Monterey County

168 West Alisal Street,
1st Floor
Salinas, CA 93901
831.755.5066

Board Order

Agreement No.: A-12933

Upon motion of Supervisor Parker, seconded by Supervisor Phillips and carried by those members present, the Board of Supervisors hereby:

a. Approved and authorized the Chair of the Board of Supervisors to sign an agreement with the Central California Alliance for Health for $1,794,540 to provide health plan benefits for eligible In-Home Supportive Services (IHSS) providers for the period July 1, 2015 to June 30, 2016, including the non-standard Termination provision in Exhibit A-I, Sections 4.0 through 5.1, and non-standard Mutual Indemnification provisions in Exhibit A-I, Sections 9.14 and 9.15; and
b. Authorized the Chair of the Board of Supervisors to sign up to (3) amendments to this agreement where the total amendments do not exceed 10% of the original contract amount, and do not significantly change the scope of work.

PASSED AND ADOPTED on this 7th day of July 2015, by the following vote, to wit:

AYES: Supervisors Armenta, Phillips, 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 78 for the meeting on July 7, 2015.

Dated: July 14, 2015
File ID: A 15-237
Corrected: September 10, 2015

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

By Denise Hancock
Deputy

COUNTY OF MONTEREY STANDARD AGREEMENT
(MORE THAN $100,000)

This 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:

1.0 GENERAL DESCRIPTION.

1.01 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 goods and/or services are generally described as follows:
Provide health plan benefits for In-Home Supportive Services providers.

2.0 PAYMENT PROVISIONS.

2.01 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 $ 1,794,540.00 .

3.0 TERM OF AGREEMENT.

3.01 The term of this Agreement is from July 1, 2015 to June 30, 2016, 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.**

3.02 The County reserves the right to cancel this Agreement, or any extension of this Agreement, without cause, with a thirty day (30) written notice, or with cause immediately.

4.0 SCOPE OF SERVICES AND ADDITIONAL PROVISIONS.

4.01 The following attached exhibits are incorporated herein by reference and constitute a part of this Agreement:

Exhibit A **Scope of Services/Payment Provisions**

See List of Exhibits, Page 10 (a)

5.0 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.

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.

6.0 PAYMENT CONDITIONS.

6.01 Prices shall remain firm for the initial term of the Agreement and, thereafter, may be adjusted annually as provided in this paragraph. The County does not guarantee any minimum or maximum amount of dollars to be spent under this Agreement.

6.02 Negotiations for rate changes shall be commenced, by CONTRACTOR, a minimum of ninety days (90) prior to the expiration of the Agreement. Rate changes are not binding unless mutually agreed upon in writing by the County and the CONTRACTOR.

6.03 Invoice amounts shall be billed directly to the ordering department.

6.04 CONTRACTOR shall 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. The County 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.

7.0 TERMINATION.

(See Exhibit A-I-A, Sections 4.0 through 5.1)

~~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.~~

~~7.03 The County's payments to CONTRACTOR under this Agreement are funded by local, state and federal governments. If funds from local, state and federal sources are not obtained and continued at a level sufficient to allow for the County's purchase of the indicated quantity of services, then the 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 the County may specify in its notice, unless in the meanwhile the parties enter into a written amendment modifying this Agreement.~~

8.0 INDEMNIFICATION.

(See Exhibit A-1-A, Sections 9.14 and 9.15)

~~8.01 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.~~

9.0 INSURANCE REQUIREMENTS.

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 the County has approved such insurance. 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, Broad form 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.

(Note: any proposed modifications to these general liability insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County 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.

(Note: any proposed modifications to these auto insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County 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.

(Note: any proposed modifications to these workers' compensation insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County 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.

(Note: any proposed modifications to these insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County approval.)

9.04 Other 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.

10.0 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.

11.0 NON-DISCRIMINATION.

11.01 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.

12.0 COMPLIANCE WITH TERMS OF STATE OR FEDERAL GRANTS.

12.01 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.

13.0 INDEPENDENT CONTRACTOR.

13.01 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.

14.0 NOTICES.

14.01 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:
Bertha Gonzalez, MA II	Alan McKay, ~~Executive Director~~ Chief Executive Officer
Name and Title	Name and Title
1000 South Main Street, Suite 211C Salinas, CA 93901	1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066
Address	Address
(831) 755-4904 fax: (831) 757-9226	(831) 430-5500
Phone	Phone

15.0 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 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 section left blank intentionally*----------

16.0 SIGNATURE PAGE.

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

COUNTY OF MONTEREY	CONTRACTOR
By: _____ Contracts/Purchasing Officer	Central California Alliance for Health Contractor's Business Name*
Date: _____	By: _____ (Signature of Chair, President, or Vice-President)*
By: _____ Department Head (if applicable)	Chairperson Name and Title
Date: _____	Date: 6·16·15
By: _____ Board of Supervisors (if applicable)	By: _____ (Signature of Secretary, Asst. Secretary, CFO, Treasurer or Asst. Treasurer)*
Date: July 8, 2015	CFO Name and Title
Approved as to Form[1]	Date: 6·18·15
By: _____ Deputy County Counsel	
Date: 6/23/15	
Approved as to Fiscal Provisions[2]	
By: _____ Auditor/Controller	
Date: 6-24-15	
Approved as to Liability Provisions[3]	
By: _____ Risk Management	
Date: _____	

County Board of Supervisors' Agreement Number: A-12784, **approved on (date):** 7-7-15

*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.

[1]Approval by County Counsel is required
[2]Approval by Auditor-Controller is required
[3]Approval by Risk Management is necessary only if changes are made in paragraphs 8 or 9

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

LIST OF EXHIBITS

EXHIBIT A

SCOPE OF SERVICES/PAYMENT PROVISIONS

Central California Alliance for Health

July 1, 2015 - June 30, 2016

I. CONTACT INFORMATION

For Contractor:

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

For County:

Bertha Gonzalez, MA II
1000 S. Main Street, Suite 211C
Salinas, CA 93901
Phone: (831) 755-4904
Fax: (831) 757-9226
gonzalezb@co.monterey.ca.us

1. **Exhibit A-I** of the Agreement 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 Standard Agreement (more than $100,000), in the event of any conflict or inconsistency between the provisions of **Exhibit A-I** 'Group Agreement' and other attachments or exhibits including, but not limited to, the County of Monterey Standard Agreement (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 issue payment for health premiums which are due by the first of every month, but no later than the fifth (5th) of the month for IHSS Providers enrolled in the health plan, per **Exhibit A-I-B**.

COUNTY shall reimburse CONTRACTOR a total amount not to exceed **$1,794,540.00** for the period **July 1, 2015 through June 30, 2016.**

EXHIBIT A-I

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, 2015.

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, 2015

Monterey County
Board of Supervisors

Signature of Chair
Name July 8, 2015
Simon Salinas
Date

Santa Cruz – Monterey – Merced
Managed Medical Care
Commission

Signature of Chair
Deidre Kelsey

Date 6·16·15

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ATTACHMENT A-I-A

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 this Agreement between the PLAN and the Contract Holder which constitutes the agreement regarding the benefits, exclusions and other conditions between the PLAN and Contract Holder.

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:

3.1.1.1 upon parties written agreement to amend Attachment A-I-B of this Group Agreement;

3.1.1.2 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 thirty (30) 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. The 30 day grace period is further detailed in Section 4.3.1 of this Agreement.

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 first day after the expiration of the grace period.

SECTION IV
TERM AND TERMINATION

4.0 Effective Date

This agreement shall become effective on July 1, 2015.

4.1 Term

The term of this Agreement is July 1, 2015 through June 30, 2016.

4.2 Termination Notices

4.2.1 If Contract Holder initiates the termination, written notice will be transmitted by Contract Holder to PLAN by Certified U.S. Mail, UPS, FedEX, or other traceable

mail service, proper postage prepaid and properly addressed to the office of the PLAN as provided below:

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

4.2.2 If the PLAN initiates the termination, written notice of cancellation will be transmitted by the PLAN 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, Suite 211
Salinas, CA 93901

4.3 Termination by the PLAN

4.3.1 Termination for nonpayment

If Contract Holder fails to make a payment that is due and payable, the PLAN may terminate this Agreement consistent with this section. The PLAN may initiate the termination by sending the Contract Holder a notice of cancellation no later than five (5) business days after the last day of paid coverage.

The Contract Holder will be given a thirty (30) day grace period to pay the premiums that are due. The grace period will begin on the first day after the last day of paid coverage. During the grace period, the Members will continue to be treated as Members of the PLAN, which includes Members continuing to receive care and the PLAN continuing to pay claims for services provided to Members.

If the Contract Holder fails to pay the premium due by the expiration of the 30 day grace period, this Agreement may be terminated effective at the end of the grace period. The Contract Holder will remain responsible for any unpaid premium.

4.3.2 Termination for withdrawal from the group market

4.3.2.1 PLAN's withdrawal of this product from the group market.

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

4.3.2.1.1 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 ninety (90) days written notice to the Contract Holder; or

4.3.2.1.2 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 4.3.2.2 of this Agreement.

4.3.2.2 PLAN's withdrawal from the group market

In the event that PLAN ceases to offer coverage in the group market, the PLAN will provide the Contract Holder with one hundred and eighty (180) days prior written notice of the termination.

4.3.3 Termination Due to Loss of Eligibility

PLAN or Contract Holder may terminate a Member for failure to meet the applicable eligibility requirements, which includes: failure to meet time-based employment requirements, group participation requirements, or service area requirements.

The Contract Holder will provide thirty (30) days written notice when cancelling or termination of coverage due to Member's loss of eligibility.

4.4 Termination by the Contract Holder

Contract Holder may terminate this Agreement at any time upon sixty (60) days written notice to PLAN.

4.4.1 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.

4.4.2 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.

4.5 Termination by either Contract Holder or PLAN for fraud or intentionally furnishing incorrect or incomplete information

Either party may terminate this Agreement upon thirty (30) days prior written notice to the other party, if the other party commits fraud or intentionally furnishes incorrect or incomplete material information to the noticing party.

4.6 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 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

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. Amendments to this Agreement shall only be effective, provided it is in writing and signed by duly authorized representatives of both Parties.

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. Member Termination for Fraud or Misrepresentation

A Member can be terminated for Fraud or Material Misstatements in a manner consistent with the provisions in Member's Evidence of Coverage.

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 Section 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.

ATTACHMENT A-I-B

PREMIUM SCHEDULE
(July 1, 2015 – June 30, 2016)

Premium .....$309/per member/per month

ATTACHMENT A-I-C

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.

ATTACHMENT A-I-E

Alliance Care
IHSS Health Plan

Member Handbook
Combined Evidence of Coverage
and Disclosure Form

Central California Alliance for Health

1-800-700-3874 Toll Free
1-877-548-0857 TTY Line

www.ccah-alliance.org

Benefit Year July 1, 2015 –June 30, 2016

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will be provided through the use of a telephone language line. 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 handbook, 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**.

Member Identification Card

All Members of the Plan 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** 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 Plan 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. If you let someone else use your Member Identification Card, the Alliance may not be able to keep you in the Plan.

Alliance Nurse Advice Line

When you have health questions, the Alliance Nurse Advice Line is a good place to start. It's free, fast and easy. You won't spend hours waiting in the emergency room. You'll get expert advice and quick answers to your health care questions.

The Alliance Nurse Advice Line connects you to a registered nurse for a one-on-one conversation to discuss your health problem. The nurse can help you decide:

- If you need to see a doctor.
- If it is safe to wait or if you need care right away.
- What to do if your symptoms get worse.
- What you can do at home to feel better.

The Alliance Nurse Advice Line is available 24 hours a day, 7 days a week. Call toll-free at 1-844-971-8907. The phone number is also on your Alliance ID card. Hearing or speech impaired members can call 1-800-735-2929.

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.
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Copayment

A fee for a particular covered benefit which a provider collects directly from a Member at the time the service is rendered. Also called a "copay".

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.

Evidence of Coverage and Disclosure Form (EOC)

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

Exclusion

Any medical, surgical, hospital or other treatment for which the Plan 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.

Formulary

A list of generic and brand-name prescription drugs approved for coverage and available without prior authorization from the Plan. 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.

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 the Plan'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 Plan's Service Area and who is not designated by the Plan as a Local Out of Service Area Provider.

Participating Mental Health Provider
A physician, hospital, licensed professional or qualified autism service provider, professional or paraprofessional that, at the time care is rendered to a Member, has a written agreement in effect with the Plan or its sub-contractor, to provide covered mental health care services to its Members.

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 the Plan to provide covered services to Members in accordance with the terms of this agreement.

Plan Provider or Contracted 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, entered into a written agreement with the Plan 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 the Plan or is employed by a clinic contracted with the Plan 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 handbook. 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.

Triage or Screening

The assessment of a Member's health concerns via communication, with a doctor, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care, for the purpose of determining the urgency of the Member's need for care.

Triage or Screening Waiting Time

The time waiting to talk by telephone with a doctor, registered nurse, or other qualified professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care.

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 the Plan, or about health care services you received, to the Plan.
- Receive information about the Plan, 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 Plan correct information.

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 Plan 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 or in the online directory at **www.ccah-alliance.org,** you will find a list of doctors and clinics that are contracted with the Plan. 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 Plan 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.

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.r
- You make appointments but do not show up for them or call to cancel.
- 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 Plan, 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 Plan will provide continuity of care for new Members who are receiving medical services from a Non-Contracted Provider, such as a doctor or hospital, when the Plan determines that continuing treatment with a Non-Contracted Provider is medically appropriate. If you are a new Member, you may request permission to continue receiving medical services from a Non-Contracted Provider if you were receiving this care before enrolling in the Plan 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 Plan in consultation with you and the Non-Contracted Provider and consistent with good professional practice. Completion of covered services may not exceed twelve (12) months from the time you enroll with the Plan.
- 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 Plan.
- 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-Contracted Provider to occur within one hundred eighty (180) days of the time you enroll with the Plan.
- 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.

- 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-Contracted 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 Plan 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 file a complaint. For more information about filing a complaint, please see the section of this document called, "The Grievance Process".

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 TTY 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 Plan must authorize the services before you receive them. Mental health and substance use disorder services requiring prior authorization must be authorized by the Plan's Contractor, OptumHealth.

Your PCP or the treating provider will obtain the necessary referrals and authorizations for you. Prior authorization means that both your doctor and the Plan or the Plan's Contractor agree that the services you will get are medically necessary. If you need something that requires prior authorization, the health care provider will submit 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, orthotics and nebulizers.
- Some outpatient diagnostic tests, such as MRIs and PET scans.

Your PCP will refer you to an In Service Area Contracted Provider or a Local Out of Service Area Provider. If there are none available to see you, your PCP may request authorization from the Plan to refer you to an In Service Area Non-Contracted Provider 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 for a 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 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 Plan to request a list of In Service Area Contracted Providers or Local Out of Service Area Providers who have demonstrated expertise in treating the condition or disease for which you have been given a standing referral. If there are no In Service Area Contracted Providers or Local Out of Service Area Providers available to treat your condition or disease, your PCP may request authorization from the Plan to refer you to an In Service Area Non-Contracted or an Out of Area Provider. If you have any difficulty getting a standing referral, call Member Services at **1-800-700-3874**. If you feel that your needs have not been met after calling us, please see the grievance section of this document called "The Grievance Process".

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 Plan'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.

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 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 Plan covers urgent care services any time you are outside our Service Area or on nights and weekends when you are

without prior authorization. If you are not sure if your condition is urgent, call your PCP if you are able.

You can also call the Alliance's Nurse Advice Line at 1-844-971-8907, 24 hours a day, 7 days a week at no cost to you. Hearing or speech impaired members can call the Alliance's Nurse Advice Line through the California Telecommunications Relay Service at 1-800-735-2929 (TTY/TDD) or 1-800-854-7784 (speech-to-speech).

Post Stabilization and Follow-up Care After an Emergency

Once your emergency medical condition has been treated at a hospital and an emergency no longer exists because your condition is stabilized, the doctor who is treating you may want you to stay in the hospital for a while longer before you can safely leave the hospital. The services you receive after an emergency condition is stabilized are called "post-stabilization services."

If the hospital where you received emergency services is a Non-Contracted Hospital, it must contact the Plan to get approval for the post-stabilization stay. If the Plan approves your continued stay in the Non-Contracted Hospital, you will not have to pay for services except for any copayments normally required by the Plan.

If the Plan has notified the Non-Contracted Hospital that you can safely be moved to one of the Plan's Contracted Hospitals, the Plan will arrange and pay for you to be moved.

If the Plan determines that you can be safely transferred to a Contracted Hospital, and you do not agree to you being transferred, the Non-Contracted Hospital must give you a written notice stating that you will have to pay for all of the cost of post-stabilization services provided to you at the Non-Contracted Hospital after your emergency condition is stabilized.

Also, you may have to pay for services if the Non-Contracted Hospital cannot find out what your name is and cannot get contact information at the Plan to ask for approval to provide services once you are stable.

If you think that you were wrongly billed for services that you received from a Non-Contracted Hospital following an emergency, contact the Alliance's Member Services Department at **1-800-700-3874**, Monday-Friday, between 8:00 a.m. and 6:00 p.m.

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 Plan 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.

Services to Keep You Well

The Plan 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).

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.

For Female Patients Only			
Test	**Ages 18–39**	**Ages 40–64**	**Ages 65+**
Bone Health			Discuss one-time screening with your doctor.
Chlamydia Exam (For sexually active women)	Every year for ages 16– 24 if sexually active. Age 25 and older, only if at high risk, even if pregnant	Age 40 and older, only if at high risk, even if pregnant.	Age 65 and older, if at high risk.

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 Plan. 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 Plan 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.

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.	▪ $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 contracted facilities.	$25 per visit (waived if the Member is admitted to the hospital).
Mental Health Care Services	Diagnosis and treatment of a mental health condition.	

Benefits*	Services	Cost to Member (copayment)
Chiropractic	Requires a referral from the Member's PCP and prior authorization from the Alliance. Services must be obtained from an In Service Area Contracted Provider.	$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. Services must be obtained from an In Service Area Contracted Provider.	$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.

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 are covered for neuromuscular conditions that have been proven to respond to that treatment. You must have a referral from your Primary Care Provider and treatment must be authorized by the Plan. Services must be obtained from an In Service Area Contracted Provider.

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

Coverage for clinical trials may be restricted to contracted 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 PCP.

Diagnostic X-Ray and Laboratory Services

Cost to Member

No copayment
Members must receive services from a Contracted lab except for emergency services.

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).

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 Plan's Service Area, and in Contracted and Non-Contracted facilities.

Family Planning Services

Cost to Member

No copayment

Description

Services must be obtained from an In Service Area Contracted Provider. Voluntary family planning services are covered, including:

- Office visits including lab and x-ray services and pregnancy tests.
- Counseling and surgical procedures for sterilization, as permitted by state and federal law.
- Diaphragms and 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 Plan at **1-800-700-3874** to ensure that you can obtain the health care services that you need.

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 Plan 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.

Maternity Care

Cost to Member

No copayment

Description

Services must be obtained from an In Service Area Contracted 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.
- 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, unless an extended stay is authorized by the Plan. 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 cesarean 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 Plan 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 Plan offers a $25 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 Plan.

Mental Health Care Services - Outpatient

Cost to Member

$10 per visit

Description

Mental health care services when ordered and performed on an outpatient basis by a Participating Mental Health Provider. Prior authorization is required for some services.

Office visits for counseling or medication management do not require prior authorization, but the member or provider must Optum intake and customer service staff.

For non-routine services such as extended counseling services beyond 45 minutes in length, psychological testing, Behavioral Health Treatment or other non-routine services, the provider must request prior authorization from Optum. The requesting provider may be the member's Alliance PCP or an appropriately licensed or certified psychiatrist, psychologist, clinical social worker or therapist. The request will be reviewed by appropriately qualified professionals who will gather critical and relevant clinical information needed to make determination.

Covered services include:

- Partial hospital program.
- Intensive outpatient program (IOP) services.
- Behavioral health therapy (BHT) for the treatment of pervasive developmental disorder (PDD) or autism.
- Treatment of serious emotional disturbances of a child (SED).
- Treatment of a severe mental illness (SMI). Severe mental illnesses include, but are not limited to the following:
  - Schizophrenia.
  - Schizoaffective disorder.
  - Bipolar disorder (manic depressive illness).
  - Major depressive disorder.
  - Panic disorder.
  - Obsessive-compulsive disorder.
  - Pervasive developmental disorder, including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder and Asperger's Disorder.

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).

- Non-rigid devices such as elastic knee supports, corsets and elastic stockings.
- Dental appliances.
- Duplicate devices for the same condition.
- The cost to replace orthoses that you damage or lose.

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 contracted pharmacies.
- $5 copayment for contraceptive devices.

*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

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

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.
- Human Immunodeficiency Virus (HIV) testing.
- Cytology examinations on a reasonable periodic basis.
- Well Woman exams (pelvic exam, Pap smear, and breast exam) and any other gynecological service from your PCP or an In Service Area Contracted OB/GYN Provider.
- 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, except:

- 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 when it is billed and performed as a medical service separate from an office visit, 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 and contracted with the Plan. 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.

Rehabilitative (Physical, Speech and Occupational) Therapy

Cost to Member

- No copayment for inpatient therapy services, including services received in a skilled nursing facility.
- $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 Plan 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 prior authorization from the Plan.

The Plan 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 this 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 Plan 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 section of this document called, "The Grievance Process".
- 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 Plan shall provide services at the time of need, and the Member shall cooperate to assure that the Plan is reimbursed for such benefits.

You are not required to file a complaint with the Plan 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 Plan in which you ask for an expedited review, the Plan 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 Plan 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 Plan will provide coverage for the health care services.

You can apply for an IMR if your Health Plan:

- Denies, changes or delays a service or treatment because the plan determines it is not medically necessary.
- Will not cover an experimental or investigational treatment for a serious medical condition.
- Will not pay for emergency or urgent medical services that you have already received.

If your complaint qualifies for expedited review, you are not required to file a complaint with the Plan prior to requesting an IMR. Also, the DMHC may waive the requirement that you follow the Plan'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.**

Prepayment of Fees

The Plan 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 Plan 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 Plan, 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, 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 Plan on the agreed upon due date, then the Plan will provide the Group with a thirty-day grace period. If premiums are not paid by the end of the grace period, then the Plan may cancel the Agreement. The Group will promptly mail to each Member a legible, true copy of the notice of termination no less than thirty (30) 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).

Cancellation by Group

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

Cancellation of Individual Members

Loss of Eligibility

If you cease to meet the eligibility requirements as defined in this EOC, then (subject to any applicable provisions for continuation of coverage) the Group will provide written notice to you at least thirty (30) days prior to the termination of coverage. Your coverage will terminate at midnight on the 30th day. The Group agrees to notify the Alliance immediately if you cease to meet the eligibility requirements as set forth by the Group.

If you cease to meet the eligibility requirements because you have not paid your premiums, the Group will send you a thirty-day grace period notice in writing. If you do not pay any required premiums by the end of the grace period, your coverage will be terminated. Please make sure to contact the Group if you have any questions regarding maintaining your eligibility.

Members will be sent written notice before coverage is terminated for any reason.

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.

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.

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 Plan 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 Plan 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 Plan for each of the services they give you. The Plan 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 Plan 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 Plan 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 Plan'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.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	▪ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. ▪ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee. ▪ We may say "no" to your request for certain types of records, such as psychotherapy notes or information for use in civil, criminal or administrative actions. If we deny your request, we will tell you the reason why in writing. ▪ You may have the right to have a licensed health care professional review the denial. We will let you know if this right is available.
Ask us to correct health and claims records	▪ You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. ▪ We may say "no" to your request, but we will tell you why in writing within 60 days. ▪ If your request is denied, you have the right to send us a statement to include in the record.
Request confidential communications	▪ You can ask us to contact you in a specific way (for example, using your home or work phone) or to send mail to a different address. ▪ We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	▪ You can ask us not to use or share certain health information for treatment, payment, or our operations. ▪ We are not required to agree to your request, and we may say "no" if it would affect your care. ▪ We are required to agree to your request, if you ask us not to share information with a health plan if you or someone else, other than the health plan, have paid for the care in full and when the disclosure is not required by law.

Our Uses and Disclosures

How do we typically use or share your health information. We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	▪ We can use your health information and share it with professionals who are treating you.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can make sure the services are medically necessary and are covered benefits.
Run our organization	▪ We can use and disclose your information to run our organization and contact you when necessary. ▪ We can also use and disclose your information to contractors (Business Associates) who help us with certain functions. They must sign an agreement to keep your information confidential before we share it with them. ▪ **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	**Example:** We use health information about you to develop better services for you. **Example:** We share your name and address with a contractor to print and mail our member identification cards.
Pay for your health services	▪ We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you with any other health insurance plan you have to coordinate payment for your health care.
Administer your plan	▪ We may disclose your health information to your health plan sponsor for plan administration.	**Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information,
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

How You Can Exercise These Rights

You can exercise any of your rights by calling or sending a written request to our Privacy Officer at the address below. For quicker processing, please use our request form, which is on our website at www.ccah-alliance.org.

How to File a Complaint

If you feel your privacy rights have been violated, you may file a complaint with our Privacy Officer. We will not retaliate against you in any way for filing a complaint. Filing a complaint will not affect the quality of the health care services you receive as an Alliance member.

Contact us:
Central California Alliance for Health – Privacy Officer
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
1-800-700-3874 (toll-free)
1-877-548-0857 (TDD – for hearing impaired)

If you are a Medi-Cal member, you may also file a complaint with the California Department of Health Care Services:
Privacy Officer
c/o Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
calling 916-445-4646, or emailing privacyofficer@dhcs.ca.gov

You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights:
200 Independence Avenue SW
Washington, DC 20211
calling 1-877-696-6775, or visiting **www.hhs/gov/ocr/privacy/hipaa/complaints/**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

MONTEREY COUNTY
DEPARTMENT OF SOCIAL SERVICES

ADDITIONAL PROVISIONS

I. PAYMENT BY COUNTY:

1.01 Payments by County: County shall issue payment for health premiums as outlined in **Attachment A-I-B, Premium Schedule,** by the first (1st) of each month, but no later than the fifth (5th) of the month.

1.02 Invoice: COUNTY creates payment document based upon the number of IHSS Providers enrolled in the health plan monthly.

1.03 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 **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.

1.04 Cost Control: CONTRACTOR shall not exceed by more than twenty (20) percent any contract expense line item amount in the budget without the written 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.

1.05 Payment in Full:
(a) If COUNTY certifies and pays the amount requested by CONTRACTOR, such payment shall be deemed payment in full for the month in question and may not thereafter be reviewed or modified, except to permit COUNTY's recovery of overpayments.

(b) If COUNTY certifies and pays a lesser amount than the amount requested, COUNTY shall, immediately upon certification of the lesser amount, notify CONTRACTOR in writing of such certification. If CONTRACTOR does not protest the lesser amount by delivering to COUNTY a written notice of protest within twenty (20) days after CONTRACTOR's receipt of the certification, then payment of the lesser amount shall be deemed payment in full for the month in question and may not thereafter be questioned by CONTRACTOR.

1.06 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 **Exhibit A.** CONTRACTOR shall meet the contracted level of service and the specified performance standards described in **Exhibit A**, 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: COUNTY shall notify CONTRACTOR in writing within thirty (30) days after discovering any defects in CONTRACTOR's performance. CONTRACTOR shall promptly take action to correct the problem and to prevent its recurrence. Such corrective action shall be completed and a written report made to the COUNTY concerning such action not later than thirty (30) days after the date of the COUNTY's written notice to CONTRACTOR.

2.04 Termination for cause: Notwithstanding Section 7.02 of the Agreement, if the corrective actions required above are not completed and the report to the COUNTY not made within thirty (30) days, the COUNTY may terminate this Agreement by giving five (5) days' written notice to CONTRACTOR.

2.05 Remedies for Inadequate Service Levels:

a) For each month that service falls below 80% of the contracted level, CONTRACTOR shall submit to the COUNTY an analysis of the causes of the problem and any necessary actions to be taken to correct the problem. If the problem continues for another month, the COUNTY shall meet with CONTRACTOR to explore the problem and develop an appropriate written corrective action plan with appropriate time frames.

b) If CONTRACTOR does not carry out the required corrective action within the time frame specified, sanctions shall be applied in accordance with funding source regulations.

c) Notwithstanding Section 7.02 of the Agreement, if, after the COUNTY notifies CONTRACTOR of any sanctions to be imposed, CONTRACTOR continues in its failure to take corrective action, then COUNTY may terminate this contract by giving CONTRACTOR five (5) days' written notice.

d) If all appropriate corrective actions are taken but service still falls 80% or more below contracted level, COUNTY and CONTRACTOR may renegotiate the contracted level of service.

2.06 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. Additionally, CONTRACTOR shall ensure that all staff completes Division 21 Civil Rights training.

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

2.08 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. 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 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.

IV. 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.

4.01 **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.

4.02 **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.

4.03 **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;

- **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**

4.04 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.

4.05 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.

4.06 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.

4.07 Notice to Labor Unions: CONTRACTOR shall give written notice of its obligations under paragraphs 4.01 - 4.08 to labor organizations with which it has a collective bargaining or other agreement.

4.08 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.

4.09 Binding on Subcontractors: The provisions of paragraphs 4.01 - 4.08 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.

V. CONTRACT ADMINISTRATORS

5.01 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.

5.02 Contract Administrator – COUNTY: COUNTY hereby designates the Director of the Monterey County Department of Social 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 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.

VI. 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.

VII. APPEAL PROCESS

In the event of a dispute or grievance regarding the terms and conditions of this Agreement, both parties shall abide by the following procedures:

A. CONTRACTOR shall first discuss the problem informally with the designated DSES Contact/Program Analyst. If the problem is not resolved, CONTRACTOR must, within fifteen (15) working days of the failed attempt to resolve the dispute with DSES Contact/Program Analyst, submit a written complaint, together with any evidence, to the DSES Division Deputy Director. The complaint must include a description of the disputed issues, the legal authority/basis for each issue which supports CONTRACTOR's position, and the remedy sought. The Division Deputy Director shall, within fifteen (15) working days after receipt of CONTRACTOR's written complaint, make a determination on the dispute, and issue a written decision and reasons therefore. All written communication shall be pursuant to Section 14. NOTICES of this Agreement. Should CONTRACTOR disagree with the decision of the Division Deputy Director, CONTRACTOR may appeal the decision to the Director of the Department of Social & Employment Services.

B. CONTRACTOR's appeal of the Division Deputy Director's decision must be submitted to the Department Director within ten (10) working days from the date of the decision; be in writing, state the reasons why the decision is unacceptable, and include the original complaint, the decision that is the subject of appeal, and all supporting documents. Within twenty (20) working days from the date of CONTRACTOR'S appeal, the Department Director, or his/her designee, shall meet with CONTRACTOR to review the issues raised on appeal. The Department Director shall issue a final written decision within fifteen (15) working days of such meeting.

C. CONTRACTOR may appeal the final decision of the Department Director in accordance with the procedures set forth in Division 25.1 (commencing with Section 38050) of the Health and Safety Code and the regulations adopted thereunder. (Title 1, Subchapter 2.5 commencing with Section 251, or Subchapter 3 commencing with Section 300, whichever is applicable, of the California Code of Regulations).

D. CONTRACTOR shall continue to carry out the obligations under this Agreement during any dispute.

E. Costs incurred by CONTRACTOR for administrative/court review are not reimbursable by COUNTY.

Program BUDGET

Central California Alliance for Health

Health Plan Benefits

	Hourly Rate	Projected Service Hours	Budget Total
FY 2015-16	$ 0.44	4,067,137.00	$ 1,789,540.00
COBRA			$ 5,000.00
Total Budget Shall Not Exceed:			**$ 1,794,540.00**

EXHIBIT D

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

6·16·15

Date

Elder/Adult Abuse Reporting
During Regular Business hours (831) 755-4466 or 1-800-510-2020
After hours – Call 911

EXHIBIT E

Health Insurance Portability & Accountability Act (HIPAA) Certification

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, CONTRACTOR and COUNTY have entered into an Agreement ("the Agreement") to which this Certification is an attachment whereby CONTRACTOR will provide certain services to COUNTY ; and

WHEREAS, CONTRACTOR may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under the underlying Agreement.

THEREFORE, in consideration of the Parties' continuing obligations under the Agreement, compliance with the HIPAA Privacy Rule, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, CONTRACTOR agrees to the provisions of this Certification and of the HIPAA Privacy Rule and to protect the interests of COUNTY.

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 Certification and mandatory provisions of the HIPAA Privacy Rule, as amended, the HIPAA Privacy Rule shall control. Where provisions of this Certification are different than those mandated in the HIPAA Privacy Rule, but are nonetheless permitted by the HIPAA Privacy Rule, the provisions of this Certification 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.

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

II. CONFIDENTIALITY REQUIREMENTS

(a) CONTRACTOR 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 COUNTY is required to disclose such information, or as otherwise permitted under this Certification, or the underlying Agreement ,(if consistent with this Certification 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 COUNTY; and

(ii) at termination of the Agreement, (or any similar documentation of the business relationship of the Parties), or upon request of COUNTY, whichever occurs first, if feasible CONTRACTOR will return or destroy all Protected Health Information received from or created or received by CONTRACTOR on behalf of COUNTY that CONTRACTOR still maintains in any form, and retain no copies of such information, or if such return or destruction is not feasible, CONTRACTOR 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(s), to whom it provides Protected Health Information received from or created by CONTRACTOR on behalf of COUNTY, agrees to the same restrictions and conditions that apply to CONTRACTOR with respect to such information. In addition, CONTRACTOR agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause CONTRACTOR to breach the terms of the Agreement.

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

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

(A) the disclosure is required by law; or

(B) CONTRACTOR 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 CONTRACTOR 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 CONTRACTOR for the health care operations of COUNTY pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Certification and the Agreement, data aggregation services means the combining of Protected Health Information by CONTRACTOR with the protected health information received by CONTRACTOR in its capacity as CONTRACTOR of another COUNTY, to permit data analyses that relate to the health care operations of the respective covered entities.

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

III. AVAILABILITY OF PHI

CONTRACTOR agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Privacy Rule. CONTRACTOR 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, CONTRACTOR 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 Certification or the Agreement to the contrary, COUNTY shall have the right to terminate the Agreement immediately if COUNTY determines that CONTRACTOR has violated any material term of this Certification and/or the Agreement. If COUNTY reasonably believes that CONTRACTOR will violate a material term of this Certification and/or the Agreement and, where practicable, COUNTY gives written notice to CONTRACTOR of such belief within a reasonable time after forming such belief, and CONTRACTOR fails to provide adequate written assurances to COUNTY that it will not breach the cited term of this Certification and/or the Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then COUNTY shall have the right to terminate the Agreement immediately.

V. MISCELLANEOUS

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

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

In the event that either party believes in good faith that any provision of this Certification and/or the 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 (30) days, the parties shall address in good faith such concern and amend the terms of this Certification and/or the Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Certification and/or 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.

CONTRACTOR: Central California Alliance for Health

By: [signature]

Title: Chairperson

Date: 6·16·15