COUNTY OF MONTEREY STANDARD AGREEMENT

This **Agreement** is made by and between the County of Monterey, a political subdivision of the State of California (hereinafter "County") and:

Central California Alliance for Health,

(hereinafter "CONTRACTOR").

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

1.0 GENERAL DESCRIPTION:

The County hereby engages CONTRACTOR to perform, and CONTRACTOR hereby agrees to perform, the services described in **Exhibit A** in conformity with the terms of this Agreement. The goods and/or services are generally described as follows:

Provide: health plan benefits to enrolled Monterey County In-Home Supportive Service Providers

2.0 PAYMENT PROVISIONS:

County shall pay the CONTRACTOR in accordance with the payment provisions set forth in **Exhibit A**, subject to the limitations set forth in this Agreement. The total amount payable by County to CONTRACTOR under this Agreement shall not exceed the sum of: $ 5,479,681.00

3.0 TERM OF AGREEMENT:

3.01 The term of this Agreement is from July 1, 2023 **to** June 30, 2024, unless sooner terminated pursuant to the terms of this Agreement. This Agreement is of no force or effect until signed by both CONTRACTOR and County and with County signing last, and **CONTRACTOR may not commence work before County signs this Agreement**.

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

4.0 SCOPE OF SERVICES AND ADDITIONAL PROVISIONS:

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

Exhibit A Scope of Services/Payment Provisions

Exhibit B Other: See page 11(a) for a list of Exhibits

5.0 PERFORMANCE STANDARDS:

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

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

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

6.0 PAYMENT CONDITIONS:

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

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

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

6.04 CONTRACTOR shall submit such invoice periodically or at the completion of services, but in any event, not later than 30 days after completion of services. The invoice shall set forth the amounts claimed by CONTRACTOR for the previous period, together with an itemized basis for the amounts claimed, and such other information pertinent to the invoice. The County shall certify the invoice, either in the requested amount or in such other amount as the County approves in conformity with this Agreement and shall promptly submit such invoice to the County Auditor-Controller for payment. The County Auditor-Controller shall pay the amount certified within 30 days of receiving the certified invoice.

7.0 TERMINATION: See Exhibit A-1A, Sections 4.0 through 5.1

DS
EMJ
Contractor

JD
County

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

DS EMJ Contractor

County

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

DS EMJ Contractor

County

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

8.0 INDEMNIFICATION: See Exhibit A-1-A, Section 9.14 and 9.15

DS EMJ Contractor

County

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

9.0 INSURANCE REQUIREMENTS:

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

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

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

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

Commercial General Liability Insurance: including but not limited to premises and operations, including coverage for Bodily Injury and Property Damage, Personal Injury, Contractual Liability, Broad form Property Damage, Independent Contractors, Products and Completed Operations, with a combined single limit for Bodily Injury and Property Damage of not less than $1,000,000 per occurrence.
(Note: any proposed modifications to these general liability insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County approval.)

Requestor must check the appropriate Automobile Insurance Threshold:
Requestor must check the appropriate box.

☐ **Agreement Under $100,000 Business Automobile Liability Insurance**: covering all motor vehicles, including owned, leased, non-owned, and hired vehicles, used in providing services under this Agreement, with a combined single limit for Bodily Injury and Property Damage of not less than $500,000 per occurrence.

☑ **Agreement Over $100,000 Business Automobile Liability Insurance**: covering all motor vehicles, including owned, leased, non-owned, and hired vehicles, used in providing services under this Agreement, with a combined single limit or Bodily Injury and Property Damage of not less than $1,000,000 per occurrence.

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

Workers' Compensation Insurance: if CONTRACTOR employs others in the performance of this Agreement, in accordance with California Labor Code section 3700 and with Employer's Liability limits not less than $1,000,000 each person, $1,000,000 each accident and $1,000,000 each disease.
(Note: any proposed modifications to these workers' compensation insurance requirements shall be attached as an Exhibit hereto, and the section(s) above that are proposed as not applicable shall be lined out in blue ink. All proposed modifications are subject to County approval.)

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

coverage shall continue for at least three years following the expiration or earlier termination of this Agreement.

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

9.04 Other Requirements:

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

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

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

Prior to the execution of this Agreement by the County, CONTRACTOR shall file certificates of insurance with the County's contract administrator and County's Contracts/Purchasing Division, showing that the CONTRACTOR has in effect the insurance required by this Agreement. The CONTRACTOR shall file a new or amended certificate of insurance within five calendar days after any change is made in any insurance policy, which would alter the information on the certificate then on file. Acceptance or approval of insurance shall in no way modify or change the indemnification clause in this Agreement, which shall continue in full force and effect. CONTRACTOR shall always during the term of this Agreement maintain in force the insurance coverage required under this Agreement and shall send, without demand by County, annual certificates to County's Contract Administrator and County's Contracts/Purchasing Division. If the certificate is not received by the expiration date, County shall notify CONTRACTOR and CONTRACTOR shall have five calendar days to send in the certificate, evidencing no lapse in coverage during the interim. Failure by CONTRACTOR to maintain such insurance is a default of

this Agreement, which entitles County, at its sole discretion, to terminate this Agreement immediately.

10.0 RECORDS AND CONFIDENTIALITY:

10.1 **Confidentiality:** CONTRACTOR and its officers, employees, agents, and subcontractors shall comply with any and all federal, state, and local laws, which provide for the confidentiality of records and other information. CONTRACTOR shall not disclose any confidential records or other confidential information received from the County or prepared in connection with the performance of this Agreement, unless County specifically permits CONTRACTOR to disclose such records or information. CONTRACTOR shall promptly transmit to County any and all requests for disclosure of any such confidential records or information. CONTRACTOR shall not use any confidential information gained by CONTRACTOR in the performance of this Agreement except for the sole purpose of carrying out CONTRACTOR's obligations under this Agreement.

10.2 **County Records:** When this Agreement expires or terminates, CONTRACTOR shall return to County any County records which CONTRACTOR used or received from County to perform services under this Agreement.

10.3 **Maintenance of Records:** CONTRACTOR shall prepare, maintain, and preserve all reports and records that may be required by federal, state, and County rules and regulations related to services performed under this Agreement. CONTRACTOR shall maintain such records for a period of at least three years after receipt of final payment under this Agreement. If any litigation, claim, negotiation, audit exception, or other action relating to this Agreement is pending at the end of the three-year period, then CONTRACTOR shall retain said records until such action is resolved.

10.4 **Access to and Audit of Records:** The County shall have the right to examine, monitor and audit all records, documents, conditions, and activities of the CONTRACTOR and its subcontractors related to services provided under this Agreement. Pursuant to Government Code section 8546.7, if this Agreement involves the expenditure of public funds in excess of $10,000, the parties to this Agreement may be subject, at the request of the County or as part of any audit of the County, to the examination and audit of the State Auditor pertaining to matters connected with the performance of this Agreement for a period of three years after final payment under the Agreement.

10.5 **Royalties and Inventions:** County shall have a royalty-free, exclusive and irrevocable license to reproduce, publish, and use, and authorize others to do so, all original computer programs, writings, sound recordings, pictorial reproductions, drawings, and other works of similar nature produced in the course of or under this Agreement. CONTRACTOR shall not publish any such material without the prior written approval of County.

11.0 NON-DISCRIMINATION:

11.1 During the performance of this Agreement, CONTRACTOR, and its subcontractors, shall not unlawfully discriminate against any person because of race, religious creed, color, sex, national origin, ancestry, physical disability, mental disability, medical condition, marital status, age (over 40), sexual orientation, or any other characteristic set forth in California Government code § 12940(a), either in CONTRACTOR's employment practices or in the furnishing of services to recipients. CONTRACTOR shall ensure that the evaluation and

treatment of its employees and applicants for employment and all persons receiving and requesting services are free of such discrimination. CONTRACTOR and any subcontractor shall, in the performance of this Agreement, fully comply with all federal, state, and local laws and regulations which prohibit discrimination. The provision of services primarily or exclusively to such target population as may be designated in this Agreement shall not be deemed to be prohibited discrimination.

12.0 COMPLIANCE WITH TERMS OF STATE OR FEDERAL GRANTS:

If this Agreement has been or will be funded with monies received by the County pursuant to a contract with the state or federal government in which the County is the grantee, CONTRACTOR will comply with all the provisions of said contract, to the extent applicable to CONTRACTOR as a subgrantee under said contract, and said provisions shall be deemed a part of this Agreement, as though fully set forth herein. Upon request, County will deliver a copy of said contract to CONTRACTOR, at no cost to CONTRACTOR.

13.0 COMPLIANCE WITH APPLICABLE LAWS:

13.1 CONTRACTOR shall keep itself informed of and in compliance with all federal, state, and local laws, ordinances, regulations, and orders, including but not limited to all state and federal tax laws that may affect in any manner the Project or the performance of the Services or those engaged to perform Services under this AGREEMENT as well as any privacy laws including, if applicable, HIPAA. CONTRACTOR shall procure all permits and licenses, pay all charges and fees, and give all notices require by law in the performance of the Services.

13.2 CONTRACTOR shall report immediately to County's Contracts/Purchasing Officer, in writing, any discrepancy or inconsistency it discovers in the laws, ordinances, regulations, orders, and/or guidelines in relation to the Project of the performance of the Services.

13.3 All documentation prepared by CONTRACTOR shall provide for a completed project that conforms to all applicable codes, rules, regulations, and guidelines that are in force at the time such documentation is prepared.

14.0 INDEPENDENT CONTRACTOR:

In the performance of work, duties, and obligations under this Agreement, CONTRACTOR is always acting and performing as an independent contractor and not as an employee of the County. No offer or obligation of permanent employment with the County or County department or agency is intended in any manner, and CONTRACTOR shall not become entitled by virtue of this Agreement to receive from County any form of employee benefits including but not limited to sick leave, vacation, retirement benefits, workers' compensation coverage, insurance or disability benefits. CONTRACTOR shall be solely liable for and obligated to pay directly all applicable taxes, including federal and state income taxes and social security, arising out of CONTRACTOR's performance of this Agreement. In connection therewith, CONTRACTOR shall defend, indemnify, and hold County harmless from any and all liability which County may incur because of CONTRACTOR's failure to pay such taxes.

15.0 NOTICES:

Notices required under this Agreement shall be delivered personally or by first-class, postage pre-paid mail to the County and CONTRACTOR'S contract administrators at the addresses listed below:

FOR COUNTY:	**FOR CONTRACTOR:**
Lori A. Medina, Director	Michael Schrader, Chief Executive Officer
Name and Title	Name and Title
1000 S. Main St., Suite 301, Salinas, CA 93901	1600 Green Hills Rd., Suite 101, Scotts Valley, CA 95066
Address	Address
831-755-4430	831-430-5500
Phone:	Phone:

16.0 MISCELLANEOUS PROVISIONS.

16.01 **Conflict of Interest:** CONTRACTOR represents that it presently has no interest and agrees not to acquire any interest during the term of this Agreement, which would directly, or indirectly conflict in any manner or to any degree with the full and complete performance of the services required to be rendered under this Agreement.

16.02 **Amendment:** This Agreement may be amended or modified only by an instrument in writing signed by the County and the CONTRACTOR.

16.03 **Waiver:** Any waiver of any terms and conditions of this Agreement must be in writing and signed by the County and the CONTRACTOR. A waiver of any of the terms and conditions of this Agreement shall not be construed as a waiver of any other terms or conditions in this Agreement.

16.04 **Contractor:** The term "CONTRACTOR" as used in this Agreement includes CONTRACTOR's officers, agents, and employees acting on CONTRACTOR's behalf in the performance of this Agreement.

16.05 **Disputes:** CONTRACTOR shall continue to perform under this Agreement during any dispute.

16.06 **Assignment and Subcontracting:** The CONTRACTOR shall not assign, sell, or otherwise transfer its interest or obligations in this Agreement without the prior written consent of the County. None of the services covered by this Agreement shall be subcontracted without the prior written approval of the County. Notwithstanding any such subcontract, CONTRACTOR shall continue to be liable for the performance of all requirements of this Agreement.

16.07 **Successors and Assigns:** This Agreement and the rights, privileges, duties, and obligations of the County and CONTRACTOR under this Agreement, to the extent assignable or delegable, shall be binding upon and inure to the benefit of the parties and their respective successors, permitted assigns, and heirs.

16.08 **Headings:** The headings are for convenience only and shall not be used to interpret the terms of this Agreement.

16.09 **Time is of the Essence:** Time is of the essence in each and all of the provisions of this Agreement.

16.10 **Governing Law:** This Agreement shall be governed by and interpreted under the laws of the State of California; venue shall be Monterey County.

16.11 **Non-exclusive Agreement:** This Agreement is non-exclusive and both County and CONTRACTOR expressly reserve the right to contract with other entities for the same or similar services.

16.12 **Construction of Agreement:** The County and CONTRACTOR agree that each party has fully participated in the review and revision of this Agreement and that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in the interpretation of this Agreement or any amendment to this Agreement.

16.13 **Counterparts:** This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same Agreement.

16.14 **Authority:** Any individual executing this Agreement on behalf of the County or the CONTRACTOR represents and warrants hereby that he or she has the requisite authority to enter into this Agreement on behalf of such party and bind the party to the terms and conditions of this Agreement.

16.15 **Integration:** This Agreement, including the exhibits, represent the entire Agreement between the County and the CONTRACTOR with respect to the subject matter of this Agreement and shall supersede all prior negotiations, representations, or agreements, either written or oral, between the County and the CONTRACTOR as of the effective date of this Agreement, which is the date that the County signs the Agreement.

16.16 **Interpretation of Conflicting Provisions:** In the event of any conflict or inconsistency between the provisions of this Agreement and the Provisions of any exhibit or other attachment to this Agreement, the provisions of this Agreement shall prevail and control.

17.0 CONSENT TO USE OF ELECTRONIC SIGNATURES.

17.1 The parties to this Agreement consent to the use of electronic signatures via DocuSign to execute this Agreement. The parties understand and agree that the legality of electronic signatures is governed by state and federal law, 15 U.S.C. Section 7001 et seq.; California Government Code Section 16.5; and, California Civil Code Section 1633.1 *et. seq.* Pursuant to said state and federal law as may be amended from time to time, the parties to this Agreement hereby authenticate and execute this Agreement, and any and all Exhibits to this

Agreement, with their respective electronic signatures, including any and all scanned signatures in portable document format (PDF).

17.2 **Counterparts.**

The parties to this Agreement understand and agree that this Agreement can be executed in two (2) or more counterparts and transmitted electronically via facsimile transmission or by delivery of a scanned counterpart in portable document format (PDF) via email transmittal.

17.3 **Form: Delivery by E-Mail or Facsimile.**

Executed counterparts of this Agreement may be delivered by facsimile transmission or by delivery of a scanned counterpart in portable document format (PDF) by e-mail transmittal, in either case with delivery confirmed. On such confirmed delivery, the signatures in the facsimile or PDF data file shall be deemed to have the same force and effect as if the manually signed counterpart or counterparts had been delivered to the other party in person.

********** THIS SECTION INTENTIONALLY LEFT BLANK **********

18.0 SIGNATURE PAGE.

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

COUNTY OF MONTEREY

By: _____

Contracts/Purchasing Officer

Date: _____

By: _____

Board of Supervisors (if applicable)

Date: 6/22/2023

Approved as to Form
Office of the County Counsel
Leslie J. Girard, County Counsel

By: DocuSigned by: Stacy Saetta C0ECE1B99F4[illegible]
County Counsel

Date: 5/25/2023 | 5:33 PM PDT

Approved as to Fiscal Provisions

By: DocuSigned by: Ma Mon 2617DD077D[illegible]
Auditor/Controller

Date: 5/25/2023 | 6:17 PM PDT

Approved as to Liability Provisions
Office of the County Counsel-Risk Manager
Leslie J. Girard, County Counsel-Risk Manager

By: _____

Risk Management

Date: _____

CONTRACTOR

Central California Alliance for Health

Contractor/Business Name *

By: DocuSigned by: Elsa M. Jimenez C7A30[illegible]
(Signature of Chair, President, or Vice-President)

Name and Title

Date: 5/24/2023 | 4:42 PM PDT

By: DocuSigned by: Lisa Ba [illegible]
(Signature of Secretary, Asst. Secretary, CFO, Treasurer, or Asst. Treasurer)

Name and Title

Date: 5/25/2023 | 5:00 PM PDT

County Board of Supervisors' Agreement No. _____ approved on _____

*INSTRUCTIONS: If CONTRACTOR is a corporation, including non-profit corporations, the full legal name of the corporation shall be set forth above together with the signatures of two (2) specified officers per California Corporations Code Section 313. If CONTRACTOR is a Limited Liability Corporation (LLC), the full legal name of the LLC shall be set forth above together with the signatures of two (2) managers. If CONTRACTOR is a partnership, the full legal name of the partnership shall be set forth above together with the signature of a partner who has authority to execute this Agreement on behalf of the partnership. If CONTRACTOR is contracting in an individual capacity, the individual shall set forth the name of the business, if any, and shall personally sign the Agreement or Amendment to said Agreement.

[1]Approval by County Counsel is required

[2]Approval by Auditor-Controller is required

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

LIST OF EXHIBITS

Central California Alliance for Health

Exhibit A	Scope of Services/Payment Provisions
Exhibit A-1	Group Agreement
Exhibit A-1-A	Terms and Conditions
Exhibit A-1-B	Premium Schedule
Exhibit A-1-C	COBRA and Cal-COBRA
Exhibit A-1-D	Obligations Under HIPAA
Exhibit A-1-E	2022-23 Evidence of Coverage
Exhibit B	DSS Additional Provisions
Exhibit C	Budget
Exhibit D	HIPAA Certification

SCOPE OF SERVICES/PAYMENT PROVISIONS
Central California Alliance for Health

July 1, 2023 - June 30, 2024

I. CONTACT INFORMATION

For Contractor:

Michael Schrader, Chief Executive Director
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
Phone: (831) 430-5500
Fax: (831) 430-5882
mschrader@ccah-alliance.org

For County:

Nick Ledo, Management Analyst
730 La Guardia St.
Salinas, CA 93905
Phone: (831) 755-4904
Fax: (831) 755-8487
ledon@co.monterey.ca.us

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

2. Notwithstanding Section 15.17 of County of Monterey Standard Agreement (more than $100,000), in the event of any conflict or inconsistency between the provisions of **Exhibit A-1** 'Group Agreement' and other attachments or exhibits including, but not limited to, the County of Monterey Standard Agreement (more than $100,000), the provisions of **Exhibit A-1** shall prevail and control.

II. SERVICES/PROGRAMS TO BE ADMINISTERED BY CONTRACTOR

CONTRACTOR shall provide the services outlined in **Exhibits A through A-1.**

IV. PAYMENT PROVISIONS

COUNTY shall issue payment for health premiums which are due by the first of every month, but no later than the fifth (5^{th}) of the month for IHSS Providers enrolled in the health plan per **Exhibit A-1-B.**

COUNTY shall reimburse CONTRACTOR a total amount not to exceed **five million four hundred seventy-nine thousand six hundred eighty-one dollars and zero cents ($5,479,681)** for Health Benefits for the period of **July 1, 2023 through June 30, 2024**, as described in **Exhibit C.**

EXHIBIT A-1

GROUP AGREEMENT
Between
Santa Cruz – Monterey – Merced
Managed Medical Care Commission
and
Monterey County In-Home Supportive Services Public Authority

This Group Agreement (Agreement), including the Evidence of Coverage (EOC) document(s) and attachments listed below and incorporated herein by reference, and any amendments to any of them, constitutes the contract between the Santa Cruz – Monterey –Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (PLAN) and the Monterey County In-Home Supportive Services Public Authority (Contract Holder). This Agreement is effective this 1st day of July, 2023.

Product Name: Alliance Care IHSS

Attachment	A-1-A - Terms and Conditions
Attachment	A-1-B – Premium Schedule
Attachment	A-1-C - COBRA and Cal-COBRA
Attachment	A-1-D – Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Attachment	A-1-E – Evidence of Coverage (EOC)

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

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

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

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

Group Agreement Effective Date: July 1, 2023

Monterey County
Board of Supervisors

_____
Signature

Name_____

Date

Santa Cruz – Monterey – Merced
Managed Medical Care
Commission

_____
Signature of Chair

Date

TABLE OF CONTENTS

ATTACHMENT A-1-A

TERMS AND CONDITIONS

Recital:

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

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

SECTION 1
DEFINITIONS

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

1.1 **"Beneficiary" –** shall mean a person designated by an insuring organization as eligible to receive insurance benefits.

1.2 **"Cal-COBRA" –** shall mean the California State law concerning an employee's access to continued health insurance coverage under certain circumstances when coverage would otherwise terminate. (Health & Safety Code (§1366.20 et seq.; Insurance Code (§10128.50 et seq.)

1.3 **"Commission"** shall mean the Santa Cruz – Monterey – Merced Managed Medical Care Commission.

1.4 **"Contract Holder" –** shall mean the Monterey County In-Home Supportive Services Public Authority (MCPA), the employer of record for Monterey County In-Home Supportive Services (IHSS) Workers. MCPA is authorized to execute the Group Agreement with the PLAN on behalf of eligible IHSS providers.

1.5 **"Consolidated Omnibus Budget Reconciliation Act (COBRA)" –** shall mean the federal law concerning an employee's access to continued health insurance coverage under certain circumstances when coverage would otherwise terminate.

1.6 **"Copayment" -** shall mean the portion of health care costs for covered services for which the Member has financial responsibility under the Alliance Care IHSS Program.

1.7 **"Covered Services"** shall mean those health care services and supplies which a Member is entitled to receive under the Alliance Care IHSS Program and which are set forth in the Alliance Care IHSS Program Evidence of Coverage (Attachment A-1-E, attached hereto

and hereby incorporated by reference).

1.8 **"Evidence of Coverage"** - shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the Alliance Care IHSS Program (Attachment A-1-E, hereto and incorporated herein by reference).

1.9 **"Group Agreement" –** shall mean this Agreement between the PLAN and the Contract Holder which constitutes the agreement regarding the benefits, exclusions and other conditions between the PLAN and Contract Holder.

1.10 **"Health Insurance Portability and Accountability Act of 1996 (HIPAA)" –** shall mean the federal law that, among other things, provides renewability of health care coverage to certain employees who no longer qualify for group health insurance through their employer and have an opportunity to purchase coverage from another insurer.

1.11 **"Hospital"** - shall mean a licensed general acute care hospital.

1.12 **"Member"** - shall mean an individual who is enrolled in good standing in Alliance Care IHSS.

1.13 **"Participating Provider"** - shall mean a Provider who has entered into an Agreement with the PLAN to provide Covered Services to Members. The terms "Participating Provider" and "Contracting Provider" may be used interchangeably.

1.14 **"PLAN" -** shall mean the Central California Alliance for Health, which is governed by the Santa Cruz – Monterey – Merced Managed Medical Care Commission.

1.15 **"Provider"** - shall mean any health professional or institution to render services to Members under the Alliance Care IHSS Program.

SECTION II
ENROLLMENT

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

2.1 The Contract Holder or designee shall be responsible for forwarding completed enrollment information obtained from eligible members to the PLAN.

2.2 The Contract Holder or designee shall also be responsible for forwarding enrollment information on Alliance Care IHSS Members eligible through COBRA or Cal-COBRA.

2.3 The Contract Holder will make every effort to ensure that eligibility information is transmitted electronically to the PLAN not later than the 10th of each month in order to be effective on the first of the following month.

2.4 The Contract Holder shall not change the eligibility requirements used to determine membership in the group during the term of the Group Agreement, unless agreed to in writing by the PLAN.

SECTION III
PREMIUMS

3.0 Premiums for the Covered Benefits under this Group Agreement are set forth in **Attachment A-1-B**, attached hereto, which is fully incorporated herein by reference.

3.1 Premium Change

3.1.1 PLAN may change the Premium with at least seventy-five (75) days written notice to Contract Holder as follows:

3.1.1.1 upon parties written agreement to amend **Attachment A-1-B** of this Group Agreement;

3.1.1.2 upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to Members.

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

3.2 Premium Payment

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

3.3 Premium due date and grace period

The Premium due date will be the first of the month for which coverage is provided. A thirty (30) day grace period will allow the Group Agreement to be in force beyond the premium due date. The Contract Holder remains liable for the payment of the Premium for the time coverage was in effect during the grace period and Members will remain liable for Copayments. The 30 day grace period is further detailed in Section 4.3.1 of this Agreement.

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

3.4 Retroactive Additions or Deletions

Retroactive additions or deletions are not allowed under this agreement.

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

SECTION IV
TERM AND TERMINATION

4.0 Effective Date

This agreement shall become effective on July 1, 2023.

4.1 Term

The term of this Agreement is July 1, 2023 through June 30, 2024.

4.2 Termination Notices

4.2.1 If Contract Holder initiates the termination**,** written notice will be transmitted by Contract Holder to PLAN by Certified U.S. Mail, UPS, FedEX, or other traceable mail service, proper postage prepaid and properly addressed to the office of the PLAN as provided below:

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

4.2.2 If the PLAN initiates the termination, written notice of cancellation will be transmitted by the PLAN to Contract Holder by Certified U.S. Mail, FedEx, or other traceable mail service, proper postage prepaid and properly addressed to the office of the Contract Holder as provided below.

4.3 Termination by the PLAN

4.3.1 Termination for nonpayment

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

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

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

4.3.2 Termination for withdrawal from the group market

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

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

4.3.2.1.1 PLAN is unable to enter into or maintain service contracts with sufficient numbers of providers, (hospitals and physicians) to assure adequate Member access to needed Covered Services, the PLAN may terminate this Agreement upon ninety (90) days written notice to the Contract Holder; or

4.3.2.1.2 If, the qualification of PLAN under the Federal Social Security Act is terminated or ceases or if the PLAN's contract with the State of California is terminated or ceases, Plan shall give Contract Holder immediate written notice of the foregoing termination(s) and this Agreement shall terminate in accordance with the terms of Section 4.3.2.2 of this Agreement.

4.3.2.2 PLAN's withdrawal from the group market

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

4.3.3 Termination Due to Loss of Eligibility

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

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

4.4 Termination by the Contract Holder

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

4.4.1 Termination due to non-renewal of Agreement

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

4.4.2 Termination due to Premium change

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

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

Either party may terminate this Agreement upon thirty (30) days prior written notice to the other party, if the terminating party can demonstrate the other party commited fraud or intentionally misrepresented a material fact. Such termination must occur within twenty four (24) months following the issuance of the health service plan contract.

4.6 Effect of Termination

As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect whatsoever, and each of the parties

hereto shall be relieved and discharged herefrom, except that the PLAN shall remain liable for all Benefits rendered to Members up to the date of termination and for any Benefits rendered hereunder after such date until such time as appropriate transfer (or other medically acceptable disposition) of Members receiving inpatient services as of the date of termination is achieved.

SECTION V
MEMBER NOTIFICATION OF TERMINATION

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

5.1 Termination shall not relieve the Contract Holder or PLAN from any obligation incurred prior to the date of termination of this Group Agreement.

SECTION VI
OBLIGATIONS UNDER COBRA AND CAL-COBRA

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

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

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

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

SECTION VIII
INDEPENDENT CONTRACTOR RELATIONSHIPS

8.0 Between Participating Providers and PLAN.

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

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

The PLAN will provide written notice to the member, within a reasonable period of time, of any termination or breach of contract by, or inability to perform by, any contracting provider if a member may be materially and adversely affected.

8.1 Between the Contract Holder and PLAN.

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

SECTION IX
ADMINISTRATION OF THE AGREEMENT

9.0 Entire Agreement

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

9.1 Amendments

9.1.1 This Group Agreement may be amended at any time upon written agreement of PLAN and Contract Holder. Amendments to this Agreement shall only be effective, provided it is in writing and signed by duly authorized representatives of both Parties.

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

9.2 Forms

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

9.3 Records

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

The Contract Holder or designee shall make payroll and other records directly related to Member's coverage under this Group Agreement available to PLAN for inspection, at PLAN's expense, at the Contract Holder's or designee's office, during regular business hours, upon reasonable advance request from PLAN. This provision shall survive the termination of this Group Agreement as necessary to resolve outstanding financial or administrative issues pursuant to this Group Agreement. PLAN's performance of any

obligation that depends on information to be furnished by Contract Holder or designee or Member will not arise prior to receipt of that information in the form requested by PLAN. Nor will PLAN be liable for any obligation due to information incorrectly supplied by Contract Holder or designee or Member. All records of Contract Holder that have a bearing on coverage shall be open for inspection by PLAN at any reasonable time.

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

9.4 Clerical Errors

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

9.5 Claim Determinations

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

9.6. Member Termination for Fraud or Misrepresentation

A Member can be terminated for fraud or intentional misstatements of a material fact in a manner consistent with the provisions in Member's Evidence of Coverage.

9.7 Assignability

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

9.8 Waiver

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

9.9 Notices

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

9.10 Third Parties

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

9.11 Non-Discrimination

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

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

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

9.12 Inability to Arrange Services

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

9.13 Workers' Compensation

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

9.14 Indemnification by Contractor

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

9.15 Indemnification by County

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

ATTACHMENT A-1-B

PREMIUM SCHEDULE

(July 1, 2023 – June 30, 2024)

July 1, 2023 – June 30, 2024 Premium …….. $574/per member/per month

ATTACHMENT A-1-C

CONTRACT HOLDER'S OBLIGATIONS UNDER COBRA AND CAL-COBRA

A. All parties will comply with applicable federal law, regulations and requirements regarding continuation of benefits.

B. All parties will comply with applicable state law, regulations and requirements regarding continuation benefits.

C. Contract Holder or designee agrees to forward to PLAN in a timely manner copies of any and all notices provided to Members regarding COBRA or Cal-COBRA continuation coverage.

D. Contract Holder will administer or contract for the administration of coverage under COBRA and Cal-COBRA.

ATTACHMENT A-1-D

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

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

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

Alliance Care
IHSS Health Plan

Member Handbook
Combined Evidence of Coverage
and Disclosure Form

Central California Alliance for Health

800-700-3874 Toll Free
800-735-2929 TTY Line

www.thealliance.health

Benefit Year July 1, 2022–June 30, 2023

English Tagline

ATTENTION: If you need help in your language call 1-800-700-3874 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-700-3874 (TTY: 1-800-735-2929). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-700-3874 (TTY: 1-800-735-2929)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-800-700-3874 (TTY: 1-800-735-2929)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は 1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-700-3874 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-700-3874 (TTY: 1-800-735-2929). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-700-3874 (TTY: 1-800-855-3000). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-700-3874 (TTY: 1-800-855-3000). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ
ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.

NONDISCRIMINATION NOTICE

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

The Alliance provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:

  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact the Alliance between 8AM - 5:30 PM, Monday through Friday, by calling **800-700-3874.** If you cannot hear or speak well, please call **800-735-2929** (**TTY:** Dial 711). Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Central California Alliance for Health
1600 Green Hills Rd, Suite 101
Scotts Valley, CA 95066
800-700-3874
800-735-2929 (**TTY**: Dial 711)

HOW TO FILE A GRIEVANCE

If you believe that the Alliance has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with the Alliance's Civil Rights Coordinator, also known as the Senior Grievance Specialist. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact the Alliance's Senior Grievance Specialist between 8 AM and 5:30 PM, Monday through Friday, by calling **800-700-3874**. Or, if you cannot hear or speak well, please call **800-735-2929** (**TTY**: Dial 711).

- In writing: Fill out a complaint form or write a letter and send it to:

  Central California Alliance for Health
  Attn: Senior Grievance Specialist
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066

- In person: Visit your doctor's office or the Alliance and say you want to file a grievance.

- Electronically: Visit the Alliance's website at www.thealliance.health.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

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

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint website Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Disclosure

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan's policies and coverage under the Alliance Care IHSS Plan. The Health Plan complies with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act's regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act's regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage handbook or the Health Plan contract.

Eligibility and Enrollment

Information about eligibility, enrollment, disenrollment, the starting date of coverage, transfers to another health plan, annual requalification and premium payments can be obtained by contacting the Monterey County Public Authority at **831-755-4466.**

Timely Access to Non-Emergency Health Care Services

The California Department of Managed Health Care (DMHC) adopted regulations (Title 28, Section 1300.67.2.2) for health plans to provide timely access to non-emergency health care services to members. Health care service plans must comply with these regulations.

Please contact your Primary Care Provider (PCP) at the phone number on your Alliance ID Card to access triage or screening services by telephone, 24 hours per day, 7 days per week. You can also call the Alliance's Nurse Advice Line at **844-971-8907,** 24 hours a day, 7 days a week at no cost to you. The Hearing or Speech Assisted Line is **TTY: 800-735-2929.**

Table of Contents

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 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 **800-700-3874** or use TTY for the hearing-impaired at **800-735-2929**. 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 through Friday from 8 a.m. to 5:30 p.m. You can also visit our website, **www.thealliance.health**.

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

Confidential Communication of Medical Information

The Alliance takes the required steps to accommodate all requests for confidential communication of medical information regardless of whether it involves sensitive services or a situation in which disclosure would put you in danger. This includes communications that discloses a provider’s name and address related to the receipt of a medical service. A confidential communication request (CCR) allows you to receive health plan communications containing medical information at a specific mail or e-mail address or telephone number. If you would like to receive confidential communication, you may file a CCR by contacting Member Services at **800-700-3874** (TTY: 800-735-2929 or 711) or by visiting our website at www.thealliance.health. CCR’s are implemented within 7 calendar days of receipt of an electronic request or 14 calendar

days when received by mail. CCR's are valid until the Alliance receives a revocation request from you.

Multilingual Services

If you or your representative prefers to speak in any language other than English, call us at **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 there are special circumstances that require you to have a face-to-face interpreter for a medical appointment, you or your doctor can call us for authorization. If we approve the request, an interpreter will be in the office with you for the appointment. Face-to-face and American Sign Language (ASL) interpreter services must be scheduled in advance. Requests for ASL interpreters should be made 5-7 business days before your appointment. All other requests for face-to-face interpreter services should be made 7-10 business days before your appointment. Please call us or have your doctor call us at **800-700-3874, ext. 5580.** There is no charge to you for interpreter services.

This EOC handbook, as well as other informational material, has been translated into Spanish. To request translated materials in any language other than English or Spanish, please call Alliance Member Services at **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 it or if you have lost your Member Identification Card, please call us at **800-700-3874** and we will send you a new card. Please show your Alliance Member Identification Card when you receive medical care or pick up prescriptions at the pharmacy.

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

Alliance Nurse Advice Line

The Nurse Advice Line (NAL) is a service available to all Alliance members. You can call the NAL if you have questions about your health. A registered nurse will help you with what to do next. The service is available 24 hours a day, 7 days a week at no cost to you.

Call the Nurse Advice Line when:

- You are sick and you cannot reach or get an appointment with your doctor (for example, you have a fever or rash, vomiting, etc.).
- You are not sure if you should go to the emergency room.
- You have questions about your health.
- You are under 18 years old and want to talk in private about your health concerns.

You can call the Nurse Advice Line toll-free at **844-971-8907.** The phone number is also on your Alliance ID card. The Hearing or Speech Assisted Line is **TTY: 800-735-2929**.

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.

Behavioral Health Treatment (BHT)
Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

- The treatment is prescribed by a licensed physician, surgeon or developed by a licensed psychologist.
- The treatment is provided under a treatment plan prescribed by a participating qualified autism service provider and is administered by one of the following:
    - A participating qualified autism service provider.
    - A participating qualified autism service professional supervised or employed by the participating qualified autism service provider.
    - A participating qualified autism service paraprofessional supervised or employed by a participating qualified autism service provider.

- The treatment plan has measurable goals over a specific timeline that is developed and approved by the participating qualified autism service provider for the specific Member being treated. The treatment plan will be reviewed no less than once every six months by the participating qualified autism service provider and modified whenever appropriate, and it will be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the participating qualified autism service provider does all of the following:
    - Describes the Member's behavioral health impairments to be treated.
    - Designs an intervention plan that includes the service type, number of hours and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported.
    - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
    - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
    - The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan will be made available to the Alliance upon request.

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 if it is not medically necessary or if it is not provided by a Contracted Provider and with prior authorization, as required. This applies even if the service is described as a covered service or benefit in this booklet.

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

Brand Name Drug
A drug that is marketed under a proprietary, trademark protected name. The brand name drug shall be listed in all CAPITAL letters on the formulary.

Coinsurance
A percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

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

- You cannot 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.
- You feel that the Plan has not protected your privacy.
- You feel that you have been discriminated against because of your race, color, national origin, age, disability or sex.
- You feel the Plan did not meet your language or accessibility needs.

Copayment
A fixed dollar amount that a member pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as a prescription drug benefit.

Drug Tier
A group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the member's portion of the cost of the drug.

Emergency Care
Emergency Care is for life-threatening medical emergencies. A medical emergency is a condition with severe pain or serious injury. Medical emergencies are so serious that without immediate attention, they may result in:

- Serious risk to the Member's health.
- Serious harm to the Member's bodily functions.
- Serious dysfunction of any of the Member's bodily organs or parts.

Exception Request
A request for coverage of a prescription drug. If a member, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

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.

Exigent Circumstances
Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-formulary drug.

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 complete list of prescription drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.

Generic Drug
Is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance and intended use. A generic drug is listed in ***bold and italicized lowercase*** letters on the formulary.

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.

Iatrogenic Infertility
Infertility caused directly or indirectly by surgery, chemotherapy, radiation or other medical treatment.

In Vitro Fertilization (IVF)
Laboratory medical procedures involving the actual in vitro fertilization process.

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.

Maternal Mental Health
A mental health condition that impacts a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period.

Medically Necessary
Those health care, mental health care and substance use disorder services or products that are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating provider to be consistent with the medical condition, mental illness or substance use disorder; and (c) furnished at the most appropriate type, supply and level of service that consider the potential risks, benefits and alternatives. Medically necessary treatment of mental health and substance use disorders (MH/SUD) are listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM").

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.

Over the Counter
A medicine or product available for retail sale, but which can be considered for payment by the plan with a valid prescription.

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.

Prescribing Provider
A health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

Prescription
Is an oral, written or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

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.

Psychiatric Emergency
A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being an immediate danger to self or others or immediately unable to provide for or use food, shelter or clothing, due to the mental disorder.

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.

Serious Emotional Disturbances of a Child
A child or adolescent under the age of 18 who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms.

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, such as obstetrical services.

Step Therapy
A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

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

These are your rights as a member of the Alliance:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- To make recommendations about the Alliance's member rights and responsibilities policy.
- To be able to choose a primary care provider within the Alliance's network.
- To have timely access to network providers.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances either verbally or in writing, about the organization or the care you got.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting services, including American Sign Language, for your language.
- To get free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To file an Independent Medical Review (IMR) if a service or benefit is denied, delayed or modified.
- To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To request confidential communications.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, including telehealth records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- To have a confidential relationship with your provider.
- To 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.
- To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested.To be provided written Member materials in Spanish, or other

languages, if your primary language is not English. For help with information in another language please call Member Services.
- To get help from us to understand written documents we send to you.
- To get services from providers outside of our network in an emergency.
- To ask for an external exception review if we deny a request for a medication or deny a request for an exception to our step-therapy process.
- Freedom to exercise these rights without adversely affecting how you are treated by the Alliance, your providers or the State.

The Alliance members have these responsibilities:
- Know the Alliance's rules and follow them.
- 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 **800-700-3874** and we will be happy to go over it with you.
- Tell your doctor about your health conditions, both now and in the past.
- 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.
- Keep your Alliance ID card with you at all times. Show your card and pay co-pays when you get care.
- Use the emergency room only for emergency services.
- Keep your appointments. If you have to cancel an appointment, let the office know 24 hours before you were scheduled to see the doctor.
- 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

Access for the Physically-Disabled

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 **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 **800-735-2929**.

Access for the Vision-Impaired

This Evidence of Coverage (EOC) and other important Plan materials will be made available in large print or electronic formats for the vision impaired. For alternative formats or for direct help in reading the EOC and other materials, please call us at **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 **800-700-3874** or go to our website, **www.thealliance.health**.

Services for 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 to work together. To learn more, call the Alliance Case Management Line at **800-700-3874, ext. 5512.**

Using Your Health Plan

Facilities and Provider Locations

Important: Please read the following information so you will know from whom or from 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 Providers, specialists, hospitals, allied health and other providers, please look in your Provider Directory. If you need a

Provider Directory, call Member Services at **800-700-3874** or go to our website, **www.thealliance.health.**

For information on how to find a pharmacy, see the "Getting Pharmacy Benefits" section of this book.

Choosing a Primary Care Provider

Inside the Alliance Care IHSS Provider Directory, or in the online directory at https://thealliance.health/for-members/get-started/find-a-doctor/, 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 call 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. You can also call the Alliance Nurse Advice Line at **844-971-8907**.

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 anymore. 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."

Timely Access to Care

It will take longer to get an appointment for some kinds of care than others. This shows how much time it should take to be seen:

Type of visit	Wait Time
Urgent Care (when prior authorization is **not** required)	48 hours
Urgent Care (when prior authorization is required)	96 hours
Non-Urgent Primary or Routine Care	10 business days
Non-Urgent Specialty Care	15 business days
Non-Urgent, Non-Physician Mental Health Care	10 business days
Non-Urgent, Non-Physician Mental Health Follow-Up Care or Substance Use Disorder Provider	10 business days from prior appointment
Non-Urgent Ancillary Services	15 business days
Telephone Triage or Screening	30 minutes

You have the right to interpreter services, including American Sign Language interpretation, at no cost to you when accessing plan covered services. For more information on interpreter services, see the section of this book titled "Multilingual Services."

Initial Health Exam

The Alliance recommends that as a new member, you see your new PCP in the first 120 days after enrolling for an initial health exam, also called a new patient exam. The first meeting with your new PCP is important. It is a time to get to know each other and review your health status. Your PCP will help you understand your medical needs and advise you about staying healthy. Call your PCP'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 **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 14th, you can start seeing your new doctor on October 1st.

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 do not call to cancel ahead of time.
- 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.
- Maternal mental health. Completion of services shall be provided for up to one year after delivery or diagnosis, whichever occurs later.
- 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 **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.

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, we encourage you to contact the Department of Managed Health Care, which protects consumers, at its toll-free telephone number **888-466-2219 (TDD: 877-688-9891)** or online at **www.dmhc.ca.gov**.

Continuity of Care for Terminating Providers

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.
- Pregnancy, including postpartum care.
- Maternal mental health. Completion of services shall be provided for up to one year after delivery or diagnosis, whichever occurs later.

- 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 **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 consumers, at its toll-free telephone number **888-466-2219 (TDD: 877-688-9891)** or online at **www.dmhc.ca.gov**.

Prior Authorization for Services

Your Primary Care Provider (PCP) will coordinate your health care needs and, when necessary, will arrange specialty care and services for you.

In some cases, the Plan must authorize the services before you receive them. Mental health and substance use disorder services requiring prior authorization must be authorized by the Plan's Contractor, Beacon Health Options. Prescription drugs requiring prior authorization must be authorized by the Plan's Contractor, MedImpact.

Your PCP or treating provider will obtain the necessary referrals and authorizations for you. Prior authorization means that both your doctor and the Plan or the Plan's Contractor agree that the services you will receive are medically necessary. If you need something that requires prior authorization, the health care provider will submit an Authorization Request. Your provider knows which services require prior authorization.

They include:

- Non-emergency inpatient services.
- 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.
- Intensive outpatient behavioral health services for mental health and substance use disorder treatment.
- Mental health residential treatment services.
- Inpatient substance use disorder treatment services including residential detoxification services.
- Behavioral Health Treatment services for the treatment of autism and pervasive developmental disorder (PDD), including home therapies.
- Outpatient day treatment for mental health and substance use disorder.
- Partial hospitalization for mental health and substance use disorder.
- Electroconvulsive therapy services.

Authorization Requests are reviewed by qualified clinical staff. They review each case to make sure you are getting the best and most appropriate treatment for your condition.

Medical and Behavioral Health Authorization Requests
Most authorization requests are approved, but sometimes a request is denied. 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 72 hours.

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 was approved. If you receive services before you receive the required authorization, you will be responsible for paying the cost of the treatment. If a request for prior authorization is denied, you will receive 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 policies, please call Member Services at 800-700-3874.

Pharmacy Authorization Requests
Information about the prior authorization process for prescription medications is in the "Getting Pharmacy Benefits" section of this document. This includes a description of the timeframes for responding to pharmacy prior authorization requests and your copay amounts. It also includes information about your right to file a complaint and your right

to ask for an external exception review if we deny a request for a medication or deny a request for an exception to our step-therapy process.

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. 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. For a list of specialists, please see your Provider Directory, call Member Services at **800-700-3874** or go to our website**,** www.thealliance.health**.**

If your PCP feels that you need to see a specialist, he or she will send 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.

There are some services you can receive without needing a referral from your PCP. These include family planning services, testing and treatment of sexually transmitted infections, HIV testing and sexual assault treatment services. Women can also see an OB/GYN for an annual well woman exam, pap smear, breast exam and pregnancy care. 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 **800-700-3874**. If you feel that your needs have not been met after calling us, please see the 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 **800-700-3874.**

Telehealth Services
The Alliance provides coverage for telehealth services on the same basis and to the same extent as in-person visits. Some providers may be able to provide some of your services through telehealth. Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live video conversation with your provider. Or telehealth may involve sharing information with your provider without a live conversation. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you if you choose to use it.

You have the right to access all medical records from your telehealth services. You can contact the Alliance at **800-700-3874** to determine which types of services the Alliance may be able to provide to you through telehealth.

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 ask for a copy of our policy, please contact us at **800-700-3874.**

Getting Pharmacy Benefits

Drugs Given in a Doctor’s Office or Drugs Covered Under the Medical Benefit
Your doctor will know what drugs these are. If your doctor prescribes these, your doctor can contact us for more information about obtaining these drugs for you. These drugs can be given to you in different ways, sometimes through an injection in your vein, skin or other body part. There are no coinsurance amounts for these drugs on the Alliance care IHSS health plan.

Your doctor can ask about coverage restrictions or submit a prior authorization by calling Alliance provider services at **831-430-5504** or by calling Pharmacy prior authorizations at **831-430-5507**. Your doctor can also fax a prior authorization to us or use our online prior authorization portal.

If you have questions about coverage for drugs given to you in a doctor’s office, you can call member services at **800-700-3874**. These drugs are not listed on the Formulary.

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 presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your doctor for a particular medical condition.

You or your doctor can request that the pharmacy fill only part of the prescription at one time. You would get the rest of the prescribed amount later.
This is called a “partial fill” and applies only to what are called Schedule 2 drugs. These are drugs like opioids and stimulants. Your copayment on a partial fill will be prorated and will be less than the copayment stated in the drug tier section.

Your pharmacy can call MedImpact to ask for a 5-day emergency supply override for you at any time.

How to get Prior Authorization for a Drug
Drugs that require a prior authorization are noted with the symbol "PA" on the formulary guide. The request for prior authorization lets us know why you need that drug. Prior authorization means that both your doctor and the Plan or the Plan's Contractor agree that the services you will receive are medically necessary. We will need to approve the request before covering that drug for you. 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." Your provider may request an exception to the step therapy process for a prescription drug. This is known as "step therapy exception."

We contract with a company called MedImpact for pharmacy services. Prescription drugs requiring a prior authorization must be authorized by MedImpact. When MedImpact gets a request for prior authorization for a drug, MedImpact will reply to your doctor within 24 hours from the receipt of an urgent request and 72 hours from the receipt of a routine request. If MedImpact does not respond within this timeframe , the request is considered to be approved.

Authorization requests for exigent circumstances will be given priority and a 5-day supply of the covered outpatient drug will be dispensed until a determination has been made or the 24-hour period has expired. Please see the "Definitions" section of this document for an explanation of the term "exigent circumstances."

If MedImpact approves the request, you can get the drug. If MedImpact denies the request, you or your provider have the right to file a complaint. As part of the grievance process, you, your personal representative or your provider may ask for an external exception review. This means we would send the authorization request and the information we received from your provider to an outside physician who would review our decision. For more information on how to file a complaint or asking for an external exception review, please call Member Services at **800-700-3874.**

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.

How to Find a Pharmacy
If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with the Alliance. We contract with a company called MedImpact for pharmacy services and we use their network of pharmacies. You must go to one of these pharmacies for your prescription drugs. Some of the pharmacies have locations throughout California.

You can find a list of pharmacies that work with the Alliance in the Alliance Provider Directory at https://thealliance.health/MedimpactLocator.

You can also find a pharmacy near you by calling Member Services at **800-700-3874 (TTY: 800-735-2929 or 711).**

Once you choose a pharmacy, take your prescription to the pharmacy. Give the pharmacy your prescription with your Alliance ID card. Make sure the pharmacy knows about all drugs you are taking and any allergies you have. If you have any questions about your prescription, make sure you ask the pharmacist. 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 800-700-3874. We will explain to the pharmacy how they can bill us for the drug.

Your pharmacy can also call MedImpact to get a 5-day emergency supply of drugs for you. If there is a state of emergency issued in your local area, your pharmacy can also call MedImpact to get an emergency override for your drugs.

Some drugs are known as specialty drugs. These drugs may have special handling or storage requirements. You might also need extra guidance from a care team at the pharmacy for that drug. The pharmacy will let you know if any of the drugs you are prescribed are specialty drugs and what you need to do with them.

The Alliance has a specialty pharmacy network called MedImpact Direct Specialty. Specialty drugs are required to be filled at a pharmacy in the MedImpact Direct Specialty network. These specialty drugs have the letters “SP” on the formulary. For any questions for MedImpact Direct Specialty, call **877-391-1103** (Monday through Friday, 5 a.m. to 5 p.m.).

The Alliance also offers a mail order pharmacy program. Did you know you can get a 90-day supply of most prescription drugs mailed to you through MedImpact Direct Mail? Talk to your doctor about getting a 90-day supply with free standard delivery. To set up mail-order for your drugs, visit https://www.medimpact.com/homedeliverymembers or call 855-873-8739.

Prescription Drug Tier and Copayments

Tier copayment amounts apply:

- Per prescription for a 30-day supply of generic drugs, per prescription for a 30-day supply of brand name drugs.
- Per prescription for a 90-day supply of maintenance drugs of generic drugs, per prescription for a 90-day supply of brand name drugs.
- If the cost of drug is lower than the copayment, member will pay for the lower cost.
- 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.
- Copayment may be less for a “partial fill,” please see the “What your doctor can prescribe” section for more information on what “partial fill” means.

- No copayment for contraceptives. You may get a 12-month supply of birth control pills, patches and vaginal rings.

Tier	Copayment	Description
Tier 1	$5.00 *	Generic and Specialty generic drugs
Tier 2	$15.00 *	Brand and Specialty brand drugs

**coinsurance amounts in accordance with Health and safety code 1367.656*.

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.

Getting Urgent Care

Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness, 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. If you cannot reach your PCP, you can call the Alliance Nurse Advice Line at **844-971-8907**. The Nurse Advice Line may refer you to a contracted urgent care provider.

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 or the Alliance's Nurse Advice Line 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 **800-700-3874**.

Getting Emergency Care

Emergency Care is for life-threatening medical emergencies. A medical emergency is a condition with severe pain or serious injury. Medical emergencies are so serious that without immediate attention, they may result in:

- Serious risk to your health.
- Serious harm to bodily functions.

- Serious dysfunction of any body organ or part.

  Examples include:
  - Broken bones.
  - Chest pain.
  - Severe burns.
  - Fainting.
  - Drug overdose.
  - Paralysis.
  - Severe cuts that will not stop bleeding.
  - Active labor.
  - Psychiatric emergency conditions.

For emergency care, call **911** or go to the nearest emergency room (ER). For emergency care, you do not need pre-approval (prior authorization) from the Alliance. You have the right to use any hospital or other setting for emergency care.

If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in the Alliance network. You are covered for emergency services both in and out of the Plan's Service Area and do not need pre-approval (prior authorization) to access out of area emergency care.

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 if you received treatment.

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.

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

Post-Stabilization and Follow-Up Care After an Emergency

Once your emergency medical condition has been treated at a hospital and an emergency no longer exists because your condition is stabilized, the doctor who is treating you may want you to stay in the hospital for a while longer before you can

safely be discharged. 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 be 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 of 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 **800-700-3874**.

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.

Deductibles

There is no deductible for covered services. For more information on covered services, refer to the Benefits section of this document.

Copayments

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

The Plan will track your copayments and will send you up-to-date accrual notices by mail for every month that benefits are used until your annual $3,000 copayment maximum is met. If you previously opted out from receiving Alliance mailings, you will receive the notice electronically. To opt-out from receiving mailed accrual notices and elect electronic accrual notifications, or to opt-in and continue receiving accrual notices

by mail, please contact the Alliance Member Services Department at **800-700-3874** for assistance. If you chose to receive electronic accrual notices, you can opt-in and continue receiving accrual notices by mail at any time by contacting Member Services.

You can also call the Alliance Member Services Department at **800-700-3874** for up-to-date copayment information or you can access this information on the Alliance website at **www.thealliance.health**.

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 reimburse 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).
- 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 or in cases where covered services are provided by a Non-Contracted Provider at an in-network facility where we have authorized you to receive care. You are not responsible

for any amounts beyond your copayment for the covered services you receive at in-network facilities where we have authorized you to receive care.

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

- Yearly 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 **800-700-3874, ext. 5580** can also help. They speak English and Spanish.

Adult Health Screening 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.

For All Patients			
Test	**Ages 18–39**	**Ages 40–64**	**Ages 65+**
Health exam This may include height and weight, BMI, blood pressure and hearing and eye exam	For all Alliance Members: Schedule your first check-up within 90 days (3 months) of becoming an Alliance Member.		
Tuberculosis risk check (TB)	Screening for risk at initial entry into health plan for all Members. Repeat screening at yearly checkups.		
Falls prevention: older adults			Your doctor may recommend exercise interventions to prevent falls.

For All Patients			
Hepatitis C test	Recommended at least one time for adults 18-79 years of age. All others as needed based on risk factors.		
Blood pressure	Every 1–2 years.	Every 1–2 years.	Every 1-2 years.
Lung cancer screening		Your doctor may recommend annual screening for lung cancer (adults 50-80 years old) who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.	
Tobacco use	Your doctor should ask all adults about tobacco use and offer services and support to persons ready to quit.		
Unhealthy alcohol use	Your doctor should ask about unhealthy alcohol use.		
Stool test or other colorectal screening	As determined by your doctor.	Every year at age 50 and over.	Every year until 75 years of age.
Screening for abnormal blood glucose	You may be checked for abnormal blood glucose if aged 40-70 years and are overweight or obese.		
Healthy diet and physical activity counseling	Your doctor may recommend counseling to promote a healthful diet and physical activity for stroke and heart disease prevention.		
Obesity screening and counseling	Your doctor may refer adults with a body mass index of 30 or higher to intensive, multicomponent behavioral interventions.		
Preventive Medication: Heart Disease	Your doctor may recommend low-dose aspirin to help prevent cardiovascular disease and colorectal cancer if you are 50-59 years of age and have at least a 10% risk of 10-year cardiovascular disease risk.		
Patients with diabetes	Every year: blood pressure check, foot exam, weight check, urine test and eye exam. At least 2 times a year, get a hemoglobin A1C or HbA1c test. At least once in your lifetime, get a pneumonia vaccine. Make sure that you are vaccinated against Hepatitis B. Talk with your doctor about cholesterol testing and dental exams.		
Unhealthy Drug Use Screening	Routine screening about unhealthy use of drugs in adults 18 and older.		
Depression screening	Routine depression screening is recommended for all, including teens, pregnant women and new parents.		

Sexually Transmitted Diseases, Counseling	Behavioral counseling is recommended for all adults who are sexually active and at increased risk for sexually transmitted infections.		
Preventive Medication: HIV	Persons at high risk for HIV infection may benefit from preventive treatment. Talk with your doctor about whether you may benefit from it.		
Hepatitis B screening	Screening as needed based upon risk factors.		
HIV test	One-time testing for adults 18-64 years. Again, as needed based upon risk factors.		
For Female Patients Only			
Test	**Ages 18–39**	**Ages 40–64**	**Ages 65+**
Breast cancer screening	As recommended by your doctor.	Ages 40–50, as recommended by your doctor. Ages 50–64, every 1-2 years.	Ages 65–70, every 1-2 years. Over age 75, as recommended by your doctor.
Pap smears	Ages 21-29, every 3 years Pap alone. Ages 30-65, Pap alone every 3 years, HPV testing alone every 5 years OR Pap with HPV testing every 5 years.	Ages 30-65, Pap alone every 3 years, HPV testing alone every 5 years OR Pap with HPV testing every 5 years.	None, if had regular screenings before age 65 and not at high risk.
BRCA risk assessment and genetic counseling/testing	Your doctor may ask about your family history of cancer and could recommend further genetic testing.		
Preventive Medication: Breast Cancer	Your doctor may offer medication to reduce risk of breast cancer if you are 35 years or older and at increased risk of breast cancer.		
Bone Health		Postmenopausal women younger than 65 years should be screened.	Screening is recommended.

Folic Acid	All women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.		
Chlamydia, gonorrhea, and syphilis testing: sexually active women	Every year for ages 12– 24 if sexually active. Ages 25 and older if at high risk, even if pregnant.	Only if at risk, especially if pregnant.	Ages 65 and older, if at risk.
Intimate partner violence screening	Your doctor should ask about potential for intimate partner violence.		

For Pregnant Patients Only	
Test	**Recommendations**
Bacteriuria screening	Your urine will be checked for bacteria at 12-16 weeks gestation or at the first prenatal visit, if later.
Preeclampsia screening	Your doctor will monitor your blood pressure for preeclampsia during your pregnancy. Preeclampsia is a pregnancy complication that is characterized by high blood pressure.
Hepatitis B screening	It is strongly recommended that you are checked for the hepatitis B virus infection at your first prenatal visit.
Perinatal depression	Your doctor will provide or refer you to counseling interventions if at risk of depression.
HIV screening	Your doctors may screen you for HIV during prenatal care and during labor if your HIV status is unknown.
Rh incompatibility screening	Rh (D) blood typing and antibody testing is recommended for all pregnant women during their first visit for pregnancy-related care. Testing is repeated for Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative.
Breastfeeding interventions	Your doctor will recommend interventions during pregnancy and after birth to support breastfeeding.
Gestational diabetes mellitus screening	Your doctor will recommend screening for gestational diabetes mellitus after 24 weeks of gestation for women without symptoms.

Preventive medication: healthy baby development	All women who are planning or capable of becoming pregnant should take a daily supplement of folic acid. Consult with your doctor about this medication.
Preventive medication: blood pressure management	Your doctor may recommend use of low-dose aspirin after 12 weeks for persons at high risk for preeclampsia

For Male Patients Only			
Test	**Ages 18–39**	**Ages 40–64**	**Ages 65+**
Abdominal aortic aneurysm screening: men			One-time screening for abdominal aortic aneurysm by ultrasonography in men 65-75 years old who have ever smoked.

Adult Immunization Guidelines
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.

Routine Adult Immunization Guidelines			
Vaccinations/Shots	**Ages 19-49**	**Ages 50-64**	**Ages 65+**
Influenza	1 dose annually.		
Tetanus, Diphtheria, pertussis (Td and Tdap)	1 dose of Tdap, then Td or Tdap every 10 years. Pregnant women need Tdap with every pregnancy.		
Pneumococcal (PCV15 and PCV20)	Recommended for people with health risk factors.	Recommended for people with health risk factors.	If no prior vaccine received or history is unknown, one dose of PCV15 or 1 dose of PCV20. If PCV15 is used, it should be followed by a dose of PPSV23 at least a year later.

Measles, Mumps and Rubella	1-2 doses at least 1 month apart.	Talk to your doctor.	Talk to your doctor.
Hepatitis B (Hep B) All adults 19-59 years	Dose and schedule depend upon type of vaccine.		
Hepatitis A (Hep A)	2 doses at least 6 months apart if would like protection from infection.		
Meningococcal ACWY	Indicated for people with health concerns or certain living conditions. 1 or 2 doses and then a booster every 5 years if risk remains.		
Meningococcal type B	2 or 3 doses of MenB depending upon risk.		
Zoster		Herpes Zoster Recombinant Vaccine recommended: 2 doses at least 2 months apart per lifetime for those 50 years of age and older.	
***Haemophilus influenzae* type b (Hib)**	1 or 3 doses depending on indication		
Human Papilloma Virus (HPV) Routine vaccination through age 26. Adults 27-45 may be vaccinated based on their doctor's recommendation.	3 doses are needed if unvaccinated. 2nd dose 2 months after first and the 3rd dose 6 months after the first dose.		
Varicella	2 doses of vaccine given 4-8 weeks apart if no history of disease and born in 1980 or later.		

Eligibility and Enrollment

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

- Work at least the minimum number of months and hours per month as established by the In-Home Supportive Services Public Authority of Monterey County, also referred to as the Public Authority.
- Either live or work in Monterey County.
- Not have been previously terminated by the Alliance for fraud, deception or failing to provide complete information.
- Have submitted the required enrollment information to the Public Authority.
- 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 visit or telehealth appointment except: ▪ No copayment for hospital inpatient professional services. ▪ No copayment for surgery, anesthesia, or radiation, chemotherapy or dialysis treatments. ▪ No copayment for pediatric vision screening. ▪ No copayment for hearing testing or for hearing aids.

Benefits*	Services	Cost to Member (copayment)
Preventive Health Service	Periodic health examinations including all routine diagnostic testing, Sexually Transmitted Diseases (STD) testing, Human Immunodeficiency Virus (HIV) testing, laboratory services appropriate for such examinations, colorectal cancer screening and testing, 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.
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 (Drug Tier 1), $15 per prescription for a 30-day supply of brand name drugs (Drug Tier 2). $5 per prescription for a 90-day supply of maintenance drugs of generic drugs (Drug Tier 1), $15 per prescription for a 90-day supply of brand name drugs (Drug Tier 2). If the cost of drug is lower than the copayment, member will pay for the lower cost.

Benefits*	Services	Cost to Member (copayment)
		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. No copayments for contraceptives. **coinsurance amounts in accordance with Health and safety code 1367.656.*
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.
Medical Transportation Services	Emergency ambulance, including air 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).

Benefits*	Services	Cost to Member (copayment)
Mental Health Care Services Inpatient Mental Health Care Services	Diagnosis and treatment of a mental health condition. 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 Use Disorder Services	Inpatient substance abuse treatment services and residential treatment services.	No copayment. Unlimited days.
Outpatient Substance Use Disorder Services	Crisis intervention and outpatient treatment of a substance use disorder condition.	$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.

Benefits*	Services	Cost to Member (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 Service Area Contracted Provider.	$10 per visit. Benefit is limited to 20 visits per benefit year.
Chiropractic	Requires a referral from the Member's PCP and prior authorization from the Alliance. 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.

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 **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 is 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 **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.
- 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 that:

- Primarily serves a medical purpose.
- Is intended for repeated use.
- 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. A medical emergency is a condition with severe pain or serious injury. Medical emergencies are so serious that without immediate attention, they may result in:

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

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.
- Treatment of medical conditions of the reproductive system.
- Standard fertility preservation services are covered as basic health services, when a covered treatment may directly or indirectly cause iatrogenic infertility. Please see the "Definitions" section of this document for an explanation of the term "iatrogenic infertility."

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 **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 **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 may decide 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.

Medical Transportation Services

Cost to Member
No copayment.

Description
Emergency ambulance transportation, including air ambulance 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. Benefit also includes non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or from facility to home when the transportation is:

- Medically necessary.
- Requested by a Plan provider.
- 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 Beacon Health Options (Beacon). Please call them at **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. The facility or attending physician must call Beacon for pre-authorization. The request will be reviewed by appropriately qualified professionals who will gather critical and relevant clinical information needed to make a determination.

Behavioral Health Treatment for pervasive developmental disorder (PDD) or autism. Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member with PDD or autism, and that meet the criteria required by California law. Please refer to the “Definitions” section for a description of the required criteria.

Covered services include:

- Mental health residential treatment.
- Behavioral health therapy (BHT) for the treatment of pervasive developmental disorder (PDD) or autism.
- Treatment of serious emotional disturbances of a child (SED).

- Treatment of a severe mental illness (SMI). Severe mental illnesses include, but are not limited to the following:
    a. Schizophrenia.
    b. Schizoaffective disorder.
    c. Bipolar disorder (manic depressive illness).
    d. Major depressive disorder.
    e. Panic disorder.
    f. Obsessive-compulsive disorder.
    g. Pervasive developmental disorder, including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder and Asperger's Disorder.
    h. Anorexia nervosa.
    i. Bulimia nervosa.

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 for some services.

Behavioral Health Treatment for pervasive developmental disorder (PDD) or autism. Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member with PDD or autism, and that meet the criteria required by California law. Please refer to the "Definitions" section for a description of the required criteria.

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

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

In addition to the services described above, covered services also include:

- Outpatient day treatment.
- Partial hospitalization.

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

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 tobacco 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.
- If the cost of drug is lower than the copayment, you will pay for the actual cost of the drug. This will count towards your annual copayment maximum amount.
- No copayment for contraceptives. You may get a 12-month supply of birth control pills, patches and vaginal rings.

Tier	Copayment	Description
Tier 1	**$5.00 ***	**Generic and Specialty generic drugs**
Tier 2	**$15.00 ***	**Brand and Specialty brand drugs**

**coinsurance amounts in accordance with Health and safety code 1367.656*.

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 self-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.
- 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, 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 section of this document called "The Grievance Process."

Mail Order Pharmacy

You can also receive medications by mail through MedImpact Direct Mail. Mail order prescription delivery offers a convenience if you cannot travel to retail pharmacies.
For more information about mail order, please visit our website at:
https://thealliance.health/for-members/get-care/prescription-drugs-and-pharmacy-benefits/

Preventive Health Service

Cost to Member
No copayment.

Description
Annual 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 and pnuemococcall vaccines.

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, including FDA-approved STD home test kits and associated laboratory processing costs, when medically necessary and ordered by an in-network provider.
- Human Immunodeficiency Virus (HIV) testing.
- 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.
- Colorectal cancer screening is routinely recommended for adults 50-75 years of age. Other adults aged 45-49 may be recommended for the screening by their doctor.
    - The required colonoscopy for a positive result on a test or procedure, other than a colonoscopy, will also be provided without any cost sharing.
- 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 pediatric vision screening.
- No copayment for 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.)
- Routine eye care (adults).
- 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 Use Disorder Services

Substance use disorder services are provided through Beacon Health Options (Beacon). Please call them at **800-808-5796** to access these services. Please let them know that you are an Alliance member.

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

Substance Use Disorder Services – Inpatient

Please call Beacon at **800-808-5796** to access these services. Prior authorization is required**.** The facility or attending physician must call Beacon for pre-authorization. The request will be reviewed by appropriately qualified professionals who will gather critical and relevant clinical information needed to make a determination, in accordance with all applicable laws and regulations.

Cost to Member
No copayment.

Description
Covered services include:

- Inpatient substance abuse treatment services.
- Residential treatment services, including residential detoxification.

Limitations
Unlimited days.

Substance Use Disorder Services - Outpatient

Please call Beacon Health Options (Beacon) at **800-808-5796** to access these services. Some services require prior authorization.

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

When the request is for intensive outpatient services, day treatment, partial hospitalization or other non-routine services, the provider must request prior authorization from Beacon. The request will be reviewed by appropriately qualified professionals who will gather critical and relevant clinical information needed to make determination, in accordance with all applicable laws and regulations.

Cost to Member
$10 per visit.

Description
Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically necessary. Medically necessary treatment of mental health and substance use disorders (MH/SUD) are listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM").

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.
  - Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.
  - 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.
- In Vitro Fertilization (IVF).
- 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 Services Department at **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 website.

Grievance Department
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
Phone: 800-700-3874
Fax: 831-430-5579
www.thealliance.health

The Plan will send you a letter within five (5) calendar 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) calendar 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, your personal representative 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 seventy-two (72) hours from receipt of your request.

You are not required to file a complaint with the Plan before asking the Department of Managed Health Care (DMHC) 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 DMHC about your complaint involving an imminent and serious threat to your health.
- We will respond to you and DMHC 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.

Filing a Complaint for Discrimination or Accessibility
If you believe that the Alliance did not provide you with free interpreter services when you needed them or written Member information in another format or language; or feel you were treated differently or discriminated against because of race, color, national origin, age, disability or sex, you can file a complaint with us by phone, fax, mail, online or in person.

- Phone: Call a Member Services Representative at 800-700-3874 / TTY: 800-735-2929 or a Grievance Coordinator at 800-700-3874, ext. 5816.

- Website: https://thealliance.health/for-members/member-services/file-a-grievance/

- Fax: 831-430-5579

- Email: GrievanceCoordinator@ccah-alliance.org

- Mail: Grievance Department
  ATTN: Grievance Coordinator
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066

You can also file a civil rights complaint with the U.S. Department of Health and Human Services. You do not have to file a complaint with the Alliance first.

You can send your complaint electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

- U.S. Department of Health and Human Services
  Office of Civil Rights
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  800-368-1019, TDD 800-537-7697
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

External Exception Review

You, your personal representative or your provider may file a grievance requesting an external exception review if one of the following applies:

- You object to the Plan's denial of a request for prior authorization for a non-formulary medication.

- You object to the Plan's denial of a request for an exception to the Plan's pharmacy step-therapy process.

An external exception review means we would send the denied request and any information we received from your provider to an outside physician who would review our decision.

Information on how to file a request for an external exception review will be included in the denial notice you receive from the Plan's Contractor, MedImpact. MedImpact will respond to non-urgent external exception requests within 72 hours. If exigent circumstances exist, MedImpact will respond within 24 hours. Please see the "Definitions" section of this document for an explanation of the term "exigent circumstances." The right to request an external exception review is in addition to your right to file a complaint or request an Independent Medical Review from DMHC.

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 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 we:

- Deny, change or delay 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 **800-700-3874**.

Independent Medical Review for Denials of Investigational or Experimental Therapies

You may also be entitled to an IMR through the DMHC, when we deny, modify or delay a service, including services 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.

California Department of Managed Health Care Statement

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 700-3874 or TDD (877) 548-0857** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

Your health plan's grievance process and the department'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 will provide the Group with a thirty-day grace period. If premiums are not paid by the end of the grace period, then the Plan may cancel the Agreement.

The Group will promptly mail to each Member a legible, true copy of the notice of termination no less than thirty (30) days prior to termination, at which time all rights to benefits will end for all Members, including those who are hospitalized or undergoing treatment for an ongoing condition (unless you may be covered under Extension of Benefits due to Total Disability).

Cancellation by Group

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

Cancellation of Individual Members

Loss of Eligibility

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

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

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

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 thirty days after 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, requirements for health care services or another reason, you may request a review by the California Department of Managed Health Care. You must request this review within 180 days from the date of the notice of cancellation or non-renewal.

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 **800-700-3874** for more information.

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

General Information

Coordination of Benefits (COB) Applicability

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

If you have Alliance Care IHSS and any other insurance, your Alliance Care IHSS insurance will be your primary insurance most of the time. There are some exceptions to this rule.

For example, if you have insurance through another employer where you are the primary subscriber and you became enrolled in that insurance before you enrolled in Alliance Care IHSS, that insurance will be your primary insurance. But if you are the dependent on someone else's insurance and have Alliance Care IHSS, Alliance Care IHSS will be your primary insurance. If you have questions about which insurance is your primary, please call Member Services.

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

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

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

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

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 **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, you can file a claim form and tell us why you had to pay. Call Member Services to ask for a form. The Alliance will review your claim to see if you can get money back.

We will need the following information:

- 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.
- 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 **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, representatives of both 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 **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 the last section of this document called "Notice of Privacy Practices," or call Member Services at **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 Website (www.organdonor.gov) has additional information on donating your organs and tissues.

Notice of Privacy Practices

Effective Date: October 15, 2021

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

In this notice, we use “the Alliance,” “we,” “us,” and “our” to describe Central California Alliance for Health.

Why am I receiving this notice? This notice tells you about the ways in which we may collect, use, or disclose (share) your protected health information. We understand that health information about you is personal and we are committed to protecting your privacy. This notice only describes the Alliance’s Privacy Practices. Your doctor may have different policies or notices regarding their use and disclosure of your health information created in the doctor’s office.

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. You must make your request in writing. 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. Ask us how to do this. ▪ 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, or those required by law). We will provide one accounting a year for free but may 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. ▪ You can also find this notice on our website at www.thealliance.health.
Choose someone to act for you	▪ If you have given someone medical power of attorney, if someone is your legal guardian, or if you have given us written authorization to act as your personal representative, 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.
File a complaint if you feel we have violated your rights	▪ You can complain if you feel your rights are violated by contacting us at the information in the "Our Responsibilities" section on page 5 of this notice. ▪ You can also file a complaint with the Department of Health Care Services (DHCS), and the U.S. Department of Health and Human Services Office for Civil Rights.

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 the cases where you *can* tell us your choices about what we share, you have the right 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 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.	***Example:*** We use health information about you to develop better services for you.

	▪ 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.**	***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. **Example:** Your County contracts with us to provide a health plan for IHSS members, and we provide the County 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.
Health Information Exchange (HIE)	▪ We participate in health information exchanges (HIEs), which allow providers to coordinate care and provide faster access to our members. HIEs can also assist providers and public health officials in: ▪ making more informed decisions; ▪ avoiding duplicate care (such as tests); and, ▪ reducing the likelihood of medical errors. ▪ If you don't want us to share your health information in this way, you can notify us by completing the HIE Member Opt Out Form for PHI.
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 are required to provide you with this notice describing how we are legally required to protect your protected health information, and how we will do this. We will update this notice if there is a change to the information we can or must share.
- 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, or by contacting Member Services. You can also request a copy of your records by completing a Records Access Request form, which is available on our website at **www.thealliance.health.**

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
(800) 700-3874 (toll-free)
(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
1501 Capitol Avenue
MS0010
P.O. Box 997413,
Sacramento, CA 95899-7413
Telephone: 916-445-4646
Email: DHCSPrivacyOfficer@dhcs.ca.gov
Fax: (916) 327-4556

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 20201
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.

MONTEREY COUNTY
DEPARTMENT OF SOCIAL SERVICES

ADDITIONAL PROVISIONS

I. PAYMENT BY COUNTY:

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

1.02 Invoice: County creates payment document based on the number of IHSS providers enrolled in the health plan monthly.

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

b) Allowable costs for travel expenses incurred while providing services under this Agreement, as set forth in **Exhibit C**, must follow the Monterey County Auditor/Controller's Travel Policy www.co.monterey.ca.us/govenment/departments-a-h/auditor-controller/policies-and-procedures and should be invoiced the current per diem rates for lodging, meals, and mileage up to the rates listed online at www.irs.gov.

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

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

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

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

II. PERFORMANCE STANDARDS & COMPLIANCE

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

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

2.03 Notice of defective performance: COUNTY shall notify CONTRACTOR in writing within thirty (30) days after discovering any defects in CONTRACTOR's performance. CONTRACTOR shall promptly take action to correct the problem and to prevent its recurrence. Such corrective action shall be completed and a written report made to the COUNTY concerning such action not later than thirty (30) days after the date of the COUNTY's written notice to CONTRACTOR.

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

2.05 Remedies for Inadequate Service Levels:

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

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

c) Notwithstanding Section 7.02 of the Agreement, if, after the COUNTY notifies CONTRACTOR of any sanctions to be imposed, CONTRACTOR continues in its

failure to take corrective action, then COUNTY may terminate this contract by giving CONTRACTOR five (5) days' written notice.

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

2.06 Training for Staff: CONTRACTOR shall insure that sufficient training is provided to its volunteer and paid staff to enable them to perform effectively on the project, and to increase their existing level of skills. Additionally, CONTRACTOR shall ensure that all staff completes Division 21 Civil Rights training.

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

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

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

III. CONFIDENTIALITY

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

information and records to the extent allowed by law, and such information and records in the hands of the COUNTY shall remain confidential and may be disclosed only as permitted by law.

IV. NON-DISCRIMINATION

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

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

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

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

- **California Fair Employment and Housing Act**, California Government Code Sec. 12900 et seq., see especially Section 12940 (c), (h), (1), (i), and (j); and the administrative regulations issued thereunder, 2 Calif. Code of Regulations Secs. 7285.0 et seq. (Division 4 - Fair Employment and Housing Commission);

- **California Government Code Secs. 11135 - 11139.5,** as amended (Title 2, Div. 3, Part 1, Chap. 1, Art. 9.5) and any applicable administrative rules and regulations issued under these sections; including **Title 22 California Code of Regulations 98000-98413**.

- **Federal Civil Rights Acts of 1964 and 1991** (see especially Title VI, 42 USC Secs. 2000d et seq.), as amended, and all administrative rules and regulations issued thereunder (see especially 45 CFR Part 80);

- **The Rehabilitation Act of 1973**, Secs. 503 and 504 (29 USC Sec. 793 and 794), as amended; all requirements imposed by the applicable HHS regulations (45 CFR Parts 80, 84 and 91); and all guidelines and interpretations issued pursuant thereto;

- **7 Code of Federal Regulations (CFR),** Part 15 and **28 CFR** Part 42;

- **Title II of the Americans with Disabilities Act of 1990** (P.L. 101-336), 42 U.S.C. Secs. 12101 et seq. and 47 U.S.C. Secs. 225 and 611, and any federal regulations issued pursuant thereto (see 24 CFR Chapter 1; 28 CFR Parts 35 and 36; 29 CFR Parts 1602, 1627, and 1630; and 36 CFR Part 1191);

- **Unruh Civil Rights Act**, Calif. Civil Code Sec. 51 et seq., as amended;

- **Monterey COUNTY Code**, Chap. 2.80.;

- **Age Discrimination in Employment Act 1975,** as amended **(ADEA),** 29 U.S.C. Secs 621 et seq.;

- **Equal Pay Act of 1963**, 29 U.S.C. Sec. 206(d);

- **California Equal Pay Act**, Labor Code Sec.1197.5.

- **California Government Code** Section 4450**;**

- **The Dymally-Alatorre Bilingual Services Act; Calif. Government Code Sec. 7290 et seq.**

- **The Food Stamp Act of 1977, as amended and in particular Section 272.6.**

- **California Code of Regulations, Title 24, Section 3105A(e)**

- **Removal of Barriers to Inter-Ethnic Adoption Act of 1996, Section 1808**

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

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

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

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

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

4.09 Binding on Subcontractors: The provisions of paragraphs 4.01 - 4.08 shall also apply to all of CONTRACTOR's subcontractors. CONTRACTOR shall include the non-discrimination and compliance provisions of these paragraphs in all subcontracts to perform work or provide services under this Agreement.

V. ADDITIONAL REQUIREMENTS

5.01 Covenant Against Contingent Fees: CONTRACTOR warrants that no person or selling agency has been employed or retained to solicit this Agreement. There has been no agreement to make commission payments in order to obtain this Agreement. For breach or violation of this warranty, COUNTY shall have the right to terminate this Agreement without liability or, at its discretion, to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingency fee.

5.02 Debarment, Suspension and Fraud, and Abuse: CONTRACTOR certifies to the best of its knowledge and belief, that it and any subcontractors:

a) Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or agency.

b) Have not, within a three-year period preceding this Agreement, been convicted of, or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

c) Are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity (federal, State, or local) with commission of any of the offenses in 5.02(b).

d) Have not, within a three-year period preceding this Agreement, had one or more public transactions (federal, State, or local) terminated for cause or default.

CONTRACTOR shall report immediately to COUNTY in writing, any incidents of alleged fraud and/or abuse by either CONTRACTOR or its subcontractors.

CONTRACTOR shall maintain any records, documents, or other evidence of fraud and abuse until otherwise notified by COUNTY.

CONTRACTOR agrees to timely execute any and all amendments to this Agreement or other required documentation relating to the debarment/suspension status of any subcontractors.

VI. CONTRACT ADMINISTRATORS

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

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

VII. CONTRACT DEPENDENT ON GOVERNMENT FUNDING

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

VIII. APPEAL PROCESS

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

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

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

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

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

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

EXHIBIT C

Central California Alliance for Health

PROGRAM BUDGET

July 1, 2023 through June 30, 2024

	Hourly Rate	Projected Service Hours	Budget Total
Health Benefits	$ 0.66	8,082,971	$ 5,334,761.00
Health Benefits (Co-Pays)			$ 124,920.00
COBRA			$ 20,000.00
Total Budget For This Period			**$ 5,479,681.00**

EXHIBIT D

Health Insurance Portability & Accountability Act (HIPAA) Certification

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

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

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

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

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

I. DEFINITIONS

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

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

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

II. CONFIDENTIALITY REQUIREMENTS

(a) CONTRACTOR agrees:
(i) to use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom COUNTY is required to disclose such information, or as otherwise permitted under this Certification, or the underlying Agreement ,(if consistent with this Certification and the HIPAA Privacy Rule), or the HIPAA Privacy Rule, and (3) as would be permitted by the HIPAA Privacy Rule if such use or disclosure were made by COUNTY; and
(ii) at termination of the Agreement, (or any similar documentation of the business relationship of the Parties), or upon request of COUNTY, whichever occurs first, if feasible CONTRACTOR will return or destroy all Protected Health Information received from or created or received by CONTRACTOR on behalf of COUNTY that CONTRACTOR still maintains in any form, and retain no copies of such information, or if such return or destruction is not feasible, CONTRACTOR will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and
(iii) to ensure that its agents, including a subcontractor(s), to whom it provides Protected Health Information received from or created by CONTRACTOR on behalf of COUNTY, agrees to the same restrictions and conditions that apply to CONTRACTOR with respect to such information. In addition, CONTRACTOR agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause CONTRACTOR to breach the terms of the Agreement.

(b) Notwithstanding the prohibitions set forth in this Certification or the Agreement, CONTRACTOR may use and disclose Protected Health Information as follows:
(i) if necessary, for the proper management and administration of CONTRACTOR or to carry out the legal responsibilities of CONTRACTOR, provided that as to any such disclosure, the following requirements are met:
(A) the disclosure is required by law; or
(B) CONTRACTOR obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law, or for the purpose for which it was disclosed to the person, and the person notifies CONTRACTOR of any instances of which it is aware in which the confidentiality of the information has been breached;
(ii) for data aggregation services, if to be provided by CONTRACTOR for the health care operations of COUNTY pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Certification and the Agreement, data aggregation services means the combining of Protected Health Information by CONTRACTOR with the protected health information received by CONTRACTOR in its capacity as CONTRACTOR of another COUNTY, to permit data analyses that relate to the health care operations of the respective covered entities.

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

III. AVAILABILITY OF PHI

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

IV. TERMINATION

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

V. MISCELLANEOUS

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

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

In the event that either party believes in good faith that any provision of this Certification and/or the Agreement fails to comply with the then current requirements of the HIPAA Privacy Rule, such party shall notify the other party in writing. For a period of up to thirty (30) days, the parties shall address in good faith such concern and amend the terms of this Certification and/or the Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Certification and/or the Agreement fails to comply with the HIPAA Privacy Rule, then either party has the right to terminate upon written notice to the other party.

CONTRACTOR: Central California Alliance for Health

DocuSigned by:

By: Elsa M. Jimenez
C7A30BA59CA8423...

Title: Board Chair

Date: 5/24/2023 | 4:42 PM PDT

Monterey County
Board of Supervisors

168 West Alisal Street,
1st Floor
Salinas, CA 93901
831.755.5066
www.co.monterey.ca.us

Board Order

A motion was made by Supervisor Chris Lopez, seconded by Supervisor Glenn Church to:

Agreement No.: A-16373
a. Approve and authorize the Chair of the Board of Supervisors, or designee, to sign an agreement with the Central California Alliance for Health to provide health plan benefits for eligible In-Home Supportive Services providers for the period July 1, 2023 to June 30, 2024, including non-standard termination and mutual indemnification provisions in the amount of $5,479,681; and
b. Authorize the Chair of the Board of Supervisors to sign up to three (3) amendments to the agreement where the total amendments do not exceed 10% ($547,968) of the original contract amount and do not significantly change the scope of work not to exceed the maximum of $6,027,649.

PASSED AND ADOPTED on this 13th day of June 2023, by roll call vote:

AYES: Supervisors Alejo, Church, Lopez, Askew, and Adams
NOES: None
ABSENT: None

I, Valerie Ralph, 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 82 for the meeting June 13, 2023.

Dated: June 14, 2023
File ID: A 23-234
Agenda Item No.: 33

Valerie Ralph, Clerk of the Board of Supervisors
County of Monterey, State of California

Emmanuel H. Santos

Emmanuel H. Santos, Deputy