in CONTRACTOR's employment practices or in the furnishing of services to recipients. CONTRACTOR shall ensure that the evaluation and treatment of its employees and applicants for employment and all persons receiving and requesting services are free of such discrimination. CONTRACTOR and any subcontractor shall, in the performance of this Agreement, fully comply with all federal, state, and local laws and regulations, which prohibit discrimination. The provision of services primarily or exclusively to such target population as may be designated in this Agreement shall not be deemed to be prohibited discrimination.
12. **COMPLIANCE WITH TERMS OF STATE OR FEDERAL GRANT.** If this Agreement has been or will be funded with monies received by the County pursuant to a contract with the state or federal government in which the County is the grantee, CONTRACTOR will comply with all the provisions of said contract, to the extent applicable to CONTRACTOR as a subgrantee under said contract, and said provisions shall be deemed a part of this Agreement, as though fully set forth herein. Upon request, County will deliver a copy of said contract to CONTRACTOR, at no cost to CONTRACTOR.
13. **INDEPENDENT CONTRACTOR.** In the performance of work, duties, and obligations under this Agreement, CONTRACTOR is at all times acting and performing as an independent contractor and not as an employee of the County. No offer or obligation of permanent employment with the County or particular County department or agency is intended in any manner, and CONTRACTOR shall not become entitled by virtue of this Agreement to receive from County any form of employee benefits including but not limited to sick leave, vacation, retirement benefits, workers' compensation coverage, insurance or disability benefits. CONTRACTOR shall be solely liable for and obligated to pay directly all applicable taxes, including federal and state income taxes and social security, arising out of CONTRACTOR's performance of this Agreement. In connection therewith, CONTRACTOR shall defend, indemnify, and hold County harmless from any and all liability, which County may incur because of CONTRACTOR's failure to pay such taxes.
14. **NOTICES.** Notices required under this Agreement shall be delivered personally or by first-class, postage pre-paid mail to the County and CONTRACTOR'S contract administrators at the addresses listed below:

FOR COUNTY:	FOR CONTRACTOR:
Ethan Hurley, Management Analyst II	Alan McKay, Executive Director
Name and Title	Name and Title
713 La Guardia Street, Suite A Salinas, California 93905	1600 Green Hills Road, Suite 101 Scotts Valley, California 95066
Address	Address
(831)755-3425	(831) 430-5500
Phone	Phone

15. MISCELLANEOUS PROVISIONS.

- 15.01 Conflict of Interest. CONTRACTOR represents that it presently has no interest and agrees not to acquire any interest during the term of this Agreement, which would directly or indirectly conflict in any manner or to any degree with the full and complete performance of the professional services required to be rendered under this Agreement.
- 15.02 Amendment. This Agreement may be amended or modified only by an instrument in writing signed by the County and the CONTRACTOR.
- 15.03 Waiver. Any waiver of any terms and conditions of this Agreement must be in writing and signed by the County and the CONTRACTOR. A waiver of any of the terms and conditions of this Agreement shall not be construed as a waiver of any other terms or conditions in this Agreement.
- 15.04 Contractor. The term "CONTRACTOR" as used in this Agreement includes CONTRACTOR's officers, agents, and employees acting on CONTRACTOR's behalf in the performance of this Agreement.
- 15.05 Disputes. CONTRACTOR shall continue to perform under this Agreement during any dispute.
- 15.06 Assignment and Subcontracting. The CONTRACTOR shall not assign, sell, or otherwise transfer its interest or obligations in this Agreement without the prior written consent of the County. None of the services covered by this Agreement shall be subcontracted without the prior written approval of the County. Notwithstanding any such subcontract, CONTRACTOR shall continue to be liable for the performance of all requirements of this Agreement.
- 15.07 Successors and Assigns. This Agreement and the rights, privileges, duties, and obligations of the County and CONTRACTOR under this Agreement, to the extent assignable or delegable, shall be binding upon and inure to the benefit of the parties and their respective successors, permitted assigns, and heirs.
- 15.08 Compliance with Applicable Law. The parties shall comply with all applicable federal, state, and local laws and regulations in performing this Agreement.
- 15.09 Headings. The headings are for convenience only and shall not be used to interpret the terms of this Agreement.
- 15.10 Time is of the Essence. Time is of the essence in each and all of the provisions of this Agreement.
- 15.11 Governing Law. This Agreement shall be governed by and interpreted under the laws of the State of California.
- 15.12 Non-exclusive Agreement. This Agreement is non-exclusive and both County and CONTRACTOR expressly reserve the right to contract with other entities for the same or similar services.

- 15.13 Construction of Agreement. The County and CONTRACTOR agree that each party has fully participated in the review and revision of this Agreement and that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in the interpretation of this Agreement or any amendment to this Agreement.
- 15.14 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same Agreement.
- 15.15 Authority. Any individual executing this Agreement on behalf of the County or the CONTRACTOR represents and warrants hereby that he or she has the requisite authority to enter into this Agreement on behalf of such party and bind the party to the terms and conditions of this Agreement.
- 15.16 Integration. This Agreement, including the exhibits, represent the entire Agreement between the County and the CONTRACTOR with respect to the subject matter of this Agreement and shall supersede all prior negotiations, representations, or agreements, either written or oral, between the County and the CONTRACTOR as of the effective date of this Agreement, which is the date that the County signs the Agreement.
- 15.17 Interpretation of Conflicting Provisions. In the event of any conflict or inconsistency between the provisions of this Agreement and the Provisions of any exhibit or other attachment to this Agreement, the provisions of this Agreement shall prevail and control.

This space left blank intentionally

IN WITNESS WHEREOF, County and CONTRACTOR have executed this Agreement as of the day and year written below.

COUNTY OF MONTEREY

CONTRACTOR

By: _____
Purchasing Officer

Date: _____

By: _____
Department Head (if applicable)

Date: _____

By: x Dave Potter
Board of Supervisors (if applicable)

Date: 6/23/11

Approved as to Form¹

By: Walter Blankenship
County Counsel

Date: 5/18/2011

Approved as to Fiscal Provisions²

By: [Signature]
Auditor/Controller

Date: 5-18-11

Approved as to Liability Provisions³

By: _____
Risk Management

Date: _____

Central California Alliance for Health
Contractor's Business Name*

By: [Signature]
(Signature of Chair, President, or Vice-President)*

Jane Parker, Chair
Name and Title

Date: 5-12-11

By: [Signature]
(Signature of Secretary, Asst. Secretary, CFO, Treasurer or Asst. Treasurer)*

Julie Edgcomb, Vice-Chair
Name and Title

Date: 5-11-11

County Board of Supervisors' Agreement Number: _____

*INSTRUCTIONS: If CONTRACTOR is a corporation, including limited liability and non-profit corporations, the full legal name of the corporation shall be set forth above together with the signatures of two specified officers. If CONTRACTOR is a partnership, the name of the partnership shall be set forth above together with the signature of a partner who has authority to execute this Agreement on behalf of the partnership. If CONTRACTOR is contracting in an individual capacity, the individual shall set forth the name of the business, if any, and shall personally sign the Agreement.

¹Approval by County Counsel is required

²Approval by Auditor-Controller is required

³Approval by Risk Management is necessary only if changes are made in paragraph 8 or 9

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

LIST OF EXHIBITS

Exhibit A	Scope of Service/Payment Provisions
Exhibit A-I	Group Agreement
Attachment A-I-A	Terms and Conditions
Attachment A-I-B	Premium Schedule
Attachment A-I-C	Contract Holder's Obligations Under COBRA and CAL-COBRA
Attachment A-I-D	Contract Holder's Obligations Under HIPAA
Attachment A-I-E	Alliance Care IHSS Health Plan Member Handbook
Exhibit B	DSES Additional Provisions
Exhibit C	Program Budget FY 2011-12
Exhibit D	Elder Abuse Reporting Certification
Exhibit E	Business Associate Agreement
Exhibit F	Sample Invoice

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

SCOPE OF SERVICES/PAYMENT PROVISIONS

July 1, 2011 to June 30, 2013

I. CONTACT INFORMATION

Contractor Name: Central California Alliance for Health

Contact Person: Alan McKay
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
Executive Director
Phone: (831) 430-5500

County Contract Manager: Ethan Hurley, MA II
713 La Guardia Street, Suite A
Salinas, CA 93905
Phone: (831) 755-3425
Fax: (831) 783-7021
hurleye@co.monterey.ca.us

1. Exhibit A-I of the Contract between Monterey County and the Central California Alliance for Health is for the provision of health plan benefits for In-Home Supportive Services providers.
2. Notwithstanding Section 15.17 of County of Monterey Agreement for Professional Services (more than \$100,000), in the event of any conflict or inconsistency between the provisions of Exhibit A-I 'Group Agreement' and other attachment or exhibit, including, but not limited to the County of Monterey Agreement for Professional Services (more than \$100,000), the provisions of Exhibit A-I shall prevail and control.

II. SERVICES/PROGRAMS TO BE ADMINISTERED BY CONTRACTOR

CONTRACTOR shall provide the services outlined in Exhibits A through A-I, attached.

III. PAYMENT PROVISIONS

COUNTY shall reimburse CONTRACTOR a total amount not to exceed \$1,956,480 for the period July 1, 2011 to June 30, 2012.

GROUP AGREEMENT

Between

**Santa Cruz – Monterey – Merced
Managed Medical Care Commission**

And

Monterey County In-Home Supportive Services Public Authority

This Group Agreement (Agreement), including the Evidence of Coverage (EOC) document(s) and attachments listed below and incorporated herein by reference, and any amendments to any of them, constitutes the contract between the Santa Cruz – Monterey – Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (PLAN) and the Monterey County In-Home Supportive Services Public Authority (Contract Holder). This Agreement is effective this 1st day of July, 2011.

Product Name: Alliance Care IHSS

- Attachment A-I-A - Terms and Conditions
- Attachment A-I-B – Premium Schedule
- Attachment A-I-C - COBRA and Cal-COBRA
- Attachment A-I-D – Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Attachment A-I-E – Evidence of Coverage (EOC)

Pursuant to this Agreement, PLAN will provide covered services and supplies to Members in accord with the terms, conditions, rights, and privileges as set forth in this Agreement and the EOC.

The PLAN is subject to the requirements of state and federal laws governing health care plans, including the Knox-Keene Act of 1975 and its amendments. Any provisions required to be in this Agreement by either the applicable Statute or Regulations will bind PLAN whether or not expressly stated in this Agreement.

If any provision of this Agreement is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this Agreement shall continue in full force and effect.

This Agreement and its attachments have the same meaning given those terms in the EOC.

Group Agreement Effective Date: July 1, 2011

Monterey County
Board of Supervisors

x *Dave Potter*
 Signature of Vice-Chair
 Dave Potter
 x 6/23/11
 Date

Santa Cruz – Monterey – Merced
Managed Medical Care
Commission

Julie Edgcomb
 Signature of Vice-Chair
 Julie Edgcomb
5-7-11
 Date

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TERMS AND CONDITIONS

Recital:

- A. Commission has entered into or will enter into and shall maintain a contract with the Monterey County In-Home Supportive Services Public Authority pursuant to which individuals who subscribe and are enrolled under Alliance Care IHSS will receive, through the Commission, health services hereinafter defined as "Covered Services."

NOW, THEREFORE, it is agreed that the above Recital is true and correct and as follows:

SECTION 1 DEFINITIONS

As used in this agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

- 1.1 **"Beneficiary"** – shall mean a person designated by an insuring organization as eligible to receive insurance benefits.
- 1.2 **"Cal-COBRA"** – shall mean the California State law concerning an employee's access to continued health insurance coverage under certain circumstances when coverage would otherwise terminate. (Health & Safety Code §1366.20 et seq.; Insurance Code §10128.50 et seq.)
- 1.3 **"Commission"** shall mean the Santa Cruz – Monterey – Merced Managed Medical Care Commission.
- 1.4 **"Contract Holder"** – shall mean the Monterey County In-Home Supportive Services Public Authority (MCPA), the employer of record for Monterey County In-Home Supportive Services (IHSS) Workers. MCPA is authorized to execute the Group Agreement with the PLAN on behalf of eligible IHSS providers.
- 1.5 **"Consolidated Omnibus Budget Reconciliation Act (COBRA)"** – shall mean the federal law concerning an employee's access to continued health insurance coverage under certain circumstances when coverage would otherwise terminate.
- 1.6 **"Copayment"** - shall mean the portion of health care costs for covered services for which the Member has financial responsibility under the Alliance Care IHSS Program.
- 1.7 **"Covered Services"** shall mean those health care services and supplies which a Member is entitled to receive under the Alliance Care IHSS Program and which are set forth in the Alliance Care IHSS Program Evidence of Coverage (Attachment A-I-E, attached hereto and hereby incorporated by reference).

- 1.8 **“Evidence of Coverage”** - shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the Alliance Care IHSS Program (Attachment A-I-E, hereto and incorporated herein by reference)
- 1.9 **“Group Agreement”** – shall mean the application and addenda signed by both the health plan and the enrolling entity, which constitutes the agreement regarding the benefits, exclusions and other conditions between the health plan and the enrolling unit.
- 1.10 **“Health Insurance Portability and Accountability Act of 1996 (HIPAA)”** – shall mean the federal law that, among other things, provides renewability of health care coverage to certain employees who no longer qualify for group health insurance through their employer and have an opportunity to purchase coverage from another insurer.
- 1.11 **“Hospital”** - shall mean a licensed general acute care hospital.
- 1.12 **“Member”** - shall mean an individual who is enrolled in good standing in Alliance Care IHSS.
- 1.13 **“Participating Provider”** - shall mean a Provider who has entered into an Agreement with the PLAN to provide Covered Services to Members. The terms “Participating Provider” and “Contracting Provider” may be used interchangeably.
- 1.14 **“PLAN”** - shall mean the Central California Alliance for Health, which is governed by the Santa Cruz – Monterey – Merced Managed Medical Care Commission.
- 1.15 **“Provider”** - shall mean any health professional or institution to render services to Members under the Alliance Care IHSS Program.

SECTION II ENROLLMENT

- 2.0 Members may enroll with the PLAN during the Open Enrollment or within thirty (30) days from the date the individual becomes eligible for coverage. Member eligibility conditions are described in the EOC. Eligible individuals who do not enroll during the Open Enrollment or within thirty (30) days of becoming eligible for coverage may only be enrolled during a subsequent Open Enrollment or upon satisfying special enrollment provisions stated in the EOC. Open Enrollment shall be in compliance with applicable law.
- 2.1 The Contract Holder or designee shall be responsible for forwarding completed enrollment information obtained from eligible members to the PLAN.

- 2.2 The Contract Holder or designee shall also be responsible for forwarding enrollment information on Alliance Care IHSS Members eligible through COBRA or Cal-COBRA.
- 2.3 The Contract Holder will make every effort to ensure that eligibility information is transmitted electronically to the PLAN not later than the 10th of each month in order to be effective on the first of the following month.
- 2.4 The Contract Holder shall not change the eligibility requirements used to determine membership in the group during the term of the Group Agreement, unless agreed to in writing by the PLAN.

SECTION III PREMIUMS

- 3.0 Premiums for the Covered Benefits under this Group Agreement are set forth in Attachment A-I-B, attached hereto, which is fully incorporated herein by reference.
- 3.1 Premium Change
 - 3.1.1 PLAN may change the Premium with at least sixty-one (61) days written notice to Contract Holder as follows:
 - 3.1.2 upon parties written agreement to amend Attachment A-I-B of this Group Agreement.;
 - 3.1.3 upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to Members.

Payment of the applicable Premium on and after that date does not constitute acceptance of those changes, unless acceptance is in writing, by the Contract Holder, individually and on behalf of all Members enrolled under this Group Agreement.

- 3.2 Premium Payment

Premiums are payable to the PLAN at the PLAN's corporate office by electronic file transfer via ACH, wire transfer or check via mail addressed to: Chief Financial Officer, Central California Alliance for Health, 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066.

3.3 Premium due date and grace period

The Premium due date will be the first of the month for which coverage is provided. A five (5) day grace period will allow the Group Agreement to be in force beyond the premium due date. The Contract Holder remains liable for the payment of the Premium for the time coverage was in effect during the grace period and Members will remain liable for Copayments.

3.3.1 Premiums shall be paid in full for Members whose coverage is effective on the Premium due date or whose coverage terminates on the last day of the Premium period.

3.4 Retroactive Additions or Deletions

Retroactive additions or deletions are not allowed under this agreement.

3.4.1 The Contract Holder shall be responsible for any claims paid by PLAN and Member to the extent PLAN relied on the Contract Holder's submitted enrollment to confirm coverage where coverage was not valid.

3.5 Non-payment of Premium

3.5.1 If the Premiums are not paid by the Premium due date, PLAN will require the Contract Holder to pay interest on the overdue amount at 1 1/2% for each month overdue, not to exceed 10% of the total amount due, commencing on the thirty first (31st) day after the Premium due date.

**SECTION IV
TERM AND TERMINATION**

4.0 Effective Date

This agreement shall become effective on July 1, 2011.

4.1 Term

The term of this Agreement is July 1, 2011 through June 30, 2013.

4.2 Termination on Notice

This Agreement may be terminated by either party as follows:

4.2.1 If terminated by Contract Holder, termination will require at least sixty (60) days advance written notice of intent to terminate. Contract Holder may terminate this Agreement at any time and for any reason upon sixty (60) days written notice, transmitted by Contract Holder to Commission by Certified U.S. Mail, UPS, FedEx, or other traceable mail service, proper postage prepaid and properly addressed to the office of the Commission as provided below:

Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

4.2.2 If termination is initiated by Commission, the termination will require at least sixty (60) days advance written notice of intent to terminate. Commission may terminate this Agreement at any time and for any reason upon sixty (60) days written notice transmitted by Commission to Contract Holder by Certified U.S. Mail, FedEx, or other traceable mail service, proper postage prepaid and properly addressed to the office of the Contract Holder as provided below.

Monterey County In-Home Supportive Services Public Authority
1000 South Main Street
Salinas, CA 93901

4.3 Termination for nonpayment

If Contract Holder fails to make any past-due payment within thirty (30) days after PLAN's initial written notice to Contract Holder of amount payable, PLAN may terminate this Agreement immediately by giving written notice to Contract Holder and Contract Holder is liable for all unpaid Premiums through the termination date.

4.4 Termination due to non-acceptance of amendments

All amendments shall be accepted by Contract Holder in writing. Contract Holder shall give PLAN written notice of non-acceptance at least thirty (30) days before the effective date of the amendment and remits all amount payable related to this Agreement, including Premiums, for the period prior to the amendment effective date. The Contract Holder shall notify the Commission in writing of termination within sixty (60) days of notice of said Amendment.

4.5 Termination due to non-renewal of Agreement

The Contract Holder may terminate this Group Agreement as of its renewal date, by providing PLAN written notice of non-renewal not less than sixty (60) days prior to the renewal date.

4.6 Termination due to Premium change

The Contract Holder may terminate this Group Agreement as of the date any Premium change would become effective, by providing PLAN with written notice of termination not less than sixty (60) days prior to such effective date.

4.7 Termination for discontinuance of a product or all products within a market

4.7.1 PLAN may terminate a particular product offered as permitted by the Health Insurance Portability and Accountability Act (HIPAA) if;

4.7.1.1 PLAN is unable to enter into or maintain service contracts with sufficient numbers of providers, (hospitals and physicians) to assure adequate Member access to needed Covered Services, the PLAN may terminate this Agreement upon sixty (60) days written notice to the Contract Holder; or

4.7.1.2 if, the qualification of PLAN under the Federal Social Security Act is terminated or ceases or if the PLAN's contract with the State of California is terminated or ceases, Plan shall give Contract Holder immediate written notice of the foregoing termination(s) and this Agreement shall terminate in accordance with the terms of Section 4.7.2 of this Agreement.

4.7.2 In the event there are (1) substantial changes effected in the PLAN's Medi-Cal contract with the State of California, or (2) substantial changes effected in Alliance Care IHSS, or (3) changes in the Federal Medicaid or SCHIP Programs, or (4) changes in the Federal Medicare Program, or (5) substantial changes under other public or private health care insurance programs or policies any of which changes will have a material detrimental financial effect on the operations of the Contract Holder or PLAN, Contract Holder or PLAN may terminate this Group Agreement upon providing the other party with sixty (60) days prior written notice. In any case where such notice is provided, both parties shall negotiate in good faith during such sixty (60) day period in an effort to develop a revised Group Agreement, which, to the extent reasonably practicable, under the circumstances, will adequately protect the interests of both parties in light of the governmental program or private insurance policy changes which constituted the basis for the exercise of this termination provision.

4.8 Termination for fraud or intentionally furnishing incorrect or incomplete information

Either party may terminate this Agreement upon fifteen (15) days prior written notice to the other party, if either party commits fraud or intentionally furnishes incorrect or incomplete material information to the other party.

4.9 Termination for cause

PLAN may terminate this Group Agreement if the Contract Holder:

- 4.9.1 Admits in writing its inability to pay debts as they come due;
- 4.9.2.1 consents to the appointment of a trustee or receiver, or if a trustee or receiver is appointed for the Contract Holder or for all or a substantial part of its properties or business;
- 4.9.2.2 becomes insolvent;
- 4.9.2.3 files a petition in bankruptcy;
- 4.9.2.4 files a petition seeking any reorganization, arrangement, composition or similar relief under any federal or state law regarding insolvency or relief for debtors;
- 4.9.2.5 has begun any voluntary or involuntary liquidation process; or
- 4.9.2.6 changes eligibility requirements, employer (employer of record) contribution or other material information stated in the Contract Holder's application or Service Agreement, without PLAN's prior written approval.

Termination will be effective immediately following the date PLAN gives the Contract Holder written notice of termination—Or upon the occurrence of any event set forth in paragraph 4.9.2 above

4.10 Effect of Termination

As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect whatsoever, and each of the parties hereto shall be relieved and discharged herefrom, except that the PLAN shall remain liable for all Benefits rendered to Members up to the date of termination and for any Benefits rendered hereunder after such date until such time as appropriate transfer (or other medically acceptable disposition) of Members receiving inpatient services as of the date of termination is achieved.

SECTION V MEMBER NOTIFICATION OF TERMINATION

- 5.0 It is the responsibility of the Contract Holder or designee to notify the Members of the termination of the Group Agreement in compliance with all applicable laws. However, PLAN reserves the right to notify Members' of termination of the Group Agreement. When PLAN delivers a notice of cancellation or termination to Contract Holder, Contract Holder or designee will promptly notify each member of that fact.

- 5.1. In accordance with the EOC, the Contract Holder or designee shall also provide written notice to Members of Member's continuation and conversion rights upon termination of coverage.
- 5.2 Termination shall not relieve the Contract Holder or PLAN from any obligation incurred prior to the date of termination of this Group Agreement.

**SECTION VI
OBLIGATIONS UNDER COBRA AND CAL-COBRA**

- 6.0 The Contract Holder is subject to the requirements of state and federal law governing continuation of health care coverage for Members. The federal law is the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). The California state law is the California Continuation Benefits Replacement Act ("Cal-COBRA"). Any provisions required to be in this Group Agreement by either the applicable Code or Regulation governing COBRA or Cal-COBRA will bind the Contract Holder whether or not expressly stated in the Group Agreement or any Attachments. Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to COBRA and/or Cal-COBRA continuation coverage.

**SECTION VII
THE HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

- 7.0 The Contract Holder is subject to the requirements of state and federal law governing the portability of health care coverage for Members ("creditable coverage"). The federal law is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any provisions required to be in this Group Agreement by either the applicable Statute or Regulation governing HIPAA will bind the Contract Holder whether or not expressly stated in the Group Agreement or any Attachments.

Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to HIPAA continuation coverage.

**SECTION VIII
INDEPENDENT CONTRACTOR RELATIONSHIPS**

- 8.0 Between Participating Providers and PLAN.
The relationship between PLAN and Participating Providers is a contractual relationship among independent contractors. Participating Providers are not agents or employees of PLAN nor is PLAN an agent or employee of any Participating Provider.

Participating Providers maintain the provider-patient relationship with Members and are solely responsible to their Member patients for any health services rendered to their Member patients. PLAN and Contract Holder make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Physician, Hospital or other Participating Provider. In no event will PLAN or Contract Holder be liable for the negligence, wrongful acts, or omissions in a Participating Provider's delivery of services regardless of whether such services are or would be covered under this Group Agreement, nor will PLAN or Contract Holder be liable for services or facilities which for any reason beyond its control are unavailable to the Member.

A Contracting Provider's participation may be terminated at any time without advance notice to the Contract Holder or Members.

8.1 Between the Contract Holder and PLAN.

The relationship between PLAN and the Contract Holder is limited to a contractual relationship between independent contractors. Neither party is an agent nor employee of the other in performing its obligations pursuant to this Group Agreement.

SECTION IX ADMINISTRATION OF THE AGREEMENT

PLAN may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Group Agreement.

9.0 Entire Agreement

This Group Agreement, including the Group Application, Evidence of Coverage, Schedule of Benefits, any amendments, endorsements, insets or attachments, and as provided for under applicable state or federal law, constitutes the entire Group Agreement between the Contract Holder and PLAN, and on the Effective Date of Coverage, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations and discussions between the parties, whether written or oral, previously issued by PLAN for Covered Benefits provided by this Group Agreement.

9.1 Amendments

9.1.1 This Group Agreement may be amended at any time upon written agreement of PLAN and Contract Holder. Upon 60 days prior written notice to Contract Holder, Plan may extend the term of this Agreement and/or make other changes by amending this Agreement. Extending the term of this Agreement will be contingent upon Contract Holder's acceptance of all amendments, including Premiums and benefits, as described under "Acceptance of Amendments" below.

9.1.2 The terms of the Group Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended (Health and Safety Section 1340), and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind PLAN and the Participating Providers as appropriate, whether or not provided herein. If the Director of the Department of Managed Health Care or his/her successor requires further amendments to this Group Agreement, PLAN shall notify Contract Holder in writing of such amendments. The Contract Holder will have thirty (30) days from the date of PLAN's notice to accept or reject the proposed amendments by written notice of acceptance or rejection to PLAN. Amendments for this purpose shall include, but not be limited to, material changes to PLAN's Utilization Management, Quality Assessment and Improvement and Complaint and Grievance programs and procedures and to the health care services covered by this Group Agreement. Without limiting the foregoing, the validity and enforceability of this Agreement, as well as the rights and duties of the parties herein shall be governed by California law.

9.2 Forms

PLAN shall supply the Contract Holder or designee with a reasonable supply of its forms and descriptive literature. The Contract Holder or designee shall distribute PLAN's forms and descriptive literature to any eligible individual who becomes eligible for coverage. The Contract Holder shall, within sixty-two (62) days of receipt from an eligible individual, forward all applicable forms and other required information to PLAN.

9.3 Records

The PLAN maintains records and information to allow the administration of a Member's coverage. The Contract Holder or designee shall provide the PLAN information to allow for the administration of a Member's benefits. This includes information on enrollment, continued eligibility, and termination of eligibility. The PLAN shall not be obligated to provide coverage prior to receipt of information needed to administer the benefits or confirm eligibility in a form satisfactory to the PLAN.

The Contract Holder or designee shall make payroll and other records directly related to Member's coverage under this Group Agreement available to PLAN for inspection, at PLAN's expense, at the Contract Holder's or designee's office, during regular business hours, upon reasonable advance request from PLAN. This provision shall survive the termination of this Group Agreement as necessary to resolve outstanding financial or administrative issues pursuant to this Group Agreement. PLAN's performance of any obligation that depends on information to be furnished by Contract Holder or designee or Member will not arise prior to receipt of that information in the form requested by PLAN. Nor will PLAN be liable for any obligation due to information incorrectly supplied by Contract Holder or designee or Member. All records of Contract Holder that have a

bearing on coverage shall be open for inspection by PLAN at any reasonable time.

The PLAN shall make all relevant business records, which apply to the administration of this contract, available to Contract Holder for inspection, at Contract Holder's expense, at the PLAN's or designee's office, during regular business hours, upon reasonable advance request from Contract Holder. This provision shall survive the termination of this Group Agreement as necessary to resolve outstanding financial or administrative issues pursuant to this Group Agreement.

9.4 Clerical Errors

Incorrect information furnished to PLAN may be corrected, provided that PLAN has not acted to its prejudice in reliance thereon. In accordance with Section 3.4 there will be no retroactive enrollment additions or deletions.

9.5 Claim Determinations

PLAN has authority to review all claims for Covered Benefits under this Group Agreement. In exercising such responsibility, PLAN shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this Group Agreement. PLAN shall be deemed to have properly exercised such authority unless PLAN abuses its discretion by acting arbitrarily and capriciously.

9.6. Fraudulent or Material Misstatements

If any relevant fact as to a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to remain in force

9.7 Assignability

No rights or benefits under this Group Agreement are assignable by the either party to any other party unless approved by PLAN or Contract Holder.

9.8 Waiver

The failure to implement, or insist upon compliance with, any provision of this Group Agreement or the terms of the EOC incorporated hereunder, by either party, at any given time or times, shall not constitute a waiver of that party's right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of Premiums or benefits. This applies whether or not the circumstances are the same.

9.9 Notices

Any notice required or permitted under this Group Agreement shall be in writing and shall be deemed to have been given on the date when delivered in person, or, if delivered by first-class United States mail, FedEx, or other traceable mail service, on the date mailed, proper postage prepaid, and properly addressed to the offices of the PLAN or Contract Holder.

9.10 Third Parties

This Group Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

9.11 Non-Discrimination

9.11.1 No person shall, on the grounds of race, color, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, or political affiliation be denied any benefits or subject to discrimination under this agreement.

9.11.2 Both parties shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this agreement. Either party's equal employment policies shall be made available to the other party upon request.

9.11.3 Both parties shall comply with ' 504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this contract.

9.12 Inability to Arrange Services

In the event that due to circumstances not within the reasonable control of PLAN, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of PLAN's Participating Providers or entities with whom PLAN has arranged for services under this Group Agreement, or similar causes, the rendition of medical or Hospital benefits or other services provided under this Group Agreement is delayed or rendered impractical, PLAN shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by PLAN on the date such event occurs. PLAN is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.13 Workers' Compensation

The Contract Holder is responsible to notify plan immediately upon becoming aware of any worker's compensation claims submitted by an eligible individual. PLAN shall be reimbursed, by the appropriate entity, for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

9.14 Indemnification by Contractor

PLAN shall indemnify, defend, and hold harmless the County, its officers, agents, and employees, from and against any and all claims, liabilities, and losses whatsoever (including damages to property and injuries to or death of persons, court costs, and reasonable attorneys' fees) occurring or resulting to any and all persons, firms or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims, liabilities, and losses occurring or resulting to any person, firm, or corporation for damage, injury, or death arising out of or connected with the PLAN's performance of this Agreement, unless such claims, liabilities, or losses arise out of the sole negligence or willful misconduct of the County. "PLAN's performance" includes PLAN's action or inaction and the action or inaction of PLAN's officers, employees, agents and subcontractors.

9.15 Indemnification by County

COUNTY (CONTRACT HOLDER) shall indemnify, defend, and hold harmless the PLAN, its officers, agents, and employees, from and against any and all claims, liabilities, and losses whatsoever (including damages to property and injuries to or death of persons, court costs, and reasonable attorneys' fees) occurring or resulting to any and all persons, firms or corporations or supplying work, services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims, liabilities, and losses occurring or resulting to any person, firm, or corporation for damage, injury, or death arising out of or connected with the COUNTY'S performance of this Agreement, unless such claims, liabilities, or losses arise out of the sole negligence or willful misconduct of the PLAN. "COUNTY'S Performance includes COUNTY'S action or inaction and the action or inaction of COUNTY'S officers, employees, agents and subcontractors.

PREMIUM SCHEDULE
(July 1, 2011 – June 30, 2012)

Premium\$500/per member/per month

**CONTRACT HOLDER'S OBLIGATIONS UNDER
COBRA AND CAL-COBRA**

- A. All parties will comply with applicable federal law, regulations and requirements regarding continuation of benefits.
- B. All parties will comply with applicable state law, regulations and requirements regarding continuation benefits.
- C. Contract Holder or designee agrees to forward to PLAN in a timely manner copies of any and all notices provided to Members regarding COBRA or Cal-COBRA continuation coverage.
- D. Contract Holder will administer or contract for the administration of coverage under COBRA and Cal-COBRA.

ATTACHMENT A-I-D

**CONTRACT HOLDER'S OBLIGATIONS UNDER THE
HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996 (HIPAA)**

- A. Contract Holder is obligated under both federal and state law with regard to the renewability of health care coverage for Members under certain circumstances where coverage would otherwise terminate ("creditable coverage"). The federal law is the Health Insurance Portability and Accountability Act (HIPAA). The guaranteed renewability provision of HIPAA entitles a Member, who is disenrolled or terminated from employment an opportunity to purchase a health insurance plan that provides the same scope of benefits that the Member received through the Contract Holder program.

- B. Contract Holder or designee also agrees to forward to PLAN in a timely manner copies of any and all notices provided to Members regarding HIPAA.

Alliance Care
IHSS Health Plan

Member Handbook
Combined Evidence of Coverage
and Disclosure Form

Central California Alliance for Health

339 Pájaro Street, Suite E
Salinas, CA 93901

1-800-700-3874

Benefit Year July 1, 2010–June 30, 2011

Dear Alliance Care IHSS Member:

Welcome to Central California Alliance for Health. You are important to us. We want you to be happy with our staff, your doctors and other health care providers that you see as an Alliance Member. We want to help you feel comfortable talking to them about your health care needs.

It is important to us that you understand how Central California Alliance for Health (the Alliance) works, so you can get the health care you need. This Evidence of Coverage and Disclosure Form has important information about your benefits. It explains how to get care and how to get answers to questions you might have as an Alliance Care IHSS Health Plan Member. Please take time to read it now. You can also find helpful information on our Web site at www.ccah-alliance.org.

This Member Handbook and Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. You must consult the health plan contract to determine the exact terms and conditions of coverage. You may request a copy of the Plan contract by calling the Alliance.

If you have any questions, please call us at 1-800-700-3874. It is our job to make sure you understand your health plan and how to use it. You can reach one of our Member Services Representatives Monday–Friday, between 8:00 a.m. and 5:00 p.m. Our representatives speak both English and Spanish. They use a telephone language line to assist Members who speak other languages. You can reach us at one of the locations listed below.

Again, welcome to Central California Alliance for Health. We look forward to working with you to help you get the care you need.

Main Office

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
831-430-5500
1-800-700-3874 toll free

Salinas Office

339 Pájaro St., Suite E
Salinas, CA 93901
831-755-6000
1-800-700-3874 toll free

TTY for the hearing-impaired: 1-877-548-0857 (toll-free).

You will also find information on our Web site at www.ccah-alliance.org.

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Introduction

Using This Handbook

This booklet, called the Member Handbook and Evidence of Coverage and Disclosure Form, or EOC, contains detailed information about Alliance Care IHSS Health Plan benefits, how to obtain benefits, and the rights and responsibilities of Alliance Care IHSS Health Plan Members. Please read this booklet carefully and keep it on hand for future reference. If you have special health care needs, please carefully read the sections that apply to you.

Throughout this booklet, *you*, *your*, and *Member* refer to the individual enrolled in the Alliance Care IHSS Health Plan. *We*, *us*, and *our*, refer to Central California Alliance for Health (the Alliance). *Provider*, *Plan provider* or *Participating Provider* refer to a licensed physician, hospital, medical group, pharmacy or other health care provider who is responsible for providing medical services to you.

About Your Health Plan

Welcome to Central California Alliance for Health. You are important to us. We want you to be happy with our staff, your doctors and other health care providers that you see as an Alliance Member. We want to help you feel comfortable talking to them about your health care needs.

If you have any questions about this booklet, your benefits or how to get care, please call us at 1-800-700-3874 (TTY for the hearing-impaired at 1-877-548-0857). It is our job to help you understand your health plan and how to use it. You can reach one of our Member Services Representatives Monday through Friday between 8:00 a.m. and 5:00 p.m. You can also visit our Web site, www.ccah-alliance.org.

The service area we cover for the Alliance Care IHSS Health Plan is Monterey and Santa Cruz counties.

Multilingual Services

If you or your representative prefer to speak in any language other than English, call us at 1-800-700-3874 (TTY for the hearing impaired at 1-877-548-0857) to speak with an Alliance Member Services Representative. Our Member Services staff can help you find a health care provider who speaks your language or who has a regular interpreter available. You do not have to use family members or friends as interpreters. If you cannot locate a health care provider where someone speaks your language, we can arrange for interpreter services through a telephone language line that your doctor can call. Telephone interpretation can be provided immediately, with no advance notice needed.

If you or your doctor feels there are special circumstances for which you need a face-to-face interpreter for a medical appointment, you or your doctor can call us to ask for authorization. If we approve the request, we will provide an interpreter to be in the office with you for the appointment. Face-to-face interpreter services and American Sign

Language interpretation must be scheduled in advance. Please call us or have your doctor call us at 1-800-700-3874 at least 3-4 days before your appointment. There is no charge for either telephone or face-to-face interpreter services.

This EOC booklet, as well as other informational material, has been translated into Spanish. To request translated materials, please call Alliance Member Services at 1-800-700-3874 (TTY for the hearing impaired at 1-877-548-0857).

Member Identification Card

All Members of the Alliance are sent a Member Identification Card. This card contains important information regarding your medical benefits. It has the name, address and phone number of your Primary Care Provider (PCP) on it. If you have not received or if you have lost your Member Identification Card, please call us at 1-800-700-3874 (TTY for the hearing impaired at 1-877-548-0857), and we will send you a new card. Please show your Alliance Member Identification Card when you receive medical care or pick up prescriptions at the pharmacy.

Only the Alliance Member is authorized to obtain medical services using the Member Identification Card. If a card is used by or for an individual other than the Member, that individual will be billed for the services he or she receives. Additionally, if you let someone else use your Member Identification Card, we may not be able to keep you in our health care plan.

Definitions

Active Labor

When there is inadequate time to safely transfer the Member to another hospital before delivery or when transferring the Member may pose a threat to the health and safety of the mother or the unborn child.

Acute Condition

A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that lasts a relatively short time.

Appropriately Qualified Health Professional

A Primary Care Provider or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease, condition or conditions.

Authorization

The process through which a provider requests prior written approval from the Alliance for the provision of certain non-emergency, non-self-referred services to Alliance Members in order for the services to be covered by the Alliance.

Authorization Request

An Alliance form completed and submitted by a provider to request review and approval for a service, procedure or medication before services or treatment is rendered. An Authorization Request is also required when a Member's PCP is requesting review and approval for the referral of a Member to a non-contracted or Out of Service Area provider.

Authorized Referral

The request, once approved by the Alliance, for referral of an eligible Alliance Member to an Out of Service Area provider or a Non-Contracted Provider.

Benefits (Covered Services)

Those services, supplies and drugs that a Member is entitled to receive under the terms of this Agreement. Except for emergency services, a service is not a benefit, even if described as a covered service or benefit in this booklet, if it is not medically necessary or if it is not provided by a Central California Alliance for Health provider and with prior authorization, as required.

Benefit Year

The twelve-month (12-month) period beginning July 1 of each year at 12:01 a.m.

Complaint

A complaint is also called a grievance or an appeal. Examples of a complaint can be when:

- You can't get a service, treatment or medicine you need
- Your plan denies a service and says it is not medically necessary
- You have to wait too long for an appointment
- You received poor care or were treated rudely
- You get a bill that you believe you should not have to pay.

Copayment

A fee for a particular covered benefit, which the Plan provider may collect directly from a Member at the time the service is rendered.

Emergency Care

An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member's health in serious jeopardy, or
- Causing serious impairment to the Member's bodily functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Exclusion

Any medical, surgical, hospital or other treatment for which the program offers no coverage.

Experimental or Investigational Service

Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that are not recognized as being in accordance with generally accepted professional medical

standards, or if safety and effectiveness have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

Evidence of Coverage and Disclosure Form (EOC)

This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Formulary

A list of generic and brand-name prescription drugs approved for coverage and available without prior authorization from Central California Alliance for Health. The presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Group

Group refers to The In-Home Supportive Services Public Authority of Monterey County.

Hospital

A health care facility licensed by the State of California and accredited by the Joint Commission on Accreditation of Health Care Organizations as (a) an acute care hospital; (b) a psychiatric hospital; or (c) a hospital operated primarily for the treatment of alcoholism and/or substance abuse. A facility that is primarily a rest home, nursing home or home for the aged, or a distinct skilled nursing facility portion of a hospital is not included.

Inpatient

An individual admitted to a hospital as a registered bed patient who receives covered services under the direction of a physician.

In Service Area Provider

A provider whose place of service is located inside the Alliance's Service Area, which is Santa Cruz and Monterey counties.

Local Out of Service Area Provider

A specialist physician, hospital or allied health provider based in an area adjacent to the Service Area, with whom the Alliance has contracted based on an existing referral pattern and claims payment to the provider, and the need for access to the provider's specialty type.

Medically Necessary

Those health care services or products that are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply and level of service that consider the potential risks, benefits and alternatives.

Member

A person who joins Central California Alliance for Health to receive health care. In this booklet, "you" also means a Member.

Member Identification Card

The identification card provided to Members by Central California Alliance for Health. It includes the Member number, Primary Care Provider information, and important phone numbers. It is also referred to as the "Alliance ID card" in this EOC.

Mental Health Services

Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury or any other condition.

Non-Formulary Drug

A drug that is not listed in Central California Alliance for Health's Formulary and requires an authorization from Central California Alliance for Health to be covered.

Non-Participating Provider

A health care provider who is not contracted with Central California Alliance for Health to provide services to Members.

Orthotic Device

A support or brace designed for the support of a weak or ineffective joint or muscle or to improve the function of movable body parts.

Outpatient

Services under the direction of a physician that do not incur overnight charges at the facility where the services are provided.

Out-of-Area Services

Emergency care or urgent care provided outside of Central California Alliance for Health's service area that could not be delayed until the Member returned to the service area.

Out of Service Area Provider

A provider whose place of service is located outside of the Alliance's Service Area and who is not designated by the Alliance as a Local Out of Service Area Provider.

Plan

Central California Alliance for Health.

Plan Physician

A doctor of medicine or osteopathy rendering a service covered under this EOC, licensed in the state or jurisdiction of practice and practicing within the scope of his or her license, who has entered into a written agreement with Central California Alliance for Health to provide covered services to Members in accordance with the terms of this agreement.

Participating Provider or Plan Provider

A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency that, at the time care is rendered to a Member, has a contract in effect with Central California Alliance for Health to provide covered services to its Members.

Primary Care Provider (PCP)

A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist, who has contracted with Central California Alliance for Health or works at a clinic contracted with Central California Alliance for Health to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of benefits to Members in accordance with the Evidence of Coverage booklet. Nurse practitioners and physician assistants associated with a contracted Primary Care Provider are also available to Members seeking primary care.

Prosthetic Device

An artificial device used to replace a body part.

Provider

A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency.

Provider Directory

The directory of In Service Area and Local Out of Service Area Providers contracted with Central California Alliance for Health to provide services to its Members.

Serious Chronic Condition

A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without a full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Service Area

The service area for the Alliance Care IHSS Health Plan is Santa Cruz and Monterey counties.

Skilled Nursing Facility

A facility licensed by the California State Department of Health Services as a "Skilled Nursing Facility" to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

Specialist Physician

A Plan physician who provides services to a Member, usually upon referral by a primary care provider, within the range of his or her designated specialty area of practice and who is specialty board-certified or specialty board-eligible in such specialty. Some specialty services do not require a referral, e.g., obstetrical services.

Terminal Illness

An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

Urgent Care

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

Member Rights and Responsibilities

As a Central California Alliance for Health Member, you have the right to:

- Be treated with respect and dignity.
- Choose your Primary Care Provider from our Provider Directory.
- Get appointments within a reasonable amount of time.
- Participate in candid discussions and decisions about your health care needs, including appropriate or medically necessary treatment options for your condition(s), regardless of cost and regardless of whether the treatment is covered by this health plan.
- Have a confidential relationship with your provider.
- Have your records kept confidential. This means we will not share your health care information without your written approval or unless it is permitted by law.
- Voice your concerns about Central California Alliance for Health, or about health care services you received, to the Alliance.
- Receive information about the Alliance, our services and our providers.
- Make recommendations about your rights and responsibilities.
- See your medical records.
- Get services from providers outside of our network in an emergency.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- File a complaint if your language needs are not met.

Your responsibilities are to:

- Carefully read all of the information we send you after you are enrolled. This will help you understand how to use your health plan benefits. If you have trouble reading or understanding anything we send you, please call our Member Services Department at 1-800-700-3874 and we will be happy to go over it with you.
- Maintain your good health and prevent illness by making positive health choices and seeking care when needed.
- Give your providers and the Alliance correct information.
- Understand your health problems and participate in developing treatment goals, as much as possible, with your provider.
- Follow the treatment plans your doctor develops for you. If you choose not to follow your doctor's plan, you must consider and accept the risks.
- Always present your Member Identification Card when getting services.
- Use the emergency room only in an emergency or as directed by your provider.
- Make and keep medical appointments and inform your provider at least 24 hours in advance when you must cancel an appointment.
- Ask questions about any medical condition and make certain you understand your provider's explanations and instructions.
- Help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status and other health coverage.
- Notify the Alliance as soon as possible if a provider bills you inappropriately or if you have a complaint.
- Treat all Alliance personnel and health care providers with respect and courtesy.
- Pay any premiums or copayments on time.

Accessing Care

Physical Access

Central California Alliance for Health has made every effort to ensure that our offices and the offices and facilities of Alliance providers are accessible to the disabled. If you are not able to locate an accessible provider, please call us toll free at **1-800-700-3874** and we will help you find a different provider.

Access for the Hearing-Impaired

The hearing impaired may contact us through our TTY number at 1-877-548-0857, Monday through Friday, from 8:00 a.m. to 5:00 p.m. between 5:00 p.m. and 8:00 a.m. and on weekends, call the California Relay Service TTY at 711 to get the help you need.

Access for the Vision-Impaired

This Evidence of Coverage (EOC) and other important Plan materials will be made available in large print and enlarged computer disk for the vision impaired. For alternative formats or for direct help in reading the EOC and other materials, please call us at **1-800-700-3874**.

The Americans with Disabilities Act of 1990

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

Disability Access Grievances

If you believe the Plan or its providers have failed to respond to your disability access needs, you may file a complaint with the Alliance by calling **1-800-700-3874**.

Services for Members with Disabilities

To learn more about any of the services below, call the Health Education Line at **1-800-700-3874 ext. 5580**.

Members with Disabilities

Our Medical Social Workers help Members get durable medical equipment and services. They can help the many different agencies that you may get services from work together.

Using Your Health Plan

Facilities and Provider Locations

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

The Alliance has contracted with providers throughout Santa Cruz and Monterey counties. For the locations of the Plan's Primary Care Provider's, specialists, hospitals, allied health providers, pharmacies and other providers, please look in your Provider Directory. If you need a Provider Directory, call Member Services at 1-800-700-3874 or go to our website, www.ccah-alliance.org.

Choosing a Primary Care Provider

Inside the Alliance Care IHSS Provider Directory, you will find a list of doctors and clinics that are contracted with the Alliance. You will need to choose one to be your Primary Care Provider, or PCP for short. If you do not choose a PCP at the time you enroll in the Alliance Care IHSS Health Plan, the Alliance will assign you to one. Your PCP can be a physician in family practice, general practice, internal medicine or obstetrics and gynecology.

Your PCP will coordinate your health care. He or she will take care of most of your health care needs, including preventive care, such as checkups and immunizations. Your PCP will refer you to specialty physicians when you need them. Your PCP will also make arrangements for hospital services if you need to go into the hospital, unless it is an emergency. If you do need care in the hospital, you will usually go to the hospital where your doctor normally sees patients.

The Provider Directory lists the names, addresses and phone numbers of the doctors and clinics to help you find one in your area. It also lists the office hours, languages spoken by the doctor or office staff and the hospitals where the doctor sees patients.

Scheduling Appointments

To see your doctor for preventive care or when you are sick, please call the doctor's office for an appointment. When you call, please tell them you are an Alliance Care IHSS Health Plan Member. The name and phone number of your PCP are on the front of your Alliance ID card.

You can reach your PCP 24 hours a day, 7 days a week. If your doctor is not available, he or she will have an answering service or the answering machine will have instructions about how to get care after hours.

It may take longer to get an appointment for some types of care than others. Here are some general guidelines for scheduling appointments. Please keep in mind that these are

general guidelines, and the amount of time it will take you to get an appointment will depend on the office or clinic and the type of care you need:

- For routine office visits, call your doctor's office at least 2 days in advance
- For preventive health care services, such as yearly physicals and immunizations, call your doctor's office at least 3–6 weeks in advance.

If you have an urgent health care need, please call your doctor right away and ask for the next available appointment. Please explain your symptoms when you call, so the provider can determine how urgent it is.

When you have an appointment, please be on time. Call your doctor's office as soon as possible if:

- You are going to be late for your appointment
- You need to cancel or reschedule your appointment.

This will help the doctor stay on schedule and reduce the amount of time other patients have to wait.

If you miss three (3) or more appointments without calling to cancel them in advance, your doctor can decide not to see you as a patient any more. In that situation, we would contact you so that you could choose another PCP. You will remain eligible for benefits during that time, and we will let you know how you can get care until you have a new PCP. If you were unhappy with your doctor's decision to stop seeing you, you would have the right to file a complaint as this booklet describes on page 51.

Initial Health Exam

All new Members are encouraged to see their Primary Care Provider for an initial health examination, or new patient exam. New Members should get a new patient exam in the first four (4) months of becoming a Member. The first meeting with your new doctor is important. It's a time to get to know each other and review your health status. Your doctor will help you understand your medical needs and advise you about staying healthy. Call your doctor's office for an appointment today.

Changing Your Primary Care Provider

Most of the time, it is best to keep the same doctor, so he or she can really get to know your medical needs and history. You may decide, however, that you want to change doctors. If you want to change doctors, please call Member Services at **1-800-700-3874**.

You can change your doctor for any reason. When you call, we will let you know which doctors and clinics are available for you to choose from. When you change doctors, the change will be effective the first day of the following month. For example, if you call us to change doctors on September 14, you can start seeing your new doctor on October 1.

When you change doctors, we will send you a new Alliance ID card in the mail. Your new card will have the name and phone number of your new doctor on it. It will also have the date that the change is effective. You must continue to see your old PCP until the change to your new PCP becomes effective.

We may ask you to change doctors if:

- Your doctor retires or leaves the area
- Your doctor no longer accepts the Alliance health plan
- You are unable to get along with your doctor
- You make appointments but do not show up for them or call to cancel often
- You behave in a rude or abusive way or disrupt the doctor's office.

We will tell you in writing or by phone if we need to ask you to change doctors.

It is important to know that when you enroll in the Alliance, services are provided through our network of providers. We cannot guarantee that any one doctor, clinic, hospital or other provider will always be part of our network.

Continuity of Care for New Members

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

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with you and the Non-Participating Provider and consistent with good professional practice. Completion of covered services may not exceed twelve (12) months from the time you enroll with the Alliance.
- Pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time you enroll with the Alliance.
- Performance of surgery or another procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the Non-Participating Provider to occur within one hundred eighty (180) days of the time you enroll with the Alliance.
- A child age 0-36 months whose parent wishes to keep the child's existing provider for up to twelve (12) months, whether in a course of active treatment or not.

Please contact us at **1-800-700-3874** to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this Plan.

We will request that the Non-Participating Provider agree to the same contractual terms and conditions that are imposed upon Participating Providers providing similar services, including payment terms. If the Non-Participating Provider does not accept the terms and conditions, the Alliance is not required to continue that provider's services.

The Alliance is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Alliance Care IHSS Health Plan coverage. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement.

We will notify you of our decision in writing. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, you can use the Alliance's Grievance Process, which we describe on page 51.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219, or at the TDD number for the hearing impaired, 1-877-688-9891 or online at www.hmohelp.ca.gov.

Continuity of Care for Termination of Provider

If your Primary Care Provider or other health care provider stops working with the Alliance, we will let you know by mail sixty (60) days before the contract termination date, or as soon as possible after we are notified by the provider.

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

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with you and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time of the provider termination.
- Pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time of the provider termination.
- Performance of a surgery or other procedure that the Plan has authorized as part of a documented course of treatment and that has been recommended and documented by the Non-Participating Provider to occur within one hundred eighty (180) days of the provider termination.
- A child age 0–36 months whose parent wishes to keep the child's existing provider for up to twelve (12) months, whether in a course of active treatment or not.

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

Please contact us at **1-800-700-3874** to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this Plan.

We will notify you of our decision in writing. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, you can use the Alliance's Grievance, which we describe on page 51.

If you have further questions about continuity of care, we encourage you to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, **1-888-HMO-2219**, or at the TDD number for the hearing impaired, 1-877-688-9891 or online at www.hmohelp.ca.gov.

Prior Authorization for Services

Your Primary Care Provider will coordinate your health care needs and, when necessary, will arrange specialty care and services for you. In some cases, the Alliance must authorize the services before you receive them. Your PCP will obtain the necessary referrals and authorizations for you. Prior authorization means that both your doctor and the Alliance agree that the services you will get are medically necessary. If you need something that requires prior authorization, the health care provider will send us an Authorization Request. Your provider knows which services require prior authorization. They include:

- Non-emergency hospital care
- Some types of durable medical equipment, such as wheelchairs
- Some outpatient diagnostic tests, such as MRIs and PET scans
- Non-formulary medications (medications that are not on the list of drugs that we normally cover, brand name medications, etc)
- Non-emergency services received outside of the Plan's service area
- Non-emergency services received from a Non-Contracted Provider

When we get an Authorization Request, it is reviewed by our medical staff (doctors, nurses and pharmacists). They review each case to make sure you are getting the best and most appropriate treatment for your medical condition.

We approve most authorization requests, but sometimes a request is deferred. This means that we need to ask the provider for more information or ask that the doctor try another treatment first. We will let your doctor know if a request for prior authorization was approved or if we need more information. There may be times when we modify or change what your provider has asked for, and then approve it as modified. Please check

with your doctor if you want to know if a request for prior authorization has been approved or not. We respond to all completed prior authorization requests within five (5) business days from the time we get them. If a treatment is urgent, we respond within one (1) business day.

After a request for prior authorization has been approved, the provider can do the procedure or give you the service, equipment or medication, depending on what was requested and what the Alliance approved. If you receive services before you receive the required authorization, you will be responsible for paying the cost of the treatment. If the Alliance denies a request for prior authorization, the Alliance will send you a letter explaining the reason for the denial and how you can file a complaint if you do not agree with the denial.

This is a summary of the Alliance's prior authorization policy. To obtain a copy of our policy, please call Member Services at 1-800-700-3874.

Referrals to Specialty Physicians

Your Primary Care Provider may decide to refer you to a specialist to receive care for a specific medical condition. For most covered services not directly provided by your primary care provider, including specialty, non-emergency hospital, laboratory and x-ray services, you must be referred in advance by your PCP. Tell your doctor as much as you can about your medical condition and your history, so that together, you can decide what is best for you. In consultation with you, your PCP will choose a Participating Provider in Santa Cruz or Monterey County from whom you may receive services. For a list of specialists, please see your Provider Directory or call Member Services at 1-800-700-3874, or go to our website, www.ccah-alliance.org.

If your PCP feels that you need to see a specialist, he or she will fax or mail the specialist a Referral Consultation Form. This lets the specialist know that your PCP has authorized the visit. Your PCP's office may call to schedule the appointment with the specialist, or they may ask you to schedule the appointment. If there is a certain specialist you have been seeing or would like to see, please let your PCP know when you ask for the referral.

Your PCP will refer you to an In Service Area contracted provider or a Local Out of Service Area Provider. If there are no In Service Area contracted providers or Local Out of Service Area Providers available, your PCP may request authorization from the Alliance to refer you to a Non-Contracted Provider within Santa Cruz or Monterey County or to an Out of Service Area provider.

There are some services that you can receive without needing a referral from your PCP. These include family planning services. Women can also see an OB/GYN once a year for an annual pap smear and breast exam. Pregnant Members can see an OB/GYN for pregnancy care without a referral. However, even though you do not need a referral to access these services, you must still get them from an In Service Area contracted provider.

Standing Referrals

If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing referral to a specialist to receive continuing

specialized care. If you receive a standing referral to a specialist, you will not need to get authorization every time you see that specialist. You can get a standing referral to a specialist for up to one (1) year.

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

To get a standing referral, call your Primary Care Provider. You may contact the Alliance to request a list of participating providers who have demonstrated expertise in treating the condition or disease for which you have been given a standing referral. If you have any difficulty getting a standing referral, call Member Services at **1-800-700-3874** (TTY for the hearing-impaired, 1-877-548-0857). If you feel that your needs have not been met after calling us, please see the Alliance's Grievance Process on page 51.

If you see a specialist or receive specialty services before you receive the required referral, you will be responsible to pay for the cost of the treatment.

This is a summary of the Alliance's specialist referral policy. To obtain a copy of our policy, please call Member Services at **1-800-700-3874**.

Getting a Second Opinion

Sometimes you may have questions about your illness or your recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended surgical procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function or substantial impairment.
- Your provider's advice is not clear or it is complex and confusing.
- Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results.
- The treatment plan in progress has not improved your medical condition within an appropriate period of time.
- You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

Talk to your PCP and ask for a referral if you want a second opinion. You may also contact the Plan to request a second opinion. If your medical condition poses an imminent and serious threat to your health, including but not limited to the potential loss of life, limb, or other major bodily function, or if a delay would be detrimental to your ability to regain maximum function; your request for a second opinion will be processed within seventy-two (72) hours.

You will be referred to a qualified contracted provider in Santa Cruz or Monterey County for a second opinion. If there is no qualified In Service Area Contracted Provider within the Alliance's service area, your PCP may refer you to a Local Out of Service Area Provider. If there is no Local Out of Service Area Provider available, your PCP may

request authorization from the Alliance to refer you to a non-contracted In Service Area or to an Out of Service Area Provider. You will be responsible for paying all applicable copayments for the second opinion.

If your request to obtain a second opinion is denied, you will receive the denial in writing. You may appeal the denial. For information on how to appeal a denial, please see the Alliance's Grievance Process on page 51.

This is a summary of the Alliance's policy regarding second opinions. To obtain a copy of our policy, please contact us at 1-800-700-3874.

Getting Pharmacy Benefits

What Your Doctor Can Prescribe

Your PCP has a list of drugs that are approved by the Alliance. This list is called a formulary. A group of doctors and pharmacists reviews and updates the formulary list four times a year to make sure that the drugs on it are safe and useful. If your doctor thinks that you need to take a drug that isn't on this list, or if your doctor feels you need a drug that isn't usually prescribed for the specific medical condition you have, your doctor can send us a prior authorization request. The prior authorization request lets us know why you need that drug. We will need to approve the request before covering that drug for you. When we get a request for prior authorization for a drug, we will reply to your doctor by the next business day. If we approve the request, then you can get the drug. If we deny the request, you have the right to file a complaint about our decision through the Plan's Grievance Process. For more information on how to file a complaint, please see page 51.

When there is more than one drug that is appropriate for the treatment of a medical condition, we may require your doctor to try the preferred drug first, before requesting authorization to prescribe any of the others. This is known as "step therapy."

The Plan will not limit or exclude coverage for a drug you are taking if the drug had been previously approved for coverage by the Plan and your doctor continues to prescribe the drug, as long as the drug is appropriately prescribed and is considered safe and effective for treating your medical condition. This does not mean that your doctor cannot choose to prescribe a different drug or that a generic equivalent of the drug cannot be substituted.

If you would like to know if a particular drug is on the formulary list, or if you would like a copy of the Alliance formulary, you can call us at 1-800-700-3874 or go to our website, www.ccah-alliance.org. However, even if a drug is on the list, your doctor will be the one to decide which drug is best for you. Please talk to your doctor if you have questions about a medication or feel you need a specific drug.

Where to Get Your Prescriptions Filled

In our Provider Directory, you will find a list of pharmacies near you where you can get your prescriptions filled. You must go to one of those pharmacies for your prescription drugs. Some of the pharmacies in our network have locations throughout California. If you are traveling outside of Santa Cruz or Monterey Counties and need medication, you can call Member Services at 1-800-700-3874 to find out if there is a contracted pharmacy nearby.

If you need to get a prescription filled at an out-of-area pharmacy because of an emergency or for treatment of an urgent medical condition, please ask the pharmacy to call us at **1-800-700-3874**. We will explain to the pharmacy how they can bill us for the medication. If you are asked to pay or have paid for medication related to emergency or urgent care services out of area, please call Member Services at **1-800-700-3874**.

Prescription Drugs

Your costs:

- \$5 copayment per prescription for a 30-day supply of medication when generic is dispensed.
- \$15 copayment per prescription for a 30-day supply of medication when brand name is dispensed. When available, generic medications are required to be dispensed unless there is a medically necessary reason for brand name medications to be dispensed.

Injectable contraceptives and internally implanted contraceptive devices are covered under the medical benefit.

When you get your prescription filled, you will be given no more than a 30-day supply of medicine. You may get refills if your doctor wrote your prescription with refills. Usually, the pharmacy will call your doctor to check if you can get refills.

Maintenance Drugs

You must pay a \$5 copayment per prescription for a 90-day supply for generic medication or \$15 copayment per prescription for a 90-day supply for brand-name medication. The pharmacy is required to fill prescriptions with generic medications, when they are available, unless there is a medically necessary reason for brand-name medications.

Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions, such as heart disease, diabetes or high blood pressure.

Getting Urgent Care

Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness, an injury, prolonged pain, or a complication of an existing condition, including pregnancy, for which treatment cannot be delayed. The Alliance covers urgent care services any time you are outside our service area or on nights and weekends when you are inside our service area. To be covered, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor's appointment. On your first visit, talk to your Primary Care Provider about what he or she wants you to do when the office is closed and you feel urgent care may be needed.

To get urgent care on nights and weekends when you are **inside** the Alliance's service area, call your Primary Care Provider. Your PCP's phone number is on the front of your Alliance ID card. You can call your PCP any time of the day or night.

No prior authorization is needed to access urgent care when you are **outside** of the Alliance's service area. If you are not sure whether your condition is urgent, please call your PCP if you are able. Please tell the provider you go to that you are an Alliance Care IHSS Health Plan Member and show your Alliance ID card. If you get urgent care treatment while outside of the Alliance service area and you get a bill, please call Member Services at 1-800-700-3874.

Getting Emergency Care

An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms severe enough that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member's health in serious jeopardy, or
- Causing serious impairment to the Member's bodily functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Examples include:

- Broken bones
- Chest pain
- Severe burns
- Fainting
- Drug overdose
- Paralysis
- Severe cuts that won't stop bleeding
- Psychiatric emergency conditions.

If you have a medical emergency, go to the nearest emergency room or call 911. You are covered for emergency services both in and out of the Alliance's service area with no prior authorization needed. If you are seen in the emergency room, be sure to follow up with your PCP afterward and let him or her know what happened and what treatment you received.

If you get emergency care from a provider (a hospital or an emergency physicians group) that is not contracted with the Plan and you receive a bill from the provider, please call Member Services. We will contact the provider on your behalf.

What to Do If You Are Not Sure If You Have an Emergency

If you are not sure whether you have an emergency or require urgent care, use your best judgment. If you think you need emergency care, go to the nearest emergency room or call 911. If you think you need urgent care, instead, and are within the Plan's service area, call your PCP. If you are outside of the Plan's service area, call your PCP if you are able to. If you are not able to contact your PCP, you can go to an emergency or urgent care facility without prior authorization.

Follow-up Care

After receiving any emergency or urgent care services, you will need to call your Primary Care Provider for follow-up care.

Non-Covered Services

The Alliance does not cover medical services that are received in an emergency or urgent care setting for conditions that are neither emergencies nor urgent if you reasonably should have known that an emergency or urgent care situation did not exist. You will be responsible for all charges related to these services.

Copayments

You will be required to pay a small amount of money for some services. This is called a copayment (copay, for short). No copayment will be charged for routine examinations and preventive care. The maximum amount of money you will have to pay out in copayments in one benefit year is \$3,000.

Make sure to ask for and keep a receipt each time you make a copayment at a provider's office or pharmacy. When you have reached your copayment maximum, send copies of your receipts and a letter of explanation to:

Accountant
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

When we confirm that you have met your copayment maximum, we will send you a new ID card. The new card will show that you no longer have to make copayments for the rest of that benefit year.

Member Liabilities

Generally, the only amount a Member pays for covered services is the required copayment.

You may have to pay for services you receive that are NOT covered services, such as:

- Non-emergency services received in the emergency room
- Non-emergency or non-urgent services received outside of the Alliance's service area if you did not get authorization from the Alliance before receiving such services
- Specialty services you received if you did not get a required referral or authorization from the Alliance before receiving such services (see pages 17 and 18, Prior Authorization and Specialty Referrals)
- Services from a non-participating provider, unless the services are for situations allowed in this Evidence of Coverage booklet (for example, emergency services, urgent services outside of the Plan's service area or specialty services approved by the Alliance), or
- Services you received that are greater than the limits described in this Evidence of Coverage booklet unless authorized by the Alliance.

The Alliance is responsible to pay for all covered services including emergency services. You are not responsible to pay a provider for any amount owed by the health plan for any covered service.

If the Alliance does not pay a Non-Participating Provider for covered services, you do not have to pay the Non-Participating Provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage booklet. The Non-Participating Provider must bill the Alliance, not you, for any covered service. But reMember, services from a Non-Participating Provider are not “covered services” unless they fall within the situations allowed by this Evidence of Coverage booklet.

If you receive a bill for a covered service from any provider, whether participating or non-participating, contact the Alliance Member Services Department at 1-800-700-3874.

Services to Keep You Well

The Alliance covers many services to help you stay well. These are called preventive health care services. Preventive care keeps you healthy. It can help catch and treat problems before they become serious. Preventive care includes:

- Regular check-ups
- Immunizations (shots)
- Pap smears (for women)
- Mammograms (for women)
- Prenatal care (for pregnant women)
- Prostate cancer screening (for men).

Look at the charts on the next two pages. They list the preventive check-ups that adults should have. They also show how often you should have these visits. There is a chart for when to have shots to keep you from getting sick. If you have questions about preventive health care, check with your doctor. Our Health Educators at 1-800-700-3874 ext. 5580 can also help. They speak English and Spanish.

Adult Health Screening Guidelines

For All Patients			
Test	Ages 18–39	Ages 40–64	Ages > 65
Health Exam This may include height and weight, hearing and eye exams	For all Alliance Members: Schedule your first checkup within 120 days of becoming an Alliance Member		
Tuberculosis (TB) Test	Initial entry into health plan for all Members. Repeat testing at regular intervals for people at risk.		
Blood Pressure	Every 1–2 years	Every 1–2 years	Every year
Cholesterol	Men, starting at age 35	Women, starting at age 45	As needed, per your doctor
Stool Test	As determined by your doctor	Every year age 50 and over	Every year age 50 and over
Patients with Diabetes	Every year: foot exam, urine and retinal exam, HgA1c, lipids	Every year: foot exam, urine and retinal exam, HgA1c, lipids	Every year: foot exam, urine and retinal exam, HgA1c, lipids
For Female Patients Only			
Test	Ages 18–39	Ages 40–64	Ages > 65
Breast Exam (to check for lumps)	Every 1–2 years	Every year	Every year
Mammography	Women with a family history of breast cancer should start at age 35	Ages 40–50 every 1–2 years Ages 50–64 every year	Ages 65–70 every year
Pap Smears At the start of sexual activity	Every 1–3 years	Every 1–3 years	Every 1–3 years
Pelvic Exam	Every 1–3 years	Every 1–3 years	Every 1–3 years
Chlamydia Exam For sexually active women	Every year for ages 16–26		
For Male Patients Only			
Test	Ages 18–39	Ages 40–64	Ages > 65
Prostate cancer screening		Age over 40–49 if high risk, age over 50 as needed, per your doctor	As needed, per your doctor

Adult Immunization Guidelines

To keep yourself healthy, it is important to get regular health exams and the right screening tests and immunizations. Check with your doctor even if you are not sick or having problems.

Below is a list of immunizations that should be done for your age group. Some vaccinations are given only to people who are "high risk." Chronic illness or other life circumstances make some people more likely to get the disease. Ask your doctor which shots you should have and when. Your doctor may want to do some shots more often, depending on your risk.

Adult Immunization Guidelines			
Vaccinations/Shots	Ages 19-49	Ages 50-64	Ages >65
Tetanus/Diphtheria (Td)	Every 10 years	Every 10 years	Every 10 years
Influenza	Every year if chronic disease or other risk	Every year for ages 50 and over, depending on vaccine supply	Every year for ages 65 and over
Pneumococcal	One time if high risk	One time if high risk	One (1) time, although those with high risk may need another
Hepatitis B (Hep B)	3 doses if high risk	3 doses if high risk	3 doses if high risk
Hepatitis A (Hep A)	2 doses if high risk	2 doses if high risk	2 doses if high risk
Meningococcal (MCV4)	One (1) dose if high risk	One (1) dose if high risk	One (1) dose if high risk
Measles	One (1) dose if unsure whether vaccinated before, 2 doses if high risk		
Human Papilloma Virus (HPV)	3 doses (maximum age is 26 years of age). First dose usually given at age 11-12 years, second dose 2 months after the first dose and the third dose 6 months after the first dose.		
Rubella	Women who have not received the vaccination and are NOT PREGNANT		
Varicella	2 doses if high risk and no prior vaccination or chickenpox infection. Not given if patient is pregnant, immunosuppressed, or HIV+		

Eligibility and Enrollment

To be eligible to enroll, you must meet the following requirements:

- Work at least the minimum number of months and hours per month as established by the In-Home Supportive Services Public Authority of Monterey County, also referred to as the Public Authority; and
- Either live or work in Monterey County; and
- Not have been previously terminated by the Alliance for fraud, deception or failing to provide complete information; and
- Have submitted the required enrollment information to the Public Authority; and
- Apply when the Public Authority has openings to add subscribers to the Alliance Care IHSS Health Plan.

Enrollment and Effective Date of Coverage

The Public Authority will inform you when you are eligible to enroll in the Alliance Care IHSS Health Plan. After you are notified of your eligibility, you may enroll yourself by submitting an enrollment application to the Public Authority, 1000 S. Main Street, Suite 211C, Salinas, CA 93901, within thirty (30) days.

If you submit your completed application to the Public Authority by the fifth (5th) day of the month, your coverage will begin by the first (1st) day of the next month. If you submit a completed application after the designated day of the month in which you are eligible to apply, your coverage will not be effective until the first (1st) day of the second month following submission of your application to the Public Authority.

Special Enrollment Due to Loss of Other Coverage

An employee may enroll within ninety (90) days of losing other coverage by submitting to the Public Authority an enrollment or change of enrollment application in a form agreed upon by the Public Authority and the Alliance. The employee requesting enrollment must have previously waived coverage for self when originally eligible because of the other coverage, continuation of other coverage must have expired or the other employer must have ceased making contributions toward the other coverage, and the loss of coverage must not be due to nonpayment or cause. The effective date of an enrollment resulting from loss of other coverage is no later than the first (1st) day of the second (2nd) month following the date that an enrollment or change of enrollment is submitted, as long as there are openings for additional subscribers.

Open Enrollment

The Public Authority will notify you if and when there is an open enrollment period.

Premium Contributions

Members are entitled to health care coverage only for the period for which the Alliance has received the appropriate premiums from the Public Authority. You are responsible for paying a monthly premium contribution to the Public Authority. The Public Authority will tell you the amount of the premium you are responsible for and how and where to send payment. Please contact the Public Authority at **831-755-4466** for more information about eligibility, enrollment, premiums and the start of coverage.

Alliance Care IHSS Covered Benefits Matrix

This matrix is intended to be used to help you compare covered benefits and is a summary only. Please consult the benefit description section for a detailed description of covered benefits and limitations.

Benefits*	Services	Cost to Member (copayment)
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services	No copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility	No copayment except: <ul style="list-style-type: none"> ▪ \$10 per visit for physical, occupational and speech therapy performed on an outpatient basis ▪ \$25 per visit for emergency health care services (waived if the Member is admitted directly to the hospital)
Professional Services	Services and consultations by a physician or other licensed health care provider	\$10 per office or home visit except: <ul style="list-style-type: none"> ▪ No copayment for hospital inpatient professional services ▪ No copayment for surgery, anesthesia, or radiation, chemotherapy or dialysis treatments ▪ No copayment for vision or hearing testing, or for hearing aids
Preventive Health Service	Periodic health examinations including all routine diagnostic testing, Human Immunodeficiency Virus (HIV) testing, laboratory services appropriate for such examinations, immunizations, and services for the detection of asymptomatic diseases	No copayment
Diagnostic, X-Ray and Laboratory Services	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat Members	No copayment

Benefits*	Services	Cost to Member (copayment)
Diabetes Care	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription	\$10 copayment per office visit; copayment for prescriptions as described in the Prescription Drug Program section of this chart
Prescription Drug Program	Drugs prescribed by a licensed practitioner	<ul style="list-style-type: none"> ▪ \$5 per prescription for a 30-day supply of generic drugs, \$15 per prescription for a 30-day supply of brand name drugs ▪ \$5 per prescription for a 90-day supply of maintenance drugs of generic drugs, \$15 per prescription for a 90-day supply of brand name drugs ▪ No copayment for prescription drugs provided in an inpatient setting ▪ No copayment for drugs administered in the doctor's office or in an outpatient facility
Durable Medical Equipment	Medical equipment appropriate for use in the home that primarily serves a medical purpose, is intended for repeated use, and is generally not useful to a person in the absence of illness or injury	No copayment
Orthotics and Prosthetics	Original and replacement devices as prescribed by a licensed practitioner	No copayment
Cataract Spectacles and Lenses	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery	No copayment
Maternity Care	Professional and hospital services relating to maternity care	No copayment
Family Planning Services	Voluntary family planning services. Contraceptive drugs and devices pursuant to the Plan's prescription drug benefit	No copayment \$ 5 copayment for generic \$15 copayment for brand name
Medical Transportation Services	Emergency ambulance transportation and non-emergency transportation to transfer a Member from a hospital to another hospital or facility, or facility to home	No copayment
Emergency Health Care Services	Emergency services are covered both in and out of the Plan's service area and in and out of the Plan's participating facilities	\$25 per visit (waived if the Member is admitted directly to the hospital)
Inpatient Mental Health Care Services	Mental health care in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition.	

Benefits*	Services	Cost to Member (copayment)
Inpatient Mental Health Care Services	Mental health care in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition	No copayment Unlimited days
Mental Health Care Services	Diagnosis and treatment of a mental health condition	No copayment Unlimited days
Outpatient Mental Health Care Services	Mental health care when ordered and performed by a participating mental health professional.	
Mental Health Care Services	Outpatient mental health care services	\$10 per visit Unlimited visits
Inpatient Alcohol / Drug Abuse Treatment	Hospitalization to remove toxic substances from the system	No copayment Unlimited days
Outpatient Alcohol / Drug Abuse Treatment	Crisis intervention and treatment of alcoholism or drug abuse	\$10 per visit Unlimited visits
Home Health Care Services	Services provided at the home by health care personnel	No copayment, except \$10 per visit for physical, occupational, and speech therapy
Skilled Nursing Care	Services provided in a licensed skilled nursing facility	No copayment Benefit is limited to a maximum of 100 days per benefit year
Rehabilitative (Physical, Occupational, and Speech) Therapy	Therapy may be provided in a medical office or other appropriate outpatient setting	\$10 per visit when performed in an outpatient setting No copayment for inpatient therapy
Blood and Blood Products	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings	No copayment
Organ Transplants	Coverage for organ transplants and bone marrow transplants that are not experimental or investigational	No copayment
Reconstructive Surgery	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance	No copayment
Phenylketonuria (PKU)	Testing and treatment of PKU	No copayment
Clinical Cancer Trials	Coverage for a Member's participation in a cancer clinical trial, Phase I through IV, when the Member's physician has	\$10 copayment per office visit Copayment for prescriptions as described in the Prescription

Benefits*	Services	Cost to Member (copayment)
	recommended participation in the trial, and Member meets certain requirements	Drug Program section
Acupuncture	Requires a referral from the Member's PCP and prior authorization from the Alliance	\$10 per visit Benefit is limited to 20 visits per benefit year
Chiropractic	Requires a referral from the Member's PCP and prior authorization from the Alliance	\$10 per visit Benefit is limited to 20 visits per benefit year
Biofeedback	Requires a referral from the Member's PCP and prior authorization from the Alliance	\$10 per visit
Deductibles	No deductibles will be charged for covered benefits.	
Lifetime Maximums	No lifetime maximum limits on benefits apply under this Plan.	
Annual Copayment Maximum	\$3,000 per benefit year	

Benefits are provided only for services that are medically necessary.

Benefit Descriptions

Acupuncture

Cost to Member
\$10 per visit

Description
Acupuncture services require a referral from the Member's Primary Care Provider and prior authorization from the Alliance. Services must be obtained from a Participating Provider.

Limitations
Treatment is limited to a maximum of twenty (20) visits per benefit year.

Alcohol / Drug Abuse Treatment - Inpatient

Please call United Behavioral Health at 1-800-808-5796 to access these services.

Cost to Member
No copayment

Description
Hospitalization for alcoholism or drug abuse as medically necessary to remove toxic substances from the system.

Limitations
Unlimited days..

Alcohol / Drug Abuse Treatment - Outpatient

Please call United Behavioral Health at 1-800-808-5796 to access these services.

Cost to Member
\$10 per visit

Description
Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically necessary.

Limitations
Unlimited visits.

Asthma Care

Cost to Member
No copayment

Description

You can get asthma at any age. Asthma makes it hard to breathe. Luckily, most people can learn to control their asthma and stay healthy. Work with your doctor to create an Asthma Action Plan.

We cover classes for Members with asthma. You will learn:

- What asthma is and how to control it
- How to avoid the things that cause asthma attacks
- How to use medicine the best way.

Call us at 1-800-700-3874 ext. 5580 to find a class near you. You don't need a referral from your PCP.

Biofeedback**Cost to Member**

\$10 per visit

Description

Biofeedback is a covered benefit based on medical necessity. You must have a referral from your PCP and prior authorization from the Alliance before you receive these services.

Blood and Blood Products**Cost to Member**

No copayment

Description

Benefit includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Also includes the collection and storage of autologous blood when medically indicated.

Breastfeeding – Supplies and Education**Cost to Member**

No copayment

Description

Nursing is good for mom and baby! Breast milk keeps your baby healthy. It's also cheaper than buying formula. We cover education that can show you how to nurse in comfort. We will also pay for breast pumps and supplies when they are medically necessary. Call 1-800-700-3874 ext. 5580 to learn more.

Cataract Spectacles and Lenses**Cost to Member**

No copayment

Description

Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Benefits also include one pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens.

Chiropractic Services**Cost to Member**

\$10 per visit

Description

Chiropractic services require a referral from the Member's Primary Care Provider and prior authorization from the Alliance. Services must be obtained from a participating provider.

Limitations

Treatment is limited to a maximum of twenty (20) visits per benefit year.

Clinical Cancer Trials**Cost to Member**

\$10 copayment per office visit; copayments for prescriptions as described in the Prescription Drug Program section.

Description

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

- Member must be diagnosed with cancer
- Member must be accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer
- Member's treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the Member, and the trial must meet the following requirements:
 - Trials must have a therapeutic intent with documentation provided by the treating physician, and
 - Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans Administration, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for clinical cancer trials include:

- Health care services required for the provision of the investigational drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service

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

Exclusions

- Provision of non-FDA-approved drugs or devices that are the subject of the trial
- Services other than health care services, such as travel, housing, and other non-clinical expenses that a Member may incur due to participation in the trial
- 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
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental)
- Health care services that are customarily provided by the research sponsors free of charge for any enrollee in the trial.

Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California.

Diabetes Care

Cost to Member

\$10 Copayment per office visit.

Copayments for prescriptions as described in the Prescription Drug Program section.

Description

Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription, including:

- Blood glucose monitors and blood glucose testing strips
- Blood glucose monitors designed to assist the visually impaired
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Pen delivery systems for the administration of insulin
- Podiatric services to prevent or treat diabetes-related complications
- Insulin syringes
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Insulin
- Prescriptive medications for the treatment of diabetes
- Glucagon.

Coverage also includes outpatient self-management training, education, and medical nutrition therapy necessary to enable a Member to properly use the equipment, supplies, and medications and as prescribed by the Member's Alliance provider.

Diagnostic X-Ray and Laboratory Services

Cost to Member

No copayment

Description

Diagnostic laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on the care of Members. Benefit includes other diagnostic services, including, but not limited to:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin).

Durable Medical Equipment

Cost to Member

No copayment

Description

Medical equipment appropriate for use in the home which:

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

The Alliance may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Durable medical equipment includes, but is not limited to:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes
- Insulin pumps and all related necessary supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Apnea monitors
- Podiatric devices to prevent or treat diabetes complications
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing and related supplies, spacer devices for metered dose inhalers and peak flow meters and education to enable the Member to properly use the devices
- Ostomy bags and urinary catheters and supplies.

Exclusions

- Comfort or convenience items
- Disposable supplies, except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment

- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same function.

Emergency Health Care Services

Cost to Member

\$25 per visit.

Copayment will be waived if the Member is admitted to the hospital.

Description

24 hour care is covered for an emergency medical condition. An emergency medical condition is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the Member's health in serious jeopardy, or
- Causing serious impairment to the Member's bodily functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Coverage is provided both inside and outside of the Alliance's service area, and in participating and non-participating facilities.

Family Planning Services

Cost to Member

No copayment

Description

Services must be obtained from a Participating Provider. Voluntary family planning services are covered, including:

- Counseling and surgical procedures for sterilization, as permitted by state and federal law.
- Coverage for federal Food and Drug Administration approved contraceptive drugs and devices pursuant to the prescription drug benefit including coverage for emergency contraceptives (also known as the morning after pill). You can get emergency contraceptives from any pharmacist or provider licensed to dispense them, with or without a prescription. Please refer to the Prescription Drug Benefit section for more information.
- Voluntary termination of pregnancy.

Note: Some hospitals and other providers do not provide one or more of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. Call your prospective doctor, medical group, independent practice association, clinic, or the Alliance at 1-800-700-3874 (TTY for the hearing impaired at 1-877-548-0857) to ensure that you can obtain the health care services that you need.

Health Education

Cost to Member

No copayment

Description

Benefit includes health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.

When you know how to take care of your body you can make healthy choices. When you make healthy choices, your health improves. You feel better. We want you to be as healthy as possible.

Working together with your provider is the key to quality health care. Your PCP may ask you to make changes in your life. You might need to quit smoking. Your PCP might suggest a healthier diet and exercise. You may need to lower stress.

The Alliance can help. Call our health educators at 1-800-700-3874 ext. 5580. They speak English and Spanish.

- We can send you booklets on many health topics
- We can tell you about health classes and support groups
- We can also tell you about our special classes on asthma, diabetes or how to quit smoking.

You should also ask your doctor about health education programs to meet your needs.

As an Alliance Member, you will get the "Living Healthy" newsletter four times a year. The articles give tips about how to stay healthy. The newsletter also has information about health classes and other services.

Home Health Care Services

Cost to Member

No copayment, except for \$10 per visit for physical, occupational, and speech therapy performed in the home.

Description

Health services provided at home by health care personnel. Benefit includes:

- Visits by RNs, LVNs, and certified home health aides in conjunction with the service of a registered nurse or licensed vocational nurse
- Physical therapy, occupational therapy, and speech therapy
- Respiratory therapy when prescribed by a licensed Plan provider acting within the scope of his or her licensure.

Limitations

- Home health care services are limited to those services that are prescribed or directed by the Member's Primary Care Provider or another appropriate authority designated by the Alliance.

- If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the Member's Primary Care Provider or other appropriate authority designated by the Alliance to choose the setting for providing the care.
- The Alliance will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting.

Exclusions

- Custodial care
- Services for your personal care, such as help in walking, bathing, dressing, feeding or preparing food
- Long-term physical therapy and rehabilitation for chronic conditions.

Hospital Services - Inpatient

Cost to Member

No copayment

Description

General hospital services received in a room of two or more individuals containing customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Benefit includes all medically necessary ancillary services, including, but not limited to:

- Use of operating room and related facilities
- Intensive care unit and services
- Drugs, medications, and biologicals
- Anesthesia and oxygen
- Diagnostic, laboratory, and x-ray services
- Special duty nursing as medically necessary
- Physical, occupational, and speech therapy
- Respiratory therapy
- Administration of blood and blood products
- Other diagnostic, therapeutic, and rehabilitative services
- Coordinated discharge planning, including the planning of such continuing care as may be necessary.

Includes coverage for general anesthesia and associated facility charges in connection with dental procedures, when hospitalization is necessary because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to Members under seven (7) years of age; the developmentally disabled, regardless of age; and Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Alliance will coordinate the services with the Member's dental plan.

Exclusions

Personal or comfort items or a private room in a hospital are excluded unless medically necessary. Services of dentists or oral surgeons are excluded for dental procedures.

Hospital Services - Outpatient

Cost to Member

No copayment, except:

- \$10 per visit for physical, occupational and speech therapy performed on an outpatient basis
- \$25 per visit for emergency health care services, which is waived if the Member is admitted to the hospital.

Description

Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:

- Physical, speech, and occupational therapy as appropriate
- Hospital services which can reasonably be provided on an ambulatory basis
- Related services and supplies in connection with outpatient services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the Member's stay at the facility.

General anesthesia and associated facility charges and outpatient services in connection with dental procedures when the use of a hospital or surgery center is required because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is available only to Members under seven (7) years of age; to the developmentally disabled, regardless of age; and to Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Alliance will coordinate the services with the Member's participating dental plan.

Exclusions

Services of dentists or oral surgeons are excluded for dental procedures.

Hospice

Cost to Member

No copayment

Description

The hospice benefit is provided to Members who are diagnosed with a terminal illness with a life expectancy of twelve (12) months or less and who elect hospice care for such illness instead of the traditional services covered by the Plan. This benefit includes:

- Nursing care
- Medical social services
- Home health aide services
- Physician services, drugs, medical supplies and appliances
- Counseling and bereavement services
- Physical, occupational, and speech therapy for symptom control or to maintain activities of daily living and basic functional skills
- Short-term inpatient care
- Pain control and symptom management.

The hospice election may be revoked at any time.

Limitations

Members who elect hospice care are not entitled to any other benefits under the Plan for the terminal illness while the hospice election is in effect.

Maternity Care

Cost to Member

No copayment

Description

Services must be obtained from a Participating Provider. Medically necessary professional and hospital services relating to maternity care are covered including:

- Prenatal and postpartum care, including complications of pregnancy.
- Newborn examinations and nursery care for the first thirty (30) days of life.
Please reMember that your baby will only be covered under your Alliance Care IHSS Plan for the first thirty (30) days of his or her life.
- Coverage includes participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.
- Counseling for nutrition, health education and social support needs.
- Labor and delivery care, including midwifery services.

Inpatient hospital care will be provided for forty-eight (48) hours following a normal vaginal delivery and ninety-six (96) hours following delivery by cesarean section, unless an extended stay is authorized by the Alliance. You do not need specific authorization to stay in the hospital forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a C-section and you may remain in the hospital for these time periods unless you and your doctor decide otherwise. If, after consulting with you, your doctor decides to discharge you before the forty-eight (48) - or ninety-six (96) -hour time period. The Alliance will cover a post-discharge follow-up visit within forty-eight (48) hours of discharge when prescribed by your doctor. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor's office depending on the best solution for you.

After you have your baby, you will need to see your doctor six (6) weeks later. This is an important time to let your doctor see how your body is changing after delivery and make sure you and your baby are doing well. A few days after you give birth, call your doctor's office to ask for a postpartum appointment. The Alliance offers a \$20 gift card to Members who have their postpartum check-up on time.

Medical Transportation Services

Cost to Member

No copayment

Description

Emergency ambulance transportation to the first hospital that accepts the Member for emergency care is covered in connection with emergency services. Benefit includes ambulance and ambulance transport services provided through the 911 emergency response system. Also includes, non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home when the transportation is:

- Medically necessary, and
- Requested by a Plan provider, and
- Authorized in advance by the Alliance.

Exclusions

Coverage for public transportation including transportation by airplane, passenger car, taxi, or other forms of public conveyance.

Mental Health Care Services - Inpatient

Please call United Behavioral Health at 1-800-808-5796 to access these services.

Cost to Member

No copayment

Description

Mental health care in a participating hospital when ordered and performed by a participating mental health professional. Diagnosis and treatment of a mental health condition. Prior authorization is required.

Limitations

Unlimited days

Mental Health Care Services - Outpatient

Outpatient mental health services are authorized, arranged and provided through United Behavioral Health. Please call them at 1-800-808-5796 to access these services.

Cost to Member

\$10 per visit

Description

Mental health care services when ordered and performed on an outpatient basis by a participating Plan mental health provider. Prior authorization is required.

Limitation

Unlimited visits.

Nutrition and Weight

Cost to Member

No copayment

Description

Eating better can help you to stay healthy. Call us for a free booklet on healthy eating. Ask us about free or low-cost exercise and weight loss programs in your area. Or request a free exercise video or pedometer (a small device that tells you how many miles you have walked).

Organ Transplants

Cost to Member

No copayment

Description

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

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

If the Alliance denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to the Alliance's Grievance Process on page 51.

Orthotics and Prosthetics

Cost to Member

No copayment

Description

Orthotic and prosthetic benefits include original and replacement devices, including, but not limited to:

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure
- Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license
- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic devices to restore and achieve symmetry incident to mastectomy.

Covered items must be prescribed by a physician, authorized by the Alliance, and dispensed by a Plan provider. Repairs are provided unless necessitated by misuse or loss. The Alliance, at its option, may replace or repair an item.

Exclusions

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

Phenylketonuria (PKU)

Cost to Member

No-Copayment

Description

Testing and treatment of PKU, including formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Prescription Drug Program

Cost to Member

- No copayment for prescription drugs provided in an inpatient setting.
- No copayment for drugs administered in the doctor's office or in an outpatient facility setting during the Member's stay at the facility.
- \$5 per prescription for up to a 30-day supply for generic drugs and \$15 per prescription for up to a 30-day supply for brand name, including contraceptive drugs and tobacco use cessation drugs.
- \$5 per prescription for a 90-day supply of maintenance drugs for generic drugs and \$15 per prescription for a 90-day supply of maintenance drugs for brand name drugs supplied through the Plan's participating pharmacies. Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as heart disease, diabetes, or hypertension.
- \$5 copayment for contraceptive devices.

Description

Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes, but is not limited to:

- Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication.
- Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin.

- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes.
- Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term "disposable" includes devices that may be used more than once before disposal.
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription.
- Medically necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a Plan physician in connection with a covered service and obtained through a Plan-designated pharmacy.
- One cycle or course of treatment of tobacco cessation drugs per benefit year. The Member must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs.
- All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time-release contraceptives.

For information concerning the Alliance's prescription drug coverage, please refer to Getting Pharmacy Benefits on page 20 of this document.

Exclusions

- Drugs or medications prescribed solely for cosmetic purposes
- Drugs or medications prescribed solely for the treatment of hair loss, sexual dysfunction, mental performance, athletic performance or anti-aging for cosmetic purposes
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by the Plan or a Plan provider except when coverage is otherwise required in the context of emergency services
- Most patent or over-the-counter medications, including non-prescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by your doctor
- Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described)
- Dietary supplements (except for formulas or special food products, when medically necessary, including for phenylketonuria or PKU), appetite suppressants, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity
- Experimental or investigational drugs.

If the Alliance denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to the Alliance's Grievance Process on page 52.

Preventive Health Service

Cost to Member

No copayment.

Description

Periodic health examinations, including all routine diagnostic testing, Human Immunodeficiency Virus (HIV) testing and laboratory services appropriate for such examinations. Immunizations for adults as recommended by the Advisory Committee on Immunization Practices (ACIP). Immunizations such as Hepatitis B for individuals at occupational risk.

Preventive services also include services for the detection of asymptomatic diseases, including, but not limited to:

- A variety of voluntary family planning services
- Contraceptive services
- Prenatal care
- Vision and hearing testing
- Sexually transmitted disease (STD) testing
- Cytology examinations on a reasonable periodic basis
- Yearly exams (pelvic exam, Pap smear, and breast exam) and any other gynecological service from your Primary Care Provider or an OB/GYN provider in our Plan (Primary Care Provider approval not required)
- Medically accepted cancer screening tests including, but not limited to, breast and cervical cancer screening which shall also include the usual Pap test, human papillomavirus (HPV) screening test that is approved by the Federal Food and Drug Administration (FDA) and the option of any cervical cancer screening test approved by the FDA
- Effective health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.

Exclusions

Preventive services related to travel and routine physical examinations required for licensure, employment, insurance, recreational or organization activities are not covered, unless the examination corresponds to the schedule of routine physical examinations provided in the Schedule of Benefits.

Examinations, immunizations and treatment precedent to engaging in travel or for pre-marital or pre-adoption purposes and for any other purposes unrelated to screening for disease or prevention of disease.

Professional Services

Cost to Member

- \$10 per office or home visit
- No copayment for hospital inpatient professional services
- No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments
- No copayment for vision or hearing testing, or for hearing aids.

Description

Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Professional services include:

- Surgery, assistant surgery, and anesthesia (inpatient or outpatient)
- Inpatient hospital and skilled nursing facility visits
- Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment
- Home visits when medically necessary
- Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid(s): monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following receipt of a covered hearing aid.

Exclusions

- Purchase of batteries or other ancillary equipment, except those covered under the initial hearing aid purchase, and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids or repair of hearing aid after the covered one (1) year warranty period
- Replacement of a hearing aid more than once in any period of thirty-six (36) months
- Surgically implanted hearing devices
- Weight loss services, programs or supplies (This does not apply to services or supplies that are medically necessary due to morbid obesity)
- Eyeglasses or contact lenses (except for cataract spectacles or lenses and cataract contact lenses)
- Foot care like nail trimming
- Cosmetic surgery done to change or reshape normal body parts so that they look better (This does not apply to reconstructive surgery to give you back the use of a body part, or to correct a deformity caused by an injury)
- Sex change surgery or treatments, unless the surgery or treatments are medically necessary health care services and are authorized by the Alliance
- Eye surgery, just for correcting vision (like near sightedness)
- Circumcision, unless medically necessary
- Sensory integration therapy
- Learning disorder evaluation and treatment
- Loop gastric bypass, gastroplasty, duodenal switch, bilopancreatic bypass and minigastric bypass except when medically necessary and authorized by the Alliance.

Reconstructive Surgery

Cost to Member

No copayment

Description

Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors or disease to do either of the following:

- Improve function
- Create a normal appearance to the extent possible.

This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy. The length of hospital stay will be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes.

Rehabilitative (Physical, Speech and Occupational) Therapy

Cost to Member

No copayment for inpatient therapy services

\$10 copayment for services provided in an outpatient setting or in the home

Description

Rehabilitative therapy is therapy to help make a part of your body work as normally as possible.

- The Alliance covers medically necessary physical, occupational and speech therapy. For example, if you cannot speak because of a stroke, speech therapy may be covered to help you learn to talk again.
- You must have a referral from your PCP and pre-approval from the Alliance.

The Alliance may require periodic evaluations as long as therapy, which is medically necessary, is provided.

Exclusions

Services eligible under the California Children's Services (CCS) Program.

Skilled Nursing Care

Cost to Member

No copayment

Description

Medically necessary services prescribed by a Plan provider and provided in a licensed skilled nursing facility. Benefit includes:

- Skilled nursing on a 24-hour per day basis
- Bed and board
- X-ray and laboratory procedures
- Respiratory therapy
- Physical, speech, and occupational therapy
- Medical social services

- Prescribed drugs and medications
- Medical supplies
- Appliances and equipment ordinarily furnished by the skilled nursing facility.

Limitations

This benefit is limited to a maximum of one hundred (100) days per benefit year.

Exclusions

- Custodial care
- Skilled nursing care for other than a medical need, such as help with personal care like bathing or feeding
- Long-term care, more than one hundred (100) days per benefit year.

Annual or Lifetime Benefit Maximums

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

Excluded Benefits

The following health benefits are excluded under the Health Plan:

- Any services or items specifically excluded in the Benefits Description section.
- Any benefits in excess of limits specified in the Benefits Description section.
- Services, supplies, items, procedures, or equipment that are not medically necessary, unless otherwise specified in the Benefits Description section.
- Any services which were received prior to the Member's effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the Member's effective date.
- Any services that are received subsequent to the time coverage ends.
- Those medical, surgical (including implants), or other health care procedures services, products, drugs, or devices that are:
 - Experimental or investigational, or
 - Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or
 - Outmoded or not effective.
- If the Alliance denies coverage based on a determination that the procedure, service, product, drug, or device is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to the Plan's Grievance Process on page 52.
- Medical services that are received in an emergency care setting for conditions that are not emergencies, if you reasonably should have known that an emergency care situation did not exist.
- Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery that are covered under the "Cataract Spectacles and Lenses" benefit.
- The diagnoses and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

- Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when the Alliance determines they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to "Skilled Nursing Care" and "Hospice" benefits.
- Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker's compensation benefit plan. The Alliance shall provide services at the time of need, and the Member or Member's legal guardian shall cooperate to assure that the Alliance is reimbursed for such benefits.
- Services that are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The Alliance shall provide services at the time of need, and the Member or Member's legal guardian will cooperate to assure that the Alliance is reimbursed for such benefits.
- Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.
- Any services not authorized by the Alliance when prior authorization is required.
- Routine care received outside of the United States (except as authorized by the Alliance).
- Routine care received outside of California (except as authorized by the Alliance).
- Transportation by airplane, passenger car, taxi or other form of public conveyance.

The Grievance Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Plan providers to the courtesy extended to you by our representatives.

If you have questions about the services you receive from a Plan Provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call the Alliance's Member Service Department at 1-800-700-3874 (TTY for the hearing impaired at 1-877-548-0857).

Filing a Complaint

You have the right to tell us if you are not happy with a plan provider or with a decision that we have made. The way you do this is by filing a complaint with us. We handle complaints through our Grievance Process.

You may file a complaint with the Alliance at any time. A complaint must be filed within one hundred eighty (180) calendar days of the event or action that caused you to become dissatisfied. This time limit can be waived if the complaint involves a quality of care issue. You can obtain a copy of the Alliance's Grievance Policy and Procedure by calling our Member Service number in the above paragraph. To begin the Grievance Process, you can call, write, fax or submit a complaint through our Web site.

Grievance Coordinator
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
1-800-700-3874, ext. 5505 toll free
www.ccah-alliance.org

The Alliance will acknowledge receipt of your complaint within five (5) days and will resolve your complaint within thirty (30) days. If your complaint involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your provider may request that the Alliance expedite its grievance review. The Alliance will evaluate your request for an expedited review and, if your complaint qualifies as an urgent complaint, we will resolve your complaint within three (3) days from receipt of your request.

You are not required to file a complaint with the Alliance before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a complaint with the Alliance in which you ask for an expedited review, the Alliance will immediately notify you in writing that:

- You have the right to notify the Department of Managed Health Care about your complaint involving an imminent and serious threat to health, and that
- We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the complaint no later than seventy-two (72) hours from receipt of your request to expedite review of your complaint.

Independent Medical Reviews

If medical care that is requested for you is denied, delayed or modified by the Alliance or a Plan provider, you may be eligible for an Independent Medical Review (IMR). If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, the Alliance will provide coverage for the health care services.

An IMR is available in the following situations:

- Your provider has recommended a health care service as medically necessary, or
- You have received urgent care or emergency services that a provider determined was medically necessary, or
- You have been seen by an In-Plan Provider for the diagnosis or treatment of the medical condition for which you seek independent review; and
- The disputed health care service has been denied, modified, or delayed by the Alliance or one of its plan providers, based in whole or in part on a decision that the health care service is not medically necessary, and you have filed a complaint with the Alliance and the disputed decision was upheld or the complaint remains unresolved after thirty (30) calendar days.

If your complaint qualifies for expedited review, you are not required to file a complaint with the Alliance prior to requesting an IMR. Also, the DMHC may waive the

requirement that you follow the Alliance's Grievance Process in extraordinary and compelling cases.

For cases that are not urgent, the IMR organization designated by DMHC will provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; the IMR organization will provide its determination within three (3) business days. At the request of the experts, the deadline can be extended by up to three (3) days if there is a delay in obtaining all necessary documents.

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call the Alliance's Member Services Department at 1-800-700-3874 (TTY for the hearing impaired at 1-877-548-0857).

Independent Medical Review for Denials of Investigational or Experimental Therapies

You may also be entitled to an Independent Medical Review (IMR), through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

We will notify you in writing of the opportunity to request an IMR of a decision denying an experimental/investigational therapy within five (5) business days of the decision to deny coverage. You are not required to participate in the Alliance's Grievance Process before seeking an IMR of our decision to deny coverage of an experimental or investigational therapy. If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the IMR decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against the Alliance, you should first telephone the Alliance at 1-800-700-3874 (TTY for the hearing impaired at 1-877-548-0857) and use the Alliance's Grievance Process before contacting DMHC. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a complaint that has not been satisfactorily resolved by the Alliance, or a complaint that has remained unresolved for more than thirty (30) days, you may call DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view 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 and urgent medical services. DMHC has a toll-free telephone

number, 1-888-HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use DMHC's TDD line (1-877-688-9891) number, to contact DMHC. DMHC's Internet Web site (www.lmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

The Alliance's Grievance Process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Termination and Cancellation

Term and Renewal Provisions

The initial term of the Agreement between the Alliance (the Plan) and the Public Authority (the Group) became effective July 1, 2005. The Agreement will renew automatically from year to year on the anniversary date, subject to any changes in prepayment fees, other charges, benefits, coverage and termination provisions described in this section.

Prepayment of Fees

The Alliance charges a monthly premium for an eligible employee determined by the Public Authority that is enrolled in the Alliance Care IHSS Health Plan. These premium and contribution amounts are subject to changes as outlined in the contract between the Alliance and the Public Authority. If your health benefit plan premium or benefit changes as a result of collective bargaining agreements, legislative action or action by the Alliance, you will be notified of the change by the Public Authority in writing, thirty (30) days prior to the effective date of such change.

For current contribution information, contact the Public Authority health benefits representative at 831-755-4466.

Effect of Cancellation

Upon cancellation or expiration of the term, this Agreement and/or your coverage and rights under this Agreement (referred to as "coverage") are terminated subject to any applicable provisions for reinstatement, conversion to individual Membership, temporary continuation of benefits, continuation coverage or extension of benefits. Cancellation of this Agreement cancels coverage for all Subscribers of the Group.

Cancellation of Entire Agreement

Termination of Benefits for Non-Payment

If the Group fails to pay any amount due the Alliance on the agreed upon due date, then the Alliance may cancel the Agreement. The Alliance will promptly mail to each Member a legible, true copy of the notice of termination no less than fifteen (15) days prior to termination, at which time all rights to benefits will end for all Members, including those who are hospitalized or undergoing treatment for an ongoing condition (unless you may

be covered under Extension of Benefits due to Total Disability). Two examples of this timeline would be if you were to receive a notification of termination letter for employer non-payment of premium on April 28th, your coverage will end midnight May 31st. If you were to receive a notification of termination letter on April 13th, your coverage will end midnight April 30th.

These rights may be reinstated only by payment of the amounts due in accordance with the Reinstatement provisions stated in the Group Agreement.

Cancellation by Group

The Group may terminate the Agreement by giving sixty (60) days written notice to the Alliance.

Reinstatement

Receipt by the Alliance of the proper monthly prepayment fees subsequent to the Alliance's issuance of cancellation to the Group for non-payment of prepayment fees will reinstate the Group as though there never was a cancellation, if such payment is received on or before the due date for the succeeding monthly prepayment fees, unless:

- In the notice of termination, the Alliance notifies the Group that if payment is not received within fifteen (15) days, a new application is required and the conditions on which a new contract will be issued or the original contract reinstated;
- Such payment is received more than fifteen (15) days after issuance of the notice of termination, and the Alliance refunds such payment within twenty (20) business days; or
- Such payment is received more than fifteen (15) days after issuance of the notice of termination, and the Alliance issues to the Group within twenty (20) business days of receipt of such payment, a new contract accompanied by written notice stating clearly those aspects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

Cancellation of Individual Members

Loss of Eligibility

If you cease to meet the eligibility requirements as defined in this EOC, including failure to pay the required premiums, then (subject to any applicable provisions for continuation of coverage or conversion of benefits) your coverage terminates at midnight on the last day of the month in which loss of eligibility occurs. The Group agrees to notify the Alliance immediately if you cease to meet the eligibility requirements as set forth by the Group. Please make sure to contact the Group if you have any questions regarding maintaining your eligibility. Except in the event of fraud or deception as described below, the Group will provide written notice to you at least fifteen (15) days prior to the termination of coverage.

Disenrollment by Member

If you elect coverage under an alternative health benefits plan offered by the Group as an option in lieu of coverage under this Agreement, then your coverage terminated automatically at the time and date the alternate coverage becomes effective. In such event, the Group agrees to notify the Alliance immediately that you have elected coverage elsewhere.

Cancellation of Members for Good Cause

Failure to Furnish Correct or Complete Information

If you willfully or intentionally fail to furnish information required, or furnish materially incorrect or misleading enrollment or required updated information, then the Alliance may cancel your coverage fifteen (15) days after your receipt of written notice of termination from the Alliance, unless you provide the Alliance or the Group with the required information within such fifteen (15) day period.

Fraud or Deception

If you engage in fraud or deception in the use of the services or facilities of the Alliance or permit such fraud or deception by another, including but not limited to the unauthorized use of an Alliance Care IHSS Health Plan identification card or making a material misrepresentation on a Group or Alliance enrollment document, then the Alliance may cancel your coverage effective on the date the Alliance mails notice of cancellation to you.

Member's Right to Review of Certain Cancellations

If you believe that your coverage, subscription or enrollment has been cancelled or not renewed because of your health status or requirements for health care services, you may request a review by the California Department of Managed Health Care.

Extension of Benefits Upon Termination

If, when the Agreement between the Alliance and the Group is terminated as to the entire group, you are receiving treatment for a condition for which benefits are available under the Agreement and which condition has caused Total Disability as determined by a Health Plan participating provider, then you will be covered, subject to all limitations and restrictions of the Agreement, including payment of copayments and the monthly prepayment fees, for covered services directly relating to the condition causing Total Disability. This extension of benefits terminates upon the earlier of (1) the end of the twelfth month after termination of this Agreement, or (2) the date you are no longer Totally Disabled as determined by a Health Plan participating provider, or (3) the date your coverage becomes effective under any replacement contract or policy without limitation as to the disabling condition. A person is Totally Disabled if he or she satisfied the definition of Totally Disabled in this Agreement.

Determination regarding the existence of a Total Disability will be made by a Participating Provider and approved by the Alliance's Medical Director. A medical examination performed by a physician specified by the Health Plan may be required to determine the existence of a Total Disability. Proof of continuing Total Disability shall be provided to the Alliance at no less than thirty-one (31) day intervals during the period that extended benefits are available, along with appropriate certification from a Participating Provider.

Individual Conversion Coverage, Group Continuation Coverage

Conversion to Individual Non-Group Membership

In the event your coverage ends under the Agreement, you may convert your Membership to individual non-group Membership for yourself without regard to health status and requirements for health care services. However, conversion is not available if:

- The Group Agreement has been terminated and is replaced by similar coverage under another group contract within fifteen (15) days of termination of the Group Agreement
- The Agreement has been canceled or is being canceled by the Alliance
- You fail to pay amounts due to the Plan
- You are terminated by the Plan for cause
- You are eligible for benefits under Medicare or any other Federal or State program
- You are eligible for health benefits under any form of group coverage, or are covered for health benefits under an individual policy or contract
- You have not been continuously covered during the three (3) month period immediately preceding the date of termination of group coverage.

Notwithstanding any other provision to the contrary, no Member is eligible to convert to individual non-group coverage where the Member's group coverage was terminated for cause.

You may convert to non-group Membership by submitting a written application and the first premium payment no later than sixty (60) days after termination from the group, after which the Plan will issue a conversion contract effective on the day following the termination of coverage under the Group Agreement.

Federal Continuation of Coverage (COBRA)

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), Group Continuation Coverage is available, under certain conditions, to employees of most employers. If Membership in the Plan is sponsored by an employer, you may be eligible for Group Continuation of Coverage. Contact the Public Authority at 831-755-4466 for more information.

State Continuation of Coverage (Cal-COBRA)

If Membership in the Plan is sponsored by an employer, and you are eligible for and covered by Group Continuation Coverage, you may further continue coverage under the Plan through State Continuation of Benefits Coverage. Contact the Alliance's Member Services Department at 1-800-700-3874 for more information.

If you have exhausted federal COBRA coverage and have had less than thirty-six (36) months of COBRA coverage, you can continue coverage through Cal-COBRA for up to thirty-six (36) months from the date that federal COBRA coverage began.

Your Rights under HIPAA If You Lose Group Coverage

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers when they change or lose their jobs. California law provides similar and additional protections.

If you lose group health insurance coverage and you meet certain criteria, you are entitled to purchase individual health coverage (non-group) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual coverage for these benefits must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if: 1) you are an eligible person under HIPAA; 2) you agree to pay the required premiums; and 3) you live or work inside the Plan's service area.

To be considered an eligible person under HIPAA, you must meet these requirements:

- You have 18 or more months of creditable coverage without a break of sixty-three (63) days or more between any of the periods of creditable coverage or since your most recent coverage was terminated.
- Your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits (COBRA and Cal-COBRA are considered group coverage).
- You were not terminated from your most recent creditable coverage due to non-payment of premiums or fraud.
- You are not eligible for a group health plan, Medicare or Medi-Cal.
- You have no other health insurance coverage.
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage.

If you believe your HIPAA rights have been violated, contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's Web site at www.hmohelp.gov.

General Information

Coordination of Benefits (COB) Applicability

Coordination of Benefits means that if you have more than one insurance carrier, there is a specific order as to which insurance will pay first and which will pay last. The one that is billed first is your primary insurance. The insurance that is billed next is your secondary insurance. Even if you have more than one insurance carrier, the provider cannot collect more than the rate set by the insurance carriers.

If you have Alliance Care IHSS and any other insurance, your Alliance Care IHSS insurance will be your primary insurance most of the time. There are some exceptions to this rule. For example, if you have insurance through another employer where you are the primary subscriber and you became enrolled in that insurance before you enrolled in Alliance Care IHSS, that insurance will be your primary insurance. But if you are the

dependent on someone else's insurance and have Alliance Care IHSS, Alliance Care IHSS will be your primary insurance. If you have questions about which insurance is your primary, please call Member Services.

When you have more than one insurance carrier, the provider bills your primary insurance first. After the primary insurance pays, the provider then sends a claim to the secondary insurance.

Here is an example of how benefits are coordinated between primary and secondary insurance carriers:

Your doctor's charge for an office visit	The amount your primary insurance allows for an office visit	The amount your secondary insurance allows for an office visit	The secondary insurance allowable is less than what the primary has already paid the doctor, so it pays	Since the doctor has already been paid what your primary insurance allows, you owe
\$60	\$40	\$35	\$0	\$0

Coordination of benefits does not mean that you can add the two insurance payments together to pay the entire provider bill. It also does not mean that get to choose when to have one insurance be primary and when to have it be secondary.

By enrolling in the Alliance, each Member agrees to complete and submit to the Alliance such consents, releases, assignments and any other document reasonably requested by the Alliance in order to assure and obtain reimbursement and to coordinate coverage with other health benefit plans or insurance policies. The payable benefits will be reduced when benefits are available to a Member under such other plan or policy whether or not claim is made for the same.

Third-Party Recovery Process and Member Responsibilities

The Member agrees that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the Member is made whole for all other damages resulting from the wrongful act or omission before the Alliance is entitled to reimbursement, Member shall:

- Reimburse the Alliance for the reasonable cost of services paid by the Alliance to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise.
- Fully cooperate with the Alliance's effectuation of its lien rights for the reasonable value of services provided by the Alliance to the extent permitted under California Civil Code section 3040. The Alliance's lien may be filed with the person whose act caused the injuries, his or her agent or the court.
- The Alliance shall be entitled to payment, reimbursement, and subrogation in third party recoveries and Member shall cooperate to fully and completely effectuate and protect the rights of the Alliance including prompt notification of a case involving possible recovery from a third party.

Non-Duplication of Benefits with Workers' Compensation

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of medical services provided by the Alliance, we will provide the benefits of this Agreement at the time of need. The Member will agree to provide the Alliance with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Alliance. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this Agreement, Members agree to cooperate in protecting the interest of the Alliance under this provision and to execute and to deliver to the Alliance or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of the Alliance or its nominee.

Limitations of Other Coverage

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

Independent Contractors

Plan providers are neither agents nor employees of the Plan, but are independent contractors. The Alliance regularly reviews the physicians who provide services to our Members. However, in no instance shall the Alliance be liable for negligence or wrongful acts of omissions on the part of any person who provides services to you or your dependents, including any physician, hospital or other provider or their employees.

Provider Payment

The Alliance contracts with doctors and other health care providers to provide services to Members. Providers are paid fee-for-service. This means that the doctors provide health care services to their patients, and then send a claim to the Alliance for each of the services they give you. The Alliance and these health care providers agree on how much is paid for each service.

Hospitals and other health facilities are paid a fixed amount of money for the services they provide that the Alliance and the hospital or facility agree upon in advance.

If you would like more information about how providers are paid, please contact an Alliance Member Services Representative.

Reimbursement Provisions If You Receive a Bill

If you receive services in accordance with your benefits and the guidelines of the Alliance Care IHSS Health Plan, you should not be billed for covered services. The only amount you are responsible for would be any applicable copays. If you do receive a bill for services that are covered under the Alliance Care IHSS Health Plan, and you obtained benefits in accordance with Plan guidelines, follow these steps:

- Contact the provider or billing office. There is usually a phone number on the bill or statement that you are sent.
- Give them your insurance information. Tell them you are covered by the Alliance under the Alliance Care IHSS Health Plan, and give them your Alliance ID number.
- Ask them to bill the Alliance for the service. If they need information on how to bill us, you can find our billing address and phone number on the back of your Alliance ID card.

If you still receive a bill from the provider after you have done this, please call Member Services at **1-800-700-3874**. **Important Note:** Please do not wait until the bill is several months old or is in collections to call us. We will not be able to help you with bills that are more than one (1) year old.

Please note: If you are outside of the Alliance's service area, you are only covered if you need emergency or urgent care services. Give the provider your Alliance ID card and ask them to send us an insurance claim form. Our billing address and phone number are on the back of your Alliance ID card.

If the provider is not willing to send us an insurance claim form and you pay for the services, we will need the following information either from you or from the provider:

- A detailed description of the services you received from the provider(s), including date(s) of service, place(s) of service and billing codes if available; and
- Proof of payment for the service(s) you received.

If you received emergency or urgent care services out of area and have paid for them, please call Member Services at **1-800-700-3874**.

Public Participation

We have a Member Services Advisory Group to help our governing Board. This group makes sure that Plan policies meet Member's needs and takes their concerns into consideration. The Advisory Group is made up of Plan Members, representative of county and community agencies, doctors and clinics in our network and a Member of our governing Board.

If you would like more information about our Member Services Advisory Group, or would like to attend one of the meetings, please call Member Services at **1-800-700-3874**. These meetings are open to the public.

Notifying You of Changes in the Plan

Throughout the year, we may send you updates about changes in the Plan. This can include updates for the Provider Directory and Combined Evidence of Coverage and Disclosure Form. We may also send you information about changes in our Member

newsletter. We will keep you informed and are available to answer any questions you may have. Call us at the Alliance if you have any questions about changes in the Plan.

Privacy Practices

The Alliance protects the confidentiality of your information. We do not disclose your information for any purpose other than carrying out the terms of the Alliance Care IHSS Health Plan contract, in conformance with federal and state law and regulation. You have the right to file a complaint if you feel the Alliance has violated your privacy. For more information about the Alliance's privacy practices, please see pages 63 and 64 of this document, or call Member Services at 1-800-700-3874.

Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet Web site (www.organdonor.gov) has additional information on donating your organs and tissues.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed. This notice also describes how you can get access to this information. Please review it carefully.

Why am I receiving this Notice?

The Alliance is required by law to maintain the privacy of your health information. We are required to inform you of our legal duties and privacy practices.

This notice describes our privacy practices and your rights relating to your health information. It does not restrict uses or disclosures of health information that are otherwise allowed by law.

We are required to follow the terms of this Notice of Privacy Practices. We also have the right to change the terms of this notice. If we make any changes to this Notice, we will mail it to you at your address in our records.

How does the Alliance use and disclose my health information?

The Alliance stores health-related records about you, including your claims history, health plan enrollment information, case management records, and treatment authorizations and referrals for health services. We use this information and disclose it to others for the following purposes:

Treatment The Alliance uses your health information to coordinate your health care. We may disclose it to hospitals, clinics, physicians and other health care providers to allow them to provide health care services to you. For example, the Alliance maintains your health information in electronic form, and may allow health care providers to have access to it to provide treatment to you.

Payment The Alliance uses and discloses your health information to make payment for health care services you receive, determine your eligibility for benefits, and your provider's eligibility for payment. For example, we inform providers that you are a Member of our Plan, and we tell them what benefits you are eligible for.

Health care operations The Alliance uses and discloses your health information as necessary to operate our health plan. For example, we use our Members' claims information for our internal financial reports, and for quality purposes.

We also disclose health information to our contractors and agents who assist us in these functions. We require a confidentiality agreement from them before we make these disclosures. For example, companies that provide or maintain our computer services may have access to health information in the course of providing services to us.

Contacting you We may contact you to provide appointment reminders or

information about treatment options available to you. We may also contact you about other health-related services that may interest you.

Others involved in your care We may release medical information to a person responsible for paying for your care. With your verbal or written consent, we may release information to a friend, representative or family Member who is involved in your care. This includes responding to telephone calls about your eligibility, claim status, and coordination of your care.

Employee Health Benefit Plans and their Sponsors Employers sponsor employee insurance plans that provide health services to their Members. These plans may contract with us to provide services to you and pay claims. We may disclose your health information to the Plan. We may also notify the Plan sponsor if you are enrolled in or unenrolled from the Plan. We may also disclose your health information to the Plan sponsor as necessary to manage the Plan, if the sponsor agrees in writing to keep your health information confidential and secure, and not to use it for employment-related purposes.

Other Disclosures We may disclose health information without your written permission (authorization) to government agencies and others where we are allowed by law to do so. Here are the general kinds of disclosures we may make without your written permission:

- Disclosures that are required by state or federal law
- Disclosures to public health authorities or for public health activities
- To government agencies in cases of abuse or neglect of children or dependent adults, or domestic violence
- To agencies that oversee the health care system, for audits, or investigations
- For judicial proceedings, such as lawsuits
- To law enforcement agencies
- To coroners and medical examiners
- To organ procurement agencies, if you are an organ donor or a possible donor
- To researchers conducting research, with the approval of an Institutional Review Board or privacy board
- To avert a serious threat to health or safety
- If you are a Member of the armed forces or a veteran, we may release health information to a military authority to

help determine your eligibility for veterans' benefits

- For national security activities
- If you are an inmate or under the custody of a law enforcement official, we may release health information about you to them
- To other agencies conducting government health benefit programs
- To comply with workers' compensation laws.

Limitations In some circumstances, your health information may be subject to restrictions that may limit some uses or disclosures described above. For example, government health benefit programs may limit the disclosure of Members' health information for purposes unrelated to the program. There are special restrictions on disclosing information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Authorization Except as described above, we will not permit other uses and disclosures of your health information without your written permission, which you may revoke at any time.

Your Individual Rights

As an Alliance Member, you have the following rights:

- You have the right to ask us to restrict certain uses and disclosures of your health information. However, we are not required to agree to your request.
- You have the right to ask us to contact you at an alternate telephone number, post office box or other address. We will accept reasonable requests when necessary to protect your safety.
- You have the right to see and copy certain records that the Alliance maintains on you. These include your enrollment, payment, claims history, case or medical management records, and any other records that are used to make decisions about you. The Alliance may deny your request. If your request is denied, we will tell you the reason why in writing. You have the right to appeal the denial.
- If you feel that certain medical or claims information about you is wrong in our records, you have the right to ask us to amend the records. We may deny your request in certain circumstances. If your request is denied, you have the right to

submit a statement to include in the record.

- You have the right to receive a report of non-routine disclosures that we have made of your health information, up to six years before the date of your request (but not earlier than April 14, 2003). There are some exceptions: For example, we do not maintain records of disclosures made with your permission; disclosures made for providing health services, paying for health services, or conducting health plan functions of the Alliance; and certain other disclosures.
- If you received this notice electronically, you have the right to request a paper copy from us at any time.

This Notice describes your privacy rights in general. These rights may be limited by law.

How do I exercise these rights?

You can exercise any of your rights by sending a written request to our Privacy Official the address below. For quicker processing of your request, please use our request form, which you can find on our Internet site at www.ccah-alliance.org. Or you may ask by calling us at the telephone number below. You can also call or write to our Privacy Officer at the following address.

How do I file a complaint if my privacy rights are violated?

As an Alliance Member, you have the right to file a complaint with our Privacy Official. We will need information from you in writing to support your complaint. You may also file a complaint with the Secretary of Health and Human Services.

The Alliance will not retaliate against you in any way for filing a complaint. Filing a complaint will not affect the quality health care services you receive as an Alliance Member.

Contact us:

Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
1-800-700-3874, ext. 5505 toll-free

Contact the U.S. Secretary of Health and Human Service:

HHS Secretary- Civil Rights Office
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

MONTEREY COUNTY
DEPARTMENT OF SOCIAL & EMPLOYMENT SERVICES

ADDITIONAL PROVISIONS

I. PAYMENT BY COUNTY:

1.01 Monthly claims by CONTRACTOR: CONTRACTOR shall submit to COUNTY not later than June 30, 2011 a signed invoice, setting forth the amount claimed for services described in Exhibit A-I. The invoice shall be submitted in the form set forth in Exhibit F. CONTRACTOR's invoice shall also be accompanied by a report of expenditures for each subcontractor. COUNTY shall pay for the provision of health benefit services described in Exhibit A-I as set forth in Exhibit A-I, Sections 3.2, 3.3, and 3.5.

1.02 Allowable Costs: Allowable costs shall be the CONTRACTOR's actual costs of developing, supervising and delivering the services under this Agreement, as set forth in the budget, attached hereto as Exhibit C. Only the costs listed in Exhibit C as contract expenses may be claimed as allowable costs. Any dispute over whether costs are allowable shall be resolved in accordance with the provisions of 45 Code of Federal Regulations, Part 74, Sub-Part F and 48 Code of Federal Regulations (CFR), Chapter 1, Part 31.

1.03 Cost Control: CONTRACTOR shall not exceed by more than twenty (20) percent any contract expense line item amount in the budget without the approval of COUNTY, given by and through the Contract Administrator or Contract Administrator's designee. CONTRACTOR shall submit an amended budget with its request for such approval. Such approval shall not permit CONTRACTOR to receive more than the maximum total amount payable under this contract. Therefore, an increase in one line item will require corresponding decreases in other line items.

1.04 Payment in Full:

Payment shall be in accordance with paragraph 3.0 of Exhibit A-I.

1.05 Disputed payment amount: If COUNTY pays a lesser amount than the amount requested, and if CONTRACTOR submits a written notice of protest to COUNTY within twenty (20) days after CONTRACTOR's receipt of the certification, then the parties shall promptly meet to review the dispute and resolve it on a mutually acceptable basis. No court action may be taken on such dispute until the parties have met and attempted to resolve the dispute in person.

II. PERFORMANCE STANDARDS & COMPLIANCE

2.01 Outcome objectives and performance standards: CONTRACTOR shall for the entire term of this Agreement provide the service outcomes set forth in Exhibits A and

EXHIBIT B

A-1. CONTRACTOR shall meet the contracted level of service and the specified performance standards described in Exhibits A and A-I, unless prevented from doing so by circumstances beyond CONTRACTOR's control, including but not limited to, natural disasters, fire, theft, and shortages of necessary supplies or materials due to labor disputes.

2.02 County monitoring of services: COUNTY shall monitor services provided under this Agreement in order to evaluate the effectiveness and quality of services provided.

2.03 Notice of defective performance: The issues of CONTRACTOR performance, service levels and termination of the agreement shall be governed by the provisions of Exhibit A-I.

2.04 Training for Staff: CONTRACTOR shall insure that sufficient training is provided to its volunteer and paid staff, to enable them to perform effectively on the project and to increase their existing level of skills. CONTRACTOR's staff shall be required to attend all training sessions as identified by the COUNTY, including Division 21 Civil Rights training. CONTRACTOR may be excused from attendance only by prior written consent of the Department of Social and Employment Services.

2.05 Bi-lingual Services: CONTRACTOR shall ensure that qualified staff is available to accommodate non-English speaking, and limited English proficient, individuals.

2.06 Assurance of drug free-workplace: CONTRACTOR shall submit to the COUNTY evidence of compliance with the California Drug-Free Workplace Act of 1990, Government Code sections 8350 et seq., by doing the following:

- Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's or organization's workplace and specifying the actions that will be taken against employees for violations of the prohibition;
 - Establishing a drug-free awareness program to inform employees about all of the following:
 - 1) the dangers of drug abuse in the workplace;
 - 2) the organization's policy of maintaining a drug-free workplace;
 - 3) any available drug counseling, rehabilitation, and employee assistance programs;
 - 4) the penalties that may be imposed upon employees for drug abuse violations;
 - 5) requiring that each employee engaged in the performance of the contract or grant be given a copy of the company's drug-free policy statement and that, as a condition of employment on the contract or grant, the employee agrees to abide by the terms of the statement.

III. AUDIT & RECOVERY OF OVERPAYMENTS

3.01 CPA Audit on Termination:

3.01.01 Audit Requirement

At the request of COUNTY, CONTRACTOR shall give to COUNTY an audit or audit reports covering the contract period, prepared by an independent Certified Public Accountant. The audit requirement is for the purpose of determining whether the reported costs are fair and reasonable and have been computed in accordance with generally accepted accounting principles, with the provisions of this Agreement, and with all applicable COUNTY requirements. Such audit shall be performed in accordance with the "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions" as published by the Comptroller General of the United States, and in accordance with generally accepted auditing standards.

3.01.02 Audit Submission /Fiscal Year-end

CONTRACTOR shall provide COUNTY with the audit, or audit report, required herein no later than 120 days after the close of CONTRACTOR's Fiscal Year. If CONTRACTOR's fiscal records adhere to a Fiscal Year different from COUNTY's, then CONTRACTOR's audit will include a schedule(s) coinciding with COUNTY's Fiscal Year (July-June), or CONTRACTOR may submit a program specific audit coinciding with COUNTY's Fiscal Year (July-June).

In the case where providing the required audit within the specified time period represents an unreasonable hardship, CONTRACTOR shall alert COUNTY and request an extension. Additional documentation may be requested by COUNTY in order to grant the extension. The submittal of the audit will continue to be required and due no later than six (6) months after the close of CONTRACTOR's fiscal year-end.

3.01.03 Audit Format

CONTRACTOR may submit to COUNTY one of the following in satisfaction of this Audit requirement:

1) An annual independent audit and Management Letter conducted in accordance with Generally Accepted Auditing Standards (GAAS) and Government Auditing Standards (yellow book audit) issued by the Comptroller General of the United States. The audit should include as a footnote or supplemental schedule expenses of the grant program.

-OR-

2) If CONTRACTOR is not required to have an annual independent audit conducted in accordance with *both* Generally Accepted Auditing Standards (GAAS) and Government Auditing Standards (yellow book audit) issued by the Comptroller General of the United States, other than to comply with COUNTY's request, *then* an annual independent audit and Management Letter, conducted only in accordance with Generally Accepted Auditing Standards (GAAS) may be

EXHIBIT B

submitted *as long as the audit includes this grant/program as part of the testing*. The audit must include a footnote or supplemental schedule expenses of the grant program.

COUNTY reserves the right to require a program specific audit at COUNTY's discretion.

3.01.04 Payment for Audit

CONTRACTOR shall bear all costs in connection with, or resulting from, any audit and/or inspections including, but not limited to, actual cost incurred and the payment/repayment of any expenditures disallowed by COUNTY, State or Federal government entities, including any assessed interest and penalties.

If CONTRACTOR is exempt from federal audit procedures under OMB Circular 133, then payment for this audit shall be made by CONTRACTOR with resources other than grant funds, or those used for matching purposes. If CONTRACTOR is not exempt from federal audit procedures under OMB Circular 133, the cost of audits made in accordance with the provisions of this part are allowable charges to Federal awards. The charges may be considered a direct cost or an allocated indirect cost, as determined in accordance with the provisions of applicable OMB cost principles circulars, the Federal Acquisition Regulation (FAR) (48 CFR parts 30 and 31), or other applicable cost principles or regulations.

3.02 Contractor Records

Funds provided by COUNTY shall be accounted for separately in CONTRACTOR's books and records. CONTRACTOR shall keep a systematic accounting record of the receipt and disbursement of COUNTY funds. CONTRACTOR shall permit COUNTY to audit, examine and to copy excerpts and transcripts from such records and to conduct audits or reviews of all records including, but not limited to, invoices, materials, personnel records, bank account records, business records, billing statements, payroll records, business expense records, and any and all other data related to matters covered by this Agreement. CONTRACTOR shall maintain such data and records in an accessible location and condition for a period of at least three (3) years from the close of this Agreement term, or until after the conclusion of any audit, whichever occurs last. The State of California and/or any Federal agency providing funds for this Agreement shall have the same rights conferred upon COUNTY herein. CONTRACTOR shall keep records that are sufficient to permit the tracing of funds to a level of expenditure adequate to ensure that the funds have not been unlawfully spent. CONTRACTOR's records shall describe and support the use of funds for the agreed upon project or services outlined in this Agreement.

3.03 Recovery of Overpayments: If any audit shows that COUNTY has paid to CONTRACTOR any amount in excess of properly allowable costs, then CONTRACTOR shall reimburse COUNTY for that amount, either by a cash payment

EXHIBIT B

made within thirty (30) days after COUNTY notifies CONTRACTOR of the overpayment, or by an offset made by COUNTY against any payments owed by COUNTY to CONTRACTOR under this or any other contract.

IV. CONFIDENTIALITY

CONTRACTOR and its officers, employees, agents, and subcontractors shall comply with Welfare and Institutions (W & I) Code Sec. 10850, 45 CFR Sec. 205.50, and all other applicable provisions of law which provide for the confidentiality of records and prohibit their being opened for examination for any purpose not directly connected with the administration of public social services. Whether or not covered by W&I Code Sec. 10850 or by 45 CFR Sec. 205.50, confidential medical or personnel records and the identities of clients and complainants shall not be disclosed unless there is proper consent to such disclosure or a court order requiring disclosure. Confidential information gained by CONTRACTOR from access to any such records, and from contact with its clients and complainants, shall be used by CONTRACTOR only in connection with its conduct of the program under this Agreement. The COUNTY, through the Director of the Department of Social and Employment Services, and his/her representatives, shall have access to such confidential information and records to the extent allowed by law, and such information and records in the hands of the COUNTY shall remain confidential and may be disclosed only as permitted by law.

V. NON-DISCRIMINATION

CONTRACTOR certifies that to the best of its ability and knowledge it will comply with the nondiscrimination program requirements set forth in this Section.

5.01 Discrimination Defined: The term "discrimination" as used in this contract, is the same term that is used in Monterey County Code, Chapter 2.80 "Procedures for Investigation and Resolution of Discrimination Complaints"; it means the illegal denial of equal employment opportunity, harassment (including sexual harassment and violent harassment), disparate treatment, favoritism, subjection to unfair or unequal working conditions, and/or other discriminatory practice by any Monterey County official, employee or agent, due to an individual's race, color, ethnic group, national origin, ancestry, religious creed, sex, sexual orientation, age, veteran's status, cancer-related medical condition, physical handicap (including AIDS) or disability. The term also includes any act of retaliation.

5.02 Application of Monterey COUNTY Code Chapter 2.80: The provisions of Monterey COUNTY Code Chapter 2.80 apply to activities conducted pursuant to this Agreement. Complaints of discrimination made by CONTRACTOR against the COUNTY, or by recipients of services against CONTRACTOR, may be pursued using the procedures established by Chapter 2.80. CONTRACTOR shall establish and follow its own written procedures for the prompt and fair resolution of discrimination complaints made against CONTRACTOR by its own employees and agents, and shall provide a copy of such procedures to COUNTY on demand by COUNTY.

EXHIBIT B

5.03 Compliance with laws: During the performance of this Agreement, CONTRACTOR shall comply with all applicable federal, state and local laws and regulations which prohibit discrimination, including but not limited to the following:

- **California Fair Employment and Housing Act**, California Government Code Sec. 12900 et seq., see especially Section 12940 (c), (h), (1), (i), and (j); and the administrative regulations issued thereunder, 2 Calif. Code of Regulations Secs. 7285.0 et seq. (Division 4 - Fair Employment and Housing Commission);
- **California Government Code Secs. 11135 - 11139.5**, as amended (Title 2, Div. 3, Part 1, Chap. 1, Art. 9.5) and any applicable administrative rules and regulations issued under these sections; including **Title 22 California Code of Regulations 98000-98413**.
- **Federal Civil Rights Acts of 1964 and 1991** (see especially Title VI, 42 USC Secs. 2000d et seq.), as amended, and all administrative rules and regulations issued thereunder (see especially 45 CFR Part 80);
- **The Rehabilitation Act of 1973**, Secs. 503 and 504 (29 USC Sec. 793 and 794), as amended; all requirements imposed by the applicable HHS regulations (45 CFR Parts 80, 84 and 91); and all guidelines and interpretations issued pursuant thereto;
- **7 Code of Federal Regulations (CFR)**, Part 15 and **28 CFR** Part 42;
- **Title II of the Americans with Disabilities Act of 1990** (P.L. 101-336), 42 U.S.C. Secs. 12101 et seq. and 47 U.S.C. Secs. 225 and 611, and any federal regulations issued pursuant thereto (see 24 CFR Chapter 1; 28 CFR Parts 35 and 36; 29 CFR Parts 1602, 1627, and 1630; and 36 CFR Part 1191);
- **Unruh Civil Rights Act**, Calif. Civil Code Sec. 51 et seq., as amended;
- **Monterey COUNTY Code**, Chap. 2.80.;
- **Age Discrimination in Employment Act 1975**, as amended (ADEA), 29 U.S.C. Secs 621 et seq.;
- **Equal Pay Act of 1963**, 29 U.S.C. Sec. 206(d);
- **California Equal Pay Act**, Labor Code Sec.1197.5.
- **California Government Code Section 4450**;

EXHIBIT B

- **The Dymally-Alatorre Bilingual Services Act; Calif. Government Code Sec. 7290 et seq.**
- **The Food Stamp Act of 1977, as amended and in particular Section 272.6.**
- **California Code of Regulations, Title 24, Section 3105A(e)**
- **Removal of Barriers to Inter-Ethnic Adoption Act of 1996, Section 1808**

5.04 Written assurances: Upon request by COUNTY, CONTRACTOR will give any written assurances of compliance with the Civil Rights Acts of 1964 and 1991, the Rehabilitation Act of 1973 and/or the Americans with Disabilities Act of 1990, as may be required by the federal government in connection with this Agreement, pursuant to 45 CFR Sec. 80.4 or 45 CFR Sec. 84.5, and 91; 7 CFR Part 15; and 28 CFR Part 35, or other applicable State or federal regulation.

5.05 Written non-discrimination policy: Contractor shall maintain a written statement of its non-discrimination policies which shall be consistent with the terms of this Agreement. Such statement shall be available to employees, recipients of services, and members of the public, upon request.

5.06 Grievance Information: CONTRACTOR shall advise applicants who are denied CONTRACTOR's services, and recipients who do receive services, of their right to present grievances, and of their right to a State hearing concerning services received under this Agreement.

5.07 Notice to Labor Unions: CONTRACTOR shall give written notice of its obligations under paragraphs 5.01 - 5.08 to labor organizations with which it has a collective bargaining or other agreement.

5.08 Access to records by government agencies: CONTRACTOR shall permit access by COUNTY and by representatives of the State Department of Fair Employment and Housing, and any state agency providing funds for this Agreement, upon reasonable notice at any time during normal business hours, but in no case less than 24 hours' notice, to such of its books, records, accounts, facilities, and other sources of information as the inspecting party may deem appropriate to ascertain compliance with these non-discrimination provisions.

5.09 Binding on Subcontractors: The provisions of paragraphs 5.01 - 5.08 shall also apply to all of CONTRACTOR's subcontractors. CONTRACTOR shall include the non-discrimination and compliance provisions of these paragraphs in all subcontracts to perform work or provide services under this Agreement.

VI. CONTRACT ADMINISTRATORS

6.01 Contract Administrator – CONTRACTOR: CONTRACTOR hereby designates Alan McKay as its Contract Administrator for this Agreement. All matters concerning this Agreement which are within the responsibility of CONTRACTOR shall be under the direction of, or shall be submitted to, the CONTRACTOR's Contract Administrator. CONTRACTOR may, in its sole discretion, change its designation of the Contract Administrator, and shall promptly give written notice to COUNTY of any such change.

6.02 Contract Administrator – COUNTY: COUNTY hereby designates the Director of the Monterey County Department of Social and Employment Services as its Contract Administrator for this Agreement. All matters concerning this Agreement which are within the responsibility of COUNTY shall be under the direction of, or shall be submitted to, the Director or such other COUNTY employee in the Department of Social and Employment Services as the Director may appoint. COUNTY may, in its sole discretion, change its designation of the Contract Administrator, and shall promptly give written notice to CONTRACTOR of any such change.

VII. CONTRACT DEPENDENT ON GOVERNMENT FUNDING

COUNTY's payments to CONTRACTOR under this Agreement are funded by the State and Federal governments. If funds from State and Federal sources are not obtained and continued at a level sufficient to allow for COUNTY's purchase of the indicated quantity of services, then COUNTY may give written notice of this fact to CONTRACTOR, and the obligations of the parties under this Agreement shall terminate immediately, or on such date thereafter, as COUNTY may specify in its notice, unless in the meanwhile the parties enter into a written Amendment modifying this Agreement.

VIII. LOBBYING CERTIFICATION

The Contractor, by signing this Agreement, hereby certifies, to the best of his/her knowledge and belief, that, on behalf of him/herself, employees, and/or agents:

1. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

EXHIBIT B

3. The Contractor shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including subgrants, and contracts under grants, loans, and cooperative agreements which exceed \$100,000) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. This certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Program BUDGET

**Central California Alliance for Health
FY 2011-12**

	Hourly Rate	Projected Service Hours	Budget Total
Health Plan Benefits	\$ 0.60	3,260,800.00	\$ 1,956,480.00
Funding for FY 2011-12		not to exceed:	\$ 1,956,480.00

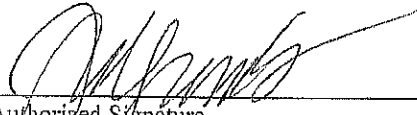
Projected Service Hours and funds available will be determined at the beginning of each contract year.

**ELDER & DEPENDENT ADULT
ABUSE & NEGLECT REPORTING
CERTIFICATION**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

HEREBY acknowledges that this contract for services will bring CONTRACTOR in contact with elders or dependent adults, and that CONTRACTOR has received from COUNTY a copy of Welfare & Institutions Code Section 15659 as required by the Elder Abuse and Dependent Adult Civil Protection Act (Welfare & Institutions Code Sections 15600, et seq). CONTRACTOR certifies that it has knowledge of the provisions of the Act, and will comply with its provisions which define a mandated reporter, and requires that reports of abuse or neglect be made by a mandated reporter when, in his or her professional capacity, or within the scope of his or her employment, he/she observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect.

CONTRACTOR further gives assurance that all of its employees, consultants, and agents performing services under this Agreement, who are mandated reporters under the Act, sign statements indicating that they know of and will comply with the Act's reporting requirements.



Authorized Signature

05-11-11

Date

Elder/Adult Abuse Reporting
During Regular Business hours (831) 755-3403
After hours - Call 911

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made effective the 1st day of July, 2011 by and between **Monterey County**, hereinafter referred to as "Covered Entity", and **Central California Alliance for Health**, hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of Covered Entity as defined in the HIPAA Privacy Rule (the agreement evidencing such arrangement is entitled **Agreement for the provision of health plan benefits for In-Home Supportive Services providers**, dated July 1, 2011, and is hereby referred to as the "Arrangement Agreement"); and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

THEREFORE, in consideration of the Parties' continuing obligations under the Arrangement Agreement, compliance with the HIPAA Privacy Rule, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Privacy Rule and to protect the interests of both Parties.

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Privacy Rule, as amended, the HIPAA Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Privacy Rule, but are nonetheless permitted by the HIPAA Privacy Rule, the provisions of this Agreement shall control.

The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Business Associate acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or is created or received by Business Associate on Covered Entity's behalf shall be subject to this Agreement.

II. CONFIDENTIALITY REQUIREMENTS

(a) Business Associate agrees:

(i) to use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and the HIPAA Privacy Rule), or the HIPAA Privacy Rule, and (3) as would be permitted by the HIPAA Privacy Rule if such use or disclosure were made by Covered Entity;

(ii) at termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and

(iii) to ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement.

(b) Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:

(i) if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:

(A) the disclosure is required by law; or

(B) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

(ii) for data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate with the protected health information received by Business Associate in its

capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

(c) Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practices related to use and disclosure of Protected Health Information to ensure Covered Entity's compliance with the terms of the HIPAA Privacy Rule. Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

III. AVAILABILITY OF PHI

Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Privacy Rule. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Privacy Rule. In addition, Business Associate agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by Section 164.528 of the HIPAA Privacy Rule.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement and, where practicable, Covered Entity gives written notice to Business Associate of such belief within a reasonable time after forming such belief, and Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

V. MISCELLANEOUS

Except as expressly stated herein or the HIPAA Privacy Rule, the parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the State of California. No change, waiver or discharge of any liability or obligation hereunder

on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Privacy Rule, such party shall notify the other party in writing. For a period of up to thirty days, the parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Privacy Rule, then either party has the right to terminate upon written notice to the other party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:
County of Monterey

By: *Dave Potter*

Title: Vice-Chair, Monterey County
Board of Supervisors

Date: *6/23/11*

BUSINESS ASSOCIATE:
Central California Alliance for Health

By: *[Signature]*

Title: *Vice Chair*

Date: *5-11-11*

INVOICE

EXHIBIT F

Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Bill to:

Monterey County
Attention: Auditor-Controller
1000 S. Main Street
Salinas, CA 93901

Date

INVOICE #1

PO Number Project: Caregiver

Description:

XXXX
XXX

Total

See attachments enclosed

Alan McKay, Executive Director