File ID 14-662 No. 79

Monterey County

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

Board Order

Agreement No.: A-11489

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

Approved and authorized the Chair of the Board of Supervisors to sign Amendment #4 to Agreement #A-11489 with Central California Alliance for Health (CCAH) for the provision of health plan benefits for In-Home Supportive Service (IHSS) providers adding $2,672,317 for the period July 1, 2014 to June 30, 2015, increasing the total contract amount to $10,189,736.

PASSED AND ADOPTED on this 24th day of June 2014, by the following vote, to wit:

AYES: Supervisors Armenta, Calcagno, Salinas, Parker and Potter
NOES: None
ABSENT: None

I, Gail T. Borkowski, Clerk of the Board of Supervisors of the County of Monterey, State of California, hereby certify that the foregoing is a true copy of an original order of said Board of Supervisors duly made and entered in the minutes thereof of Minute Book 77 for the meeting on June 24, 2014.

Dated: June 30, 2014
File Number: 14-662

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

By Denise Hancock
Deputy

ORIGINAL

COUNTY OF MONTEREY

AMENDMENT #4 to AGREEMENT **#A-11489**

Central California Alliance for Health

This Amendment is made and entered into 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").

The Amendment modifies the agreement for health plan benefits for In-Home Supportive Services providers, between the parties executed on June 23, 2011, and as amended on June 26, 2012, and as amended on August 28, 2012, and as amended on June 25, 2013, (hereinafter, "Original Agreement") **by extending the term of the agreement through June 30, 2015 and adding $2,672,317 for the period July 1, 2014 to June 30, 2015, increasing the total contract amount to $10,189,736**. Therefore, the parties agree:

1. Section 1 of the Original Agreement is amended to read as follows:

   1. SERVICES TO BE PROVIDED: The County hereby engages CONTRACTOR to perform, and CONTRACTOR hereby agrees to perform, the services described in **Exhibit A-4**, in conformity with the terms of this Agreement. The services are generally described as follows: Provide health plan benefits for In-Home Support Services (IHSS) providers.

2. Section 2 of the Original Agreement is amended to read as follows:

   2. PAYMENTS BY COUNTY: COUNTY shall pay the CONTRACTOR in accordance with the payment provisions set forth in **Exhibit A-4,** 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 **$10,189,736.**

3. Section 3 of the Original Agreement is amended to read as follows:

   3. TERM OF AGREEMENT: The term of this Agreement is from July 1, 2011 to **June 30, 2015**, unless sooner terminated pursuant to the terms of this Agreement. This Agreement is of no force or effect until signed by both CONTRACTOR and County, and with County signing last, and CONTRACTOR may not commence work before County signs this Agreement.

4. Section 4 of the Original Agreement is amended to read as follows:

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

Exhibit A-4	**Scope of Services/Payment Provisions**
Exhibit A-I	Group Agreement
Exhibit A-I-A	Terms and Conditions
Exhibit A4-I-B	**Premium Schedule**
Exhibit A-I-C	Contract Holder's Obligations Under COBRA and CAL-COBRA
Exhibit A-I-D	Contract Holder's Obligations Under HIPAA
Exhibit A3-I-E	**Alliance Care IHSS Health Plan Member Handbook 2014/2015**
Exhibit B	DSS Additional Provisions
Exhibit C-5	**Program Budget FY 2014-15**
Exhibit D	Elder Abuse Reporting Certification
Exhibit E	Business Associate Agreement
Exhibit F	Sample Invoice

5. Section 4.1 of Exhibit A-I of the Original Agreement is amended to read as follows:

4.1 TERM

The term of this Agreement is July 1, 2011 through **June 30, 2015**.

6. Sections 1.02 and 2.01 of Exhibit B of the Original Agreement are amended to read as follows:

1.02 Allowable Costs: Allowable costs shall be the CONTRACTOR's actual costs of developing, supervising and delivering the services under this Agreement as set forth in the budget, attached hereto as **Exhibit C-5**. Only the costs listed in **Exhibit C-5** 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.

2.01 Outcome objectives and performance standards: CONTRACTOR shall, for the entire term of this Agreement, provide the service outcomes set forth in **Exhibits A-4** and A-I. CONTRACTOR shall meet the contracted level of service and the specified performance standards described in **Exhibits A-4** and A-I unless prevented from doing so by circumstances beyond CONTRACTOR's control including, but not limited to, natural disasters, fire, theft and shortages of necessary supplies or materials due to labor disputes.

7. Exhibits AAA, AAA-I-B, AA-I-E, and CCCC of the Original Agreement are rescinded, and replaced by Exhibits A-4, A4-I-B, A3-I-E and C-5, attached.

Subject to the foregoing amendment, all other terms and conditions of the Original Agreement shall remain in full force and effect.

If there is any conflict or inconsistency between provisions of this amendment and the Original Agreement, the provisions of this amendment shall control in all aspects.

IN WITNESS WHEREOF, the parties hereby execute this amendment as follows:

COUNTY OF MONTEREY:

By: ____________________
Chair, Board of Supervisors
LOUIS R. CALCAGNO

Date: 7-1-14

CONTRACTOR:
Central California Alliance for Health

By: ____________________
Chair, President, Vice-Pres.

Deidre Kelsey, Chair
Print Name and Title

Date: 5/21/14

Approved as to Form:

____
Deputy County Counsel

Date: 5-28-14

By: ____________________
Secretary, CFO, Treasurer

Barry Staroh, Chief Financial Officer
Print Name and Title

Date: 5/22/14

Approved as to Fiscal Provisions:

____
Auditor-Controller's Office

Date: 5/28/14

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

SCOPE OF SERVICES/PAYMENT PROVISIONS
July 1, 2011 to **June 30, 2015**

I. CONTACT INFORMATION

Contractor Name: Central California Alliance for Health

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

County Contract Manager: **Henry R. Espinosa, Deputy Director**
1000 South Main Street, Suite 211
Salinas, CA 93901
Phone: (831) 796-3320
espinosahr@co.monterey.ca.us

1. Exhibit A-I of the Contract between Monterey County and the Central California Alliance for Health is for the provision of health plan benefits for In-Home Supportive Services providers.

2. Notwithstanding Section 15.17 of County of Monterey Agreement for Professional Services (more than $100,000), in the event of any conflict or inconsistency between the provisions of Exhibit A-I 'Group Agreement' and other attachment or exhibit, including, but not limited to the County of Monterey Agreement for Professional Services (more than $100,000), the provisions of Exhibit A-I shall prevail and control.

II. SERVICES/PROGRAMS TO BE ADMINISTERED BY CONTRACTOR

CONTRACTOR shall provide the services outlined in Exhibits **A-4** through A-I, attached.

III. PAYMENT PROVISIONS

COUNTY shall reimburse CONTRACTOR a total amount not to exceed **$10,189,736** for the period July 1, 2011 to **June 30, 2015.**

ATTACHMENT A4-I-B

PREMIUM SCHEDULE
(July 1, 2011 – **June 30, 2015)**

Premium ....$500/per member/per month

EXHIBIT A-3-IE

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, 2014–June 30, 2015

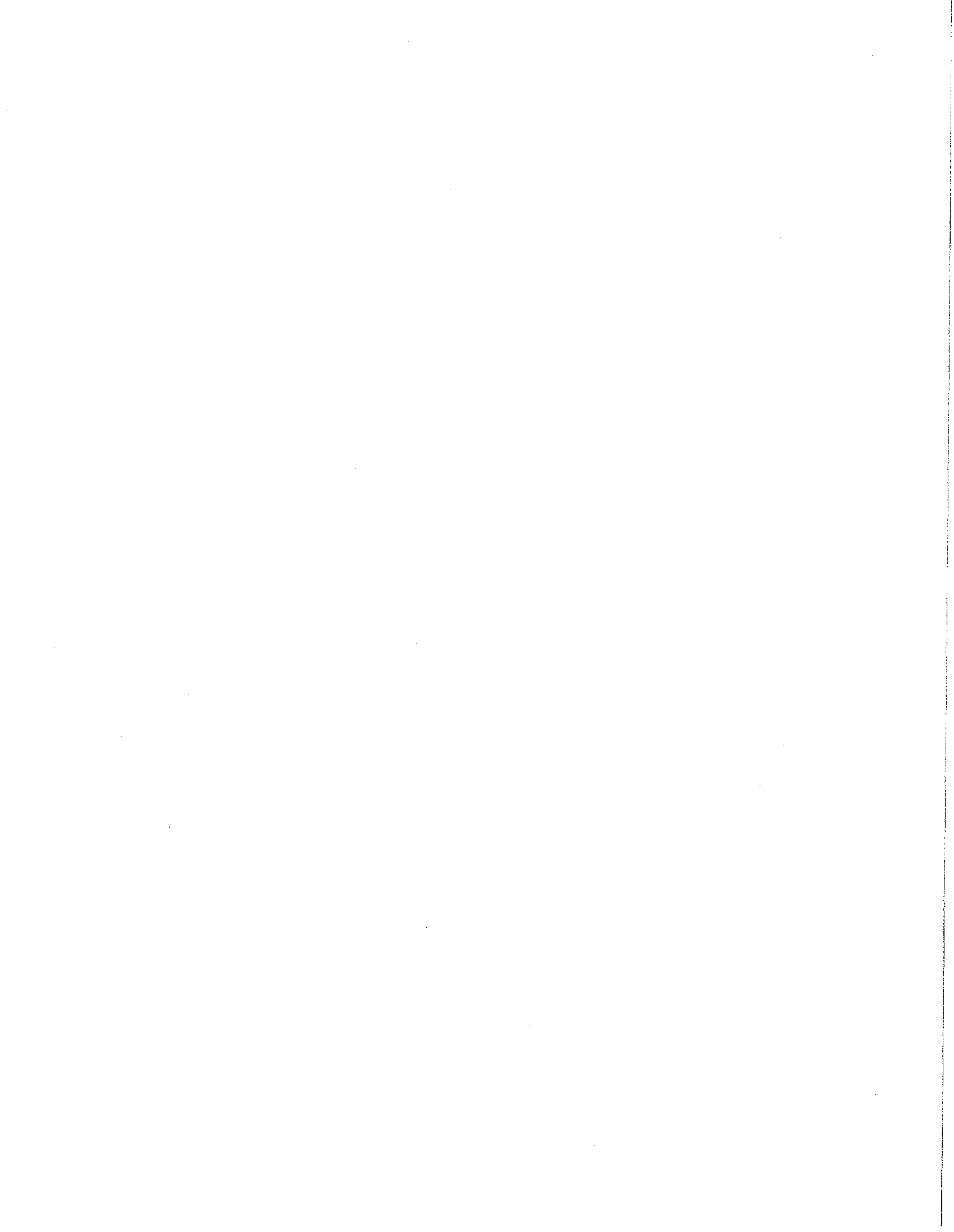

Table of Contents

Introduction **5**
Using This Handbook 5
About Your Health Plan 5
Member Identification Card 6
Definitions **6**
Member Rights and Responsibilities **11**
Accessing Care **12**
Physical Access 12
Access for the Hearing-Impaired 12
Access for the Vision-Impaired 12
~~The Americans with Disabilities Act of 1990 .... 13~~
Disability Access Grievances 13
Services for Members with Disabilities **13**
Using Your Health Plan **13**
Facilities and Provider Locations 13
Choosing a Primary Care Provider 13
Scheduling Appointments 14
Initial Health Exam 14
Changing Your Primary Care Provider 15
Continuity of Care for New Members 15
Continuity of Care for Termination of Provider 16
Prior Authorization for Services 17
Referrals to Specialty Physicians 18
Getting a Second Opinion 19
Getting Pharmacy Benefits 20
Getting Urgent Care 22
Getting Emergency Care 22
Non-Covered Services 23
Copayments 24
Member Liabilities 24
Services to Keep You Well **25**
Adult Health Screening Guidelines 26

Adult Immunization Guidelines 27
Eligibility and Enrollment 28
Enrollment and Effective Date of Coverage 28
Special Enrollment Due to Loss of Other Coverage 28
Open Enrollment 28
Premium Contributions 28
Alliance Care IHSS Covered Benefits Matrix 29
Benefit Descriptions 32
Excluded Benefits 50
The Grievance Process 51
Filing a Complaint 51
Independent Medical Reviews 52
Independent Medical Review for Denials of Investigational or Experimental Therapies 52
Review by the Department of Managed Health Care 53
Termination and Cancellation 53
Term and Renewal Provisions 53
Prepayment of Fees 54
Effect of Cancellation 54
Cancellation of Entire Agreement 54
Cancellation of Individual Members 54
Member's Right to Review of Certain Cancellations 55
Extension of Benefits Upon Termination 55
Group Continuation Coverage 55
General Information 56
Coordination of Benefits (COB) Applicability 56
Third-Party Recovery Process and Member Responsibilities 57
Non-Duplication of Benefits with Workers' Compensation 57
Limitations of Other Coverage 58
Provider Payment 58
Reimbursement Provisions If You Receive a Bill 58
Public Participation 59
Privacy Practices 59
Organ and Tissue Donation 59
Notice of Privacy Practices 61

Introduction

Using This Handbook

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

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

About Your Health Plan

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

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

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

Multilingual Services

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

If you or your doctor feels there are special circumstances for which you need a face-to-face interpreter for a medical appointment, you or your doctor can call us to ask for authorization. If we approve the request, we will provide an interpreter to be in the office with you for the appointment. If the request does not meet our criteria for face-to-face interpreter services, they 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.

Definitions

Active Labor

When there is not enough time to safely transfer the Member to another hospital before delivery or when transferring the Member may pose a threat to the health and safety of the mother or the unborn child.

Acute Condition

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

Appropriately Qualified Health Professional

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

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

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

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

Benefits (Covered Services)
Those services, supplies and drugs that a Member is entitled to receive under the terms of this Agreement. Except for emergency services, a service is not a benefit, even if described as a covered service or benefit in this booklet, if it is not medically necessary or if it is not provided by a Contracted Provider and with prior authorization, as required.

Benefit Year
The period from July 1 through June 30 of each year.

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.

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

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

In Service Area Provider
A provider whose place of service is located inside the Plan's Service Area of Monterey County and the adjacent county of Santa Cruz.

Local Out of Service Area Provider
A Contracted Provider based in a county adjacent to the Service Area who offers access to health care not readily available in Plan's Service Area.

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

Member
A person who becomes enrolled in Central California Alliance for Health to receive health care. In this handbook, a Member is also referred to as "you".

Member Identification Card

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

Mental Health Care Services

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

Non-Formulary Drug

A drug that is not listed in the Plan's Formulary and requires an authorization from the Plan to be covered.

Non Contracted Provider

A health care provider who is not contracted with the Plan to provide services to Plan Members.

Orthotic Device

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

Outpatient

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

Out-of-Area Services

Emergency care or urgent care provided outside of 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.

Provider Directory

The directory of In Service Area Contracted Providers and Local Out of Service Area Providers who are available to provide services to Plan Members.

Serious Chronic Condition

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

Service Area

The Alliance is licensed to provide Alliance Care IHSS benefits to IHSS workers who reside or work in Monterey County. Members may see Contracted Providers in both Monterey and Santa Cruz Counties.

Skilled Nursing Facility

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

Specialist Physician

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

Terminal Illness

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

Total Disability
When you are unable to obtain and hold meaningful employment due to a physical or mental disability and a Health Plan Contracted Physician concludes your condition is long term or terminal.

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.
- Understand your health problems and participate in developing treatment goals, as much as possible, with your provider.
- Follow the treatment plans your doctor develops for you. If you choose not to follow your doctor's plan, you must consider and accept the risks.
- Always present your Member Identification Card and make your copayments when getting services.
- Use the emergency room only in an emergency or as directed by your provider.
- Make and keep medical appointments and inform your provider at least 24 hours in advance when you must cancel an appointment.
- Ask questions about any medical condition and make certain you understand your provider's explanations and instructions.
- Help the Plan maintain accurate and current records by providing timely information regarding changes in address, family status and other health coverage.
- Notify the Plan as soon as possible if a provider bills you inappropriately or if you have a complaint.
- Treat all Plan personnel and health care providers with respect and courtesy.
- Pay any premiums on time.

Accessing Care

Physical Access

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

Access for the Hearing-Impaired

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

Access for the Vision-Impaired

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

The Americans with Disabilities Act of 1990

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

Disability Access Grievances

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

Services for Members with Disabilities

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

Members with Disabilities

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

Using Your Health Plan

Facilities and Provider Locations

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

The 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.

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

Scheduling Appointments

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

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

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

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

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

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

Initial Health Exam

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

Changing Your Primary Care Provider

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

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

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

We may ask you to change doctors if:

- Your doctor retires or leaves the area
- Your doctor no longer accepts the Alliance health plan
- You are unable to get along with your doctor
- You make appointments but do not show up for them or call to cancel
- 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.

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

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

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

We will notify you of our decision in writing. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, you can file a complaint. For 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, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, **1-888-HMO-2219**, or at the TTY number for the hearing impaired, 1-877-688-9891 or online at www.hmohelp.ca.gov.

Continuity of Care for Termination of Provider

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

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

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.

- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with you and the Non-Contracted Provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time of the provider termination.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time of the provider termination.
- Performance of a surgery or other procedure that the Plan has authorized as part of a documented course of treatment and that has been recommended and documented by the Non-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. Your PCP will obtain the necessary referrals and authorizations for you. Prior authorization means that both your doctor and the Plan agree that the services you will

get are medically necessary. If you need something that requires prior authorization, the health care provider will send us an Authorization Request. Your provider knows which services require prior authorization.

They include:

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

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

We approve most authorization requests, but sometimes a request is deferred. This means that we need to ask the provider for more information or ask that the doctor try another treatment first. We will let your doctor know if a request for prior authorization was approved or if we need more information. There may be times when we modify or change what your provider has asked for, and then approve it as modified. Please check with your doctor if you want to know if a request for prior authorization has been approved or not. We respond to all completed prior authorization requests within five (5) business days from the time we get them. If a treatment is urgent, we respond within one (1) business day.

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

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

Referrals to Specialty Physicians

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

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

Your PCP will refer you to an In Service Area Contracted Provider or a Local Out of Service Area Provider. If there are 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.
- Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results.
- The treatment plan in progress has not improved your medical condition within an appropriate period of time.
- You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

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

You will be referred to a qualified In Service Area Contracted Provider or Local Out of Service Area Provider for a second opinion. If there are none available, the Plan may authorize you to see an In Service Area Non-Contracted Provider or an Out of Area Provider. You will be responsible for paying all applicable copayments for the second opinion.

If your request to obtain a second opinion is denied, you will receive the denial in writing. You may appeal the denial. For information on how to appeal a denial, please see the section of this document called, "The Grievance Process".

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

Getting Pharmacy Benefits

What Your Doctor Can Prescribe

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

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

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

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

Where to Get Your Prescriptions Filled

In our Provider Directory, you will find a list of pharmacies near you where you can get your prescriptions filled. You must go to one of those pharmacies for your prescription drugs. Some of the pharmacies in our network have locations throughout California. If you are traveling 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 inside our Service Area. To be covered, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor's appointment. On your first visit, talk to your Primary Care Provider about what he or she wants you to do when the office is closed and you feel urgent care may be needed.

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

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

Getting Emergency Care

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

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

Examples include:

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

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

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

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

If you are not sure whether you have an emergency or require urgent care, call your PCP at the phone number listed on your Alliance ID Card to access triage or screening services, 24 hours per day, 7 days per week. If you think you need emergency care, go to the nearest emergency room or call 911. If you think you need urgent care and are within the Plan's Service Area, call your PCP. If you are outside of the Plan's Service Area, you may access urgent care services without prior authorization. If you are not sure if your condition is urgent, call your PCP if you are able.

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 5:00 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.

Copayments

You will be required to pay a small amount of money for some services. This is called a copayment. The maximum amount of money you are required to pay out in one benefit year is $3,000.

The Plan will track your copayments. Once we have verified that you have met your maximum for the benefit year, we will send you a new Alliance ID card that shows that you are not required to pay any more copayments for the rest of the benefit year. If you can show proof (receipts) that you paid more than $3,000 in copayments within the benefit year, the Plan will reimbursement you for the amount over $3,000.

No copayment will be charged for routine examinations and preventive care.

Member Liabilities

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

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

- Non-emergency services received in the emergency room
- Non-emergency or non-urgent services received outside of the Plan's Service Area if you did not get authorization from the Plan before receiving such services
- Specialty services you received if you did not get a required referral or authorization from the Plan before receiving such services (see Prior Authorization for Services and Referrals to Specialty Physicians in the section of this document called, "Using Your Health Plan".)
- Services from a Non- Contracted Provider, unless the services are for situations allowed in this Evidence of Coverage booklet (for example, emergency services, urgent services outside of the Plan's Service Area or specialty services approved by the Plan), or
- Services you received that are greater than the limits described in this Evidence of Coverage booklet unless authorized by the Plan.

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

If the Plan does not pay a Non-Contracted Provider for covered services, you do not have to pay the Non-Contracted Provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage handbook. The Non-Contracted Provider must bill the Plan, not you, for any covered service. But remember, services from a Non-Contracted Provider are not "covered services" unless they fall within the situations allowed by this Evidence of Coverage handbook.

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

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.

Adult Health Screening Guidelines

For All Patients			
Test	**Ages 18–39**	**Ages 40–64**	**Ages > 65**
Health Exam This may include height and weight, hearing and eye exams	For all Alliance Members: Schedule your first checkup within 120 days of becoming an Alliance Member		
Tuberculosis (TB) Test	Initial entry into health plan for all Members. Repeat testing at regular intervals for people at risk.		
Blood Pressure	Every 1–2 years	Every 1–2 years	Every year
Cholesterol	Men, starting at age 35	Women, starting at age 45	As needed, per your doctor
Stool Test	As determined by your doctor	Every year age 50 and over	Every year age 50 and over
Patients with Diabetes	Every year: foot exam, urine and retinal exam, HgA1c, lipids	Every year: foot exam, urine and retinal exam, HgA1c, lipids	Every year: foot exam, urine and retinal exam, HgA1c, lipids

For Female Patients Only			
Test	**Ages 18–39**	**Ages 40–64**	**Ages > 65**
Breast Exam by your Provider		Every year	Every year
Mammography	As recommended by your doctor.	Ages 40–50 As recommended by your doctor. Ages 50–64 every year	Ages 65–70 every 2 years. Under age 75 as recommended by your doctor.
Pap Smears	Ages 21 to 30 every 3 years Pap alone. Ages 30 to 39 Pap alone every 3 years, OR Pap with HPV testing every 5 years	Ages 40 to 64 every 3 years Pap alone OR Pap with HPV testing every 5 years.	None if had regular screenings before age 65 and not at high risk.
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.

Adult Immunization Guidelines

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

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

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

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.

Alliance Care IHSS Covered Benefits Matrix

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

Benefits*	Services	Cost to Member (copayment)
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services	No copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility	No copayment except: ▪ $10 per visit for physical, occupational and speech therapy performed on an outpatient basis ▪ $25 per visit for emergency health care services (waived if the Member is admitted to the hospital)
Professional Services	Services and consultations by a physician or other licensed health care provider	$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, or for hearing aids
Preventive Health Service	Periodic health examinations including all routine diagnostic testing, Human Immunodeficiency Virus (HIV) testing, laboratory services appropriate for such examinations, immunizations, and services for the detection of asymptomatic diseases	No copayment
Diagnostic, X-Ray and Laboratory Services	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat Members	No copayment

Benefits*	Services	Cost to Member (copayment)
Diabetes Care	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription	$10 copayment per office visit; copayment for prescriptions as described in the Prescription Drug Program section of this chart
Prescription Drug Program	Drugs prescribed by a licensed practitioner	▪ $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)
Inpatient Mental Health Care Services	Mental health care in a contracted hospital when ordered and performed by a Participating Mental Health Provider for the treatment of a mental health condition.	No copayment Unlimited days
Outpatient Mental Health Care Services	Mental health care when ordered and performed by a Participating Mental Health Provider.	$10 per visit Unlimited visits
Inpatient Substance Abuse Treatment Services	Hospitalization to remove toxic substances from the system	No copayment Unlimited days
Outpatient Substance Abuse Treatment Services	Crisis intervention and treatment of alcoholism or drug abuse	$10 per visit Unlimited visits
Home Health Care Services	Services provided at the home by health care personnel	No copayment, except $10 per visit for physical, occupational, and speech therapy
Skilled Nursing Care	Services provided in a licensed skilled nursing facility	No copayment Benefit is limited to a maximum of 100 days per benefit year
Rehabilitative (Physical, Occupational, and Speech) Therapy	Therapy may be provided in a medical office or other appropriate outpatient setting	$10 per visit when performed in an outpatient setting No copayment for inpatient therapy
Blood and Blood Products	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings	No copayment
Organ Transplants	Coverage for organ transplants and bone marrow transplants that are not experimental or investigational	No copayment
Reconstructive Surgery	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance	No copayment
Phenylketonuria (PKU)	Testing and treatment of PKU	No copayment
Clinical Cancer Trials	Coverage for a Member's participation in a cancer clinical trial, Phase I through IV, when the Member's physician has recommended participation in the trial, and Member meets certain requirements	$10 copayment per office visit Copayment for prescriptions as described in the Prescription Drug Program section
Acupuncture	Requires a referral from the Member's PCP and prior authorization from the Alliance. Services must be obtained from an In	$10 per visit Benefit is limited to 20 visits per benefit year

Benefits*	Services	Cost to Member (copayment)
	Service Area Contracted Provider.	
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.

Benefit Descriptions

Acupuncture

Cost to Member

$10 per visit

Description

Acupuncture services require a referral from the Member's Primary Care Provider and prior authorization from the 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.

Asthma Care

Cost to Member

No copayment

Description

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

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

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

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

Biofeedback

Cost to Member

$10 per visit

Description

Biofeedback is a covered benefit based on medical necessity. You must have a referral from your PCP and prior authorization from the Plan before you receive these services. Services must be obtained from an In Service Area Contracted Provider.

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.

Clinical Cancer Trials

Cost to Member

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

Description

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

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

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

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

Exclusions

- Provision of non-FDA-approved drugs or devices that are the subject of the trial

- Services other than health care services, such as travel, housing, and other non-clinical expenses that a Member may incur due to participation in the trial
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental)
- Health care services that are customarily provided by the research sponsors free of charge for any enrollee in the trial.

Coverage for clinical trials may be restricted to 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).

Durable Medical Equipment

Cost to Member
No copayment

Description
Medical equipment appropriate for use in the home which:

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

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

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

Exclusions

- Comfort or convenience items
- Disposable supplies, except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same function.

- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

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.

Health Education

Cost to Member

No copayment

Description

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

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

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

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

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

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

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

Home Health Care Services

Cost to Member

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

Description

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

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

Limitations

Home health care services are limited to those services that are prescribed or directed by the Member's Primary Care Provider or another appropriate authority designated by the Plan.
If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the Member's PCP. The Plan will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting.

Exclusions

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

Hospital Services - Inpatient

Cost to Member

No copayment

Description

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

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

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

Description

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

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

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

Exclusions

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

Hospice

Cost to Member

No copayment

Description

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

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

The hospice election may be revoked at any time.

Limitations

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

Maternity Care

Cost to Member

No copayment

Description

Services must be obtained from 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.

Exclusions

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

Mental Health Care Services - Inpatient

Mental health services are provided through OptumHealth. Please call them at **1-800-808-5796** to access these services. Please let them know you are an Alliance Member.

Cost to Member

No copayment

Description

Mental health care in a Contracted Hospital when ordered and performed by a Participating Mental Health Provider. Diagnosis and treatment of a mental health condition. Prior authorization is required.

Covered services include behavioral health therapy (BHT) for the treatment of pervasive developmental disorder (PDD) or autism.

Limitations

Unlimited days

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.

Covered services include behavioral health therapy (BHT) for the treatment of pervasive developmental disorder (PDD) or autism.

Limitation

Unlimited visits.

Nutrition and Weight

Cost to Member

No copayment

Description

Eating better can help you to stay healthy. Call us for a free booklet on healthy eating.

Ask us about free or low-cost exercise and weight loss programs in your area. Or request a free exercise video or pedometer (a small device that tells you how many miles you have walked).

Organ Transplants

Cost to Member

No copayment

Description

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

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

If the Plan denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to the grievance section of this document called, "The Grievance Process"

Orthotics and Prosthetics

Cost to Member

No copayment

Description

Orthotic and prosthetic benefits include original and replacement devices, that are medically necessary, prescribed by a Contracted Provider, authorized by the Plan and dispensed by a Contracted Provider. This benefit includes, but is not limited to:

- Footwear needed by persons who suffer from foot disfigurement preventing the use of conventional standard footwear in conditions such as cerebral palsy, arthritis, polio, spinabifida, diabetes and developmental disability.
- An artificial body part, such as a leg or hand, that helps an individual look or function as normally as possible.
- An artificial breast or breast reconstruction after a mastectomy to restore symmetry.
- An artificial voice box to restore speaking after a laryngectomy (surgery to your voice box).
- Repairs are provided unless caused by misuse or loss. The Plan, at its option, may replace or repair an item.

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

Exclusions

- Corrective shoes, shoe inserts, and arch supports, that can be purchased over-the-counter, even if prescribed by a doctor
- Supplies for treatment of corns and calluses
- 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 dispensed in pre-filled syringes. The term "disposable" includes devices that may be used more than once before disposal.
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription.
- Medically necessary drugs administered while a Member is a patient or resident in
- A rest home, nursing home, convalescent hospital, or similar facility when prescribed by a contracted physician in connection with a covered service and obtained through a contracted pharmacy.
- One cycle or course of treatment of tobacco cessation drugs per benefit year. The Member must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs.
- All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time-release contraceptives.

For information concerning the Plan's prescription drug coverage, please refer to section of this document called, "Getting Pharmacy Benefits".

Exclusions

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

If the Plan denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to the grievance section of this document called, "The Grievance Process".

Preventive Health Service

Cost to Member

No copayment.

Description

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

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

- A variety of voluntary family planning services
- Contraceptive services
- Prenatal care
- Vision and hearing testing
- Sexually transmitted disease (STD) testing
- 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
- Home visits when medically necessary
- Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid(s): monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following receipt of a covered hearing aid.

Exclusions

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

Reconstructive Surgery

Cost to Member

No copayment

Description

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

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

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

Rehabilitative (Physical, Speech and Occupational) Therapy

Cost to Member

- No copayment for inpatient therapy services, 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.

Substance Abuse Treatment Services

Substance abuse treatment services are provided through OptumHealth. Please call them at **1-800-808-5796** to access these services. Please let them know that you are an Alliance member.

Diagnosis and treatment of a substance abuse condition. If you think you may have a substance abuse condition call OptumHealth at the number above to get information on how to get services.

Substance Abuse Treatment Services – Inpatient

Please call OptumHealth at **1-800-808-5796** to access these services.

Cost to Member

No copayment

Description

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

Limitations

Unlimited days

Substance Abuse Treatment Services - Outpatient

Please call OptumHealth at **1-800-808-5796** to access these services.

Cost to Member

$10 per visit

Description

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

Limitations

Unlimited visits

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.
- Services that are eligible for reimbursement by insurance or covered under any other insurance or health care service 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.
- Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.
- Any services not authorized by the Plan when prior authorization is required.

- Routine care received outside of the United States (except as authorized by the Plan).
- Routine care received outside of California (except as authorized by the Plan).
- Transportation by airplane, passenger car, taxi or other form of public conveyance.

The Grievance Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. If you have questions about the services you receive from a Contracted Provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call the Alliance's Member Service Department at **1-800-700-3874.**

Filing a Complaint

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

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

Grievance Coordinator
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
Phone: 1-800-700-3874, ext. 5525
Fax: 831-430-5856
www.ccah-alliance.org

The Plan will send you a letter within five (5) days telling you that we received your complaint. When all of your information is received, including relevant medical records, a decision will be made within thirty (30) days. If your complaint involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your provider may request that the Plan expedite its grievance review. The Plan will evaluate your request for an expedited review and, if your complaint qualifies as an urgent complaint, we will resolve your complaint within three (3) days from receipt of your request.

You are not required to file a complaint with the 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**.

Independent Medical Review for Denials of Investigational or Experimental Therapies

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

We will notify you in writing of the opportunity to request an IMR of a decision denying an experimental/investigational therapy within five (5) business days of the decision to deny coverage. You are not required to participate in the Plan's Grievance Process before seeking an IMR of our decision to deny coverage of an experimental or investigational therapy.

If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the IMR decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against the Plan, you should first telephone the Plan at **1-800-700-3874** (TTY for the hearing impaired at 1-877-548-0857) and use the Plan's Grievance Process before contacting DMHC. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a complaint that has not been satisfactorily resolved by the Plan, or a complaint that has remained unresolved for more than thirty (30) days, you may call DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency and urgent medical services. DMHC has a toll-free telephone number, **1-888-HMO-2219**, to receive complaints regarding health plans. The hearing and speech impaired may use DMHC's TTY line (1-877-688-9891) number, to contact DMHC. DMHC's Internet Web site (**www.hmohelp.ca.gov**) has complaint forms, IMR application forms and instructions online.

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

Termination and Cancellation

Term and Renewal Provisions

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

Prepayment of Fees

The 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 may cancel the Agreement. The Plan 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).

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

Cancellation by Group

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

Reinstatement

Receipt by the Plan of the proper monthly prepayment fees subsequent to the Alliance's issuance of cancellation to the Group for non-payment of prepayment fees will reinstate the Group as though there never was a cancellation, if such payment is received within at least thirty (30) days following the date of the notification to the Group of cancellation for nonpayment.

Cancellation of Individual Members

Loss of Eligibility

If you cease to meet the eligibility requirements as defined in this EOC, including failure to pay the required premiums, then (subject to any applicable provisions for continuation of coverage or conversion of benefits) 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. Please make sure to contact the Group if you have any questions regarding maintaining your eligibility.

Disenrollment by Member

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

Cancellation of Members for Good Cause

Fraud or Intentional Misrepresentation

If the Plan can demonstrate that you have committed fraud or intentionally misrepresented material facts under the terms of the contract with regard to eligibility, enrollment, use of an Alliance Care IHSS ID Card or use of services, the Plan may cancel your coverage effective on the date the Plan mails the notice of cancellation to you.

Member's Right to Review of Certain Cancellations

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

Extension of Benefits Upon Termination

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

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

Group Continuation Coverage

Federal Continuation of Coverage (COBRA)

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), Group Continuation Coverage is available, under certain conditions, to employees of most employers. If

Membership in the Plan is sponsored by an employer, you may be eligible for Group Continuation of Coverage. Contact the Public Authority at **831-755-4466** for more information.

State Continuation of Coverage (Cal-COBRA)

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

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

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	Since the doctor has already been paid what your primary insurance allows,

			already paid the doctor, so it pays	you owe
$60	$40	$35	$0	$0

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

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

Third-Party Recovery Process and Member Responsibilities

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

- Reimburse the Plan for the reasonable cost of services paid by the Alliance to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise.
- Fully cooperate with the Plan's effectuation of its lien rights for the reasonable value of services provided by the Plan to the extent permitted under California Civil Code section 3040. The Plan's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

The Plan shall be entitled to payment, reimbursement, and subrogation in third party recoveries and Member shall cooperate to fully and completely effectuate and protect the rights of the Plan including prompt notification of a case involving possible recovery from a third party.

Non-Duplication of Benefits with Workers' Compensation

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

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

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

Limitations of Other Coverage

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

Independent Contractors

Plan Providers are neither agents nor employees of the Plan, but are independent contractors. The Alliance regularly reviews the physicians who provide services to our Members. However, in no instance shall the 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.

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

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

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

Public Participation

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

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

Notifying You of Changes in the Plan

Throughout the year, we may send you updates about changes in the Plan. This can include updates for the Provider Directory and Combined Evidence of Coverage and Disclosure Form. We may also send you information about changes in our Member newsletter. We will keep you informed and are available to answer any questions you may have. Call us at the Alliance if you have any questions about changes in the Plan.

Privacy Practices

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

Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become

involved to coordinate the activities. The Department of Health and Human Services' Internet Web site (www.organdonor.gov) has additional information on donating your organs and tissues.

Notice of Privacy Practices

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

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.

Get a list of those with whom we've shared information	▪ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. ▪ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	▪ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	▪ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ▪ We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	▪ Share information with your family, close friends, or others involved in payment for your care. ▪ Share information in a disaster relief situation. ▪ Contact you for fundraising efforts. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	▪ Marketing purposes. ▪ Sale of your information. ▪ Psychotherapy notes. ▪ Substance abuse treatment records.

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.

How else can we use or share your health information? We are allowed or required to share information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues	▪ We can share health information about you for certain situations such as: ▪ Preventing disease ▪ Helping with product recalls ▪ Reporting adverse reactions to medications ▪ Reporting suspected abuse, neglect, or domestic violence ▪ Preventing or reducing a serious threat to anyone's health or safety.
Do research	▪ We can use or share your information for health research.
Comply with the law	▪ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	▪ We can share information about you with organ procurement organizations. ▪ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	▪ We can use or share health information about you: ▪ For workers' compensation claims. ▪ For law enforcement purposes or with a law enforcement official. ▪ With health oversight agencies for activities authorized by law. ▪ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	▪ We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Limitations

In some circumstances, there may be other restrictions that may limit what information we can use or share. There are special restrictions on sharing information relating to HIV/AIDS status, mental health treatment, developmental disabilities and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

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

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

September 23, 2013

Central California Alliance for Health

Program Budget

Agreement A-11489, Amendment # 4

July 1, 2011 through June 30, 2012

	Hourly Rate	Projected Service Hours	2011-12 Budget Total
Health Plan Benefits	$0.60	3,312,500	$ 1,987,500.00

July 1, 2012 through June 30, 2013

	Hourly Rate	Projected Service Hours	2012-13 Budget Total
Health Plan Benefits	$0.69	3,840,308	$ 2,649,813.00
Cobra's			$ 12,000.00
			$2,661,813.00

July 1, 2013 through June 30, 2014

	Hourly Rate	Projected Service Hours	2013-14 Budget Total
Health Plan Benefits	$0.69	4,121,893	$ 2,844,106.00
Cobra's			$ 24,000.00
			$2,868,106.00

July 1, 2014 through June 30, 2015

	Hourly Rate	**Projected Service Hours**	**2014-15 Budget Total**
Health Plan Benefits	**$0.69**	**3,836,692**	**$ 2,647,317.00**
Cobra's			**$ 25,000.00**
			$ 2,672,317.00

Total funding for the period July 1, 2011 **through June 30, 2015 shall not exceed ten million, one hundred eighty-nine thousand, seven hundred and thirty-six dollars ($10,189,736).**