Member Handbook

What you need to know about your benefits

Central California Alliance for Health Combined Evidence of Coverage (EOC) and Disclosure Form

2020

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). The call is toll free. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

Other formats

You can get this information for free in other auxiliary formats, such as braille, 18-point font large print and audio. Call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). The call is toll free.

Interpreter services

You do not have to use a family member or friend as an interpreter. For free interpreter, linguistic and cultural services and help available 24 hours a day, 7 days a week, or to get this handbook in a different language, call

800-700-3874 (TTY 800-735-2929 or 711). The call is toll free.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-700-3874 (TTY: 1-800-735-2929).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-700-3874 (TTY: Llame al 1-800-855-3000).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-700-3874 (TTY: 1-800-735-2929).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-700-3874 (TTY: 1-800-735-2929).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-700-3874 (TTY: 1-800-735-2929) 번으로 전화해 주십시오.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-700-3874 (TTY: 1-800-735-2929）。

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խո ս ո ւ մ եք հայ ե ր ե ն , ապա ձեզ ան վ ճ ար կար ո ղ են տր ամ ադ ր վ ե լ լե զ վ ակ ան աջ ակ ց ո ւ թ յ ան ծառ այ ո ւ թյ ո ւ ն ն ե ր : Զան գ ահ ար ե ք 800-700-3874 (TTY (հ ե ռ ատի պ)՝ 1-800-735-2929):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-700-3874 (телетайп: 1-800-735-2929).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 1-800-735-2929) 800-700-3874 تماس بگیرید.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-700-3874 (TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau [1-800-700-3874] (TTY: [1-800-735-2929]).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-700-3874 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-700-3874

(رقم هاتف الصم والبكم: 1-800-735-2929). ملحوظة: إذا كنت تتحدث اذكر اللغة،

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें।

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-700-3874 (TTY: 1-800-735-2929).

ប្រយ័ត្ន៖ បរើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, ប សវាជំនួយខ្មែនកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-700-3874 (TTY: 1-800-735-2929)។

ໂປດຊາບ:ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-700-3874 (TTY: 1-800-735-2929

Notice of non-discrimination

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 and other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Alliance at 800-700-3874 (TTY 800-735-2929).
We are open 8 AM – 5:30 PM, Monday through Friday.

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 an Alliance's Grievance Coordinator. You can file a grievance in person, in writing, by phone or by email:

Central California Alliance for Health
Attn: Grievance Department
1600 Green Hills Road

Scotts Valley, CA 95066
800-700-3874 x5816 / (TTY: 1-800-735-2929)
Fax: 831-430-5579
Email: GrievanceCoordinator@ccah-alliance.org

If you need help filing a grievance, Member Services or Grievance Coordinator can help you.

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
1-916-440-7370 (TTY 711 California State Relay)
Email: CivilRights@dhcs.ca.gov

You can get complaint forms at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

If you believe you have been discriminated against on the bases 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 in writing, by phone or online:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY 1-800-537-7697)
Complaint Portal: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf

You can get complaint forms at http://www.hhs.gov/ocr/office/file/index.html.

Welcome to Central California Alliance for Health (the Alliance)!

Thank you for joining the Alliance. The Alliance is a health plan for people who have Medi-Cal. The Alliance works with the State of California to help you get the health care you need. Since you have Medi-Cal, you are now a Member of the Alliance. This means that you will see doctors who are part of our plan and we will pay your health care bills.

Member Handbook

This Member Handbook tells you about your coverage under the Alliance. Please read it carefully and completely. It will help you understand and use your benefits and services. It also explains your rights and responsibilities as a member of the Alliance. If you have special health needs, be sure to read all sections that apply to you.

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. It is a summary of the Alliance's rules and policies and based on the contract between the Alliance and Department of Health Care Services (DHCS). If you would like to learn exact terms and conditions of coverage, you may request a copy of the complete contract from Member Services.

Call Member Services at 800-700-3874 (TTY 800-735-2929 or 711) to ask for a copy of the contract between the Alliance and DHCS. You may also ask for another copy of the Member Handbook at no cost to you or visit the Alliance website at www.ccah-alliance.org to view the Member Handbook. You may also request, at no cost, a copy of the Alliance's non-proprietary clinical and administrative policies and procedures, or how to access this information on the Alliance website.

Contact us

The Alliance is here to help. If you have questions, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). The Alliance is here 8 am – 5:30 pm, Monday through Friday. The call is toll free.

You can also visit online at any time at www.ccah-alliance.org.

Thank you,
Central California Alliance for Health
1600 Green Hills Road
Scotts Valley, CA 95066

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1. Getting started as a member

How to get help

The Alliance wants you to be happy with your health care. If you have any questions or concerns about your care, the Alliance wants to hear from you!

Member services

The Alliance Member Services is here to help you. The Alliance can:

- Answer questions about your health plan and covered services
- Help you choose or change a primary care provider (PCP)
- Tell you where to get the care you need
- Offer interpreter services if you do not speak English
- Offer information in other languages and formats
- Send you a new Alliance ID card if you lose yours

If you need help, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). The Alliance is here 8 AM – 5:30 PM, Monday through Friday. The call is toll free.

You can also visit online at any time at www.ccah-alliance.org.

Who can become a member

You qualify for the Alliance because you qualify for Medi-Cal and live in Merced, Monterey or Santa Cruz county.

Merced County 209-385-3000	Monterey County 877-410-8823	Santa Cruz County 888-421-8080

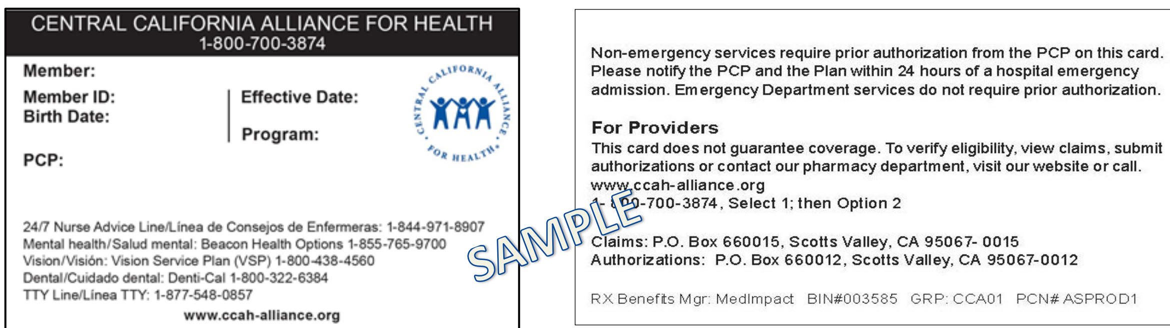
You may also qualify for Medi-Cal through Social Security.

Merced SSA office 888-632-7069	Monterey SSA office 877-696-9397	Santa Cruz SSA office 800-780-1106

You can ask questions about qualifying for Medi-Cal at your local county health and human services office. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Identification (ID) cards

As a member of the Alliance, you will get an Alliance ID card. You must show your Alliance ID card and your Medi-Cal Benefits Identification Card (BIC) when you get any health care services or prescriptions. You should carry all health cards with you at all times. Here is a sample Alliance ID card to show you what yours will look like:



If you do not get your Alliance ID card within a few weeks of enrolling, or if your card is damaged, lost or stolen, call member services right away. The Alliance will send you a new card for free. Call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

Ways to get involved as a member

The Member Services Advisory Group (MSAG)

The Alliance wants to hear from you. The Alliance has a group called Member Services Advisory Group (MSAG) that has meetings to talk about what is working well and how we can improve.

This group is made up of Alliance members and representatives of county and community agencies. Joining this group is voluntary. The group talks about how to improve Alliance policies and is responsible for:

- advising the Alliance’s Board of Directors on member issues

If you would like to be a part of this group, call 800-700-3874, ext. 5567 (TTY 800-735-2929 or 711).

The Whole Child Model Family Advisory Committee (WCMFAC)

The Whole Child Model Family Advisory Committee (WCMFAC) has meetings to improve services to children with special health care needs. These children are eligible for California Children's Services (CCS). The group is made up of Alliance staff, families with CCS children and providers. WCMFAC makes suggestions on how to meet the Whole Child Model goals. The group works to build family-centered care and is responsible for:

- maintaining quality of care and coordinating care
- making recommendations to the Alliance Board of Directors

If you would like to be a part of this group, call 800-700-3874, ext. 5567 (TTY 800-735-2929)

2. About your health plan

Health plan overview

The Alliance is a health plan for people who have Medi-Cal in these service areas: Merced, Monterey and Santa Cruz counties. The Alliance works with the State of California to help you get the health care you need.

You may talk with one of the Alliance member services representatives to learn more about the health plan and how to make it work for you. Call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

When your coverage starts and ends

When you enroll in the Alliance, you should receive an Alliance member ID card within two weeks of enrollment. Please show this card every time you go for any service under the Alliance.

Sometimes the Alliance can no longer serve you. The Alliance must end your coverage if:

- You move out of the county or are in prison
- You no longer have Medi-Cal
- You qualify for certain waiver programs
- You need a major organ transplant (excluding kidneys and corneal transplants)

Indian Health Services

If you are an American Indian, you have the right to get health care services at Indian health service facilities. You may also stay with or disenroll from the Alliance while getting health care services from these locations. American Indians have a right to not enroll in a Medi-Cal managed care plan or may leave their health plans and return to

regular (fee-for-service) Medi-Cal at any time and for any reason.

To find out more, please call Indian Health Services at 1-916-930-3927 or visit the Indian Health Services website at www.ihs.gov.

How your plan works

The Alliance is a health plan contracted with DHCS. The Alliance is a managed care health plan. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. The Alliance works with doctors, hospitals, pharmacies and other health care providers in the Alliance service area to give health care to you, the member.

Member Services will tell you how the Alliance works, how to get the care you need, how to schedule provider appointments, and how to find out if you qualify for transportation services.

To learn more, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You can also find member service information online at www.ccah-alliance.org.

Changing health plans

The Alliance is the health plan for Medi-Cal beneficiaries in Merced, Monterey and Santa Cruz counties. You will stop being an Alliance member only if you lose your Medi-Cal eligibility or if you move out of the Alliance service area. The Alliance coverage may also end if your local county health and human services office changes how you qualify for Medi-Cal. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

College students who move to a new county

If you move to a new county in California to attend college, the Alliance will cover emergency services in your new county. Emergency services are available to all Medi-Cal enrollees statewide regardless of county of residence.

If you are enrolled in Medi-Cal and will attend college in a different county, you do not need to apply for Medi-Cal in that county. There is no need for a new Medi-Cal application as long as you are still under 21 years of age, are only temporarily out of the home and are still claimed as a tax dependent in the household.

When you temporarily move away from home to attend college there are two options available to you. You may:

- Notify your local county social services office that you are temporarily moving to attend college and provide your address in the new county. The county will update the case records with your new address and county code in the State's database. If the Alliance does not operate in the new county, you will have to change your health plan to the available options in the new county. For questions and to prevent any delay in enrolling in the new health plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077).

  OR

- Choose not to change your health plan when you temporarily move to attend college in a different county. You will only be able to access emergency room services in the new county. For routine or preventive health care, you would need to use the Alliance regular network of providers located in the head of the household's county of residence.

Continuity of care

If you now go to providers who are not in the Alliance network, in certain cases you may get continuity of care and be able to go to them for up to 12 months. If your providers do not join the Alliance network by the end of 12 months, you will need to switch to providers in the Alliance network.

Continuity of care applies to 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 may not exceed twelve (12) months from the time you enroll with the Alliance.
- Pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness.
- A surgery or another procedure that your previous plan authorized as part of a documented course of treatment which occurs within one hundred eighty (180) days of the time you enroll with the Alliance.
- A child age 0–36 months whose parent wishes to keep the child's existing

provider for up to twelve (12) months.

We will request that the out-of-network provider agrees to the same contractual terms and conditions that are imposed upon the providers within the Alliance's network. If the provider does not accept the terms and conditions, the Alliance is not required to continue that provider's services.

We will notify you of our decision in writing. If we decide that you do not meet the criteria for continuity of care and you disagree with our decision, you can file an appeal. For information about filing an appeal, please see the section of this document called "Reporting and solving problems".

Providers who leave the Alliance

If your provider stops working with the Alliance, you may be able to keep getting services from that provider. This is another form of continuity of care. The Alliance provides continuity of care services for:

- 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 not exceed twelve (12) months from the time of the provider left the Alliance.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness.
- A surgery or another procedure that was approved by the Alliance and occurs within one hundred eighty (180) days from the time the provider left the Alliance.
- A child age 0–36 months whose parent wishes to keep the child's existing provider for up to twelve (12) months.

The Alliance does **not** provide continuity of care services if the reason for providers to leave the Alliance is due to medical disciplinary cause or reason, fraud or other criminal activity. We are also not required to continue the provider's services if the provider does not accept Alliance's terms and conditions including reimbursement rates before leaving the Alliance.

To learn more about continuity of care and eligibility qualifications, call Member Services.

Costs

Member costs

The Alliance serves people who qualify for Medi-Cal. The Alliance members do **not** have to pay for covered services. You will not have premiums or deductibles. For a list of covered services, go to "Benefits and services."

For members with a share of cost

You may have to pay a share of cost each month. The amount of your share of cost depends on your income and resources. Each month you will pay your own medical bills until the amount that you have paid equals your share of cost. After that, your care will be covered by the Alliance for that month. You will not be covered by the Alliance until you have paid your entire share of cost for the month. After you meet your share of cost for the month, you can go to any the Alliance doctor. If you are a member with a share of cost, you do not need to choose a PCP.

How a provider gets paid

The Alliance pays providers in these ways:

- Capitation payments
  - The Alliance pays some providers a set amount of money every month for each the Alliance member. This is called a capitation payment. The Alliance and providers work together to decide on the payment amount.
- Fee-for-service payments
  - Some providers give care to the Alliance members and then send the Alliance a bill for the services they provided. This is called a fee-for-service payment. The Alliance and providers work together to decide how much each service costs.
- Care Based Incentives
  - Alliance providers may also receive incentives for quality and access.

To learn more about how the Alliance pays providers, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

Asking the Alliance to pay a bill

If you get a bill for a covered service, call member services right away at 800-700-3874 (TTY 800-735-2929 or 711).

If you pay for a service that you think the Alliance should cover, you can file a claim. Use a claim form and tell the Alliance in writing why you had to pay. Call Member Services at 800-700-3874 (TTY 800-735-2929 or 711) to ask for a claim form. The Alliance will review your claim to decide if you can get money back.

3. How to get care

Getting health care services

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

You can begin to get health care services on your effective date of coverage. Always carry your Alliance ID card and Medi-Cal BIC card with you. Never let anyone else use your Alliance ID card or BIC card.

New members must choose a primary care provider (PCP) in the Alliance network. The Alliance network is a group of doctors, hospitals and other providers who work with the Alliance. You must choose a PCP within 30 days from the time you become a member in the Alliance. If you do not choose a PCP, the Alliance will choose one for you.

You may choose the same PCP or different PCPs for all family members in the Alliance.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in the Provider Directory. It has a list of all PCPs in the Alliance network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You can also find the Provider Directory on the Alliance website at www.ccah-alliance.org

If you cannot get the care you need from a participating provider in the Alliance network, your PCP must ask the Alliance for approval to send you to an out-of-network provider.

Read the rest of this chapter to learn more about PCPs, the Provider Directory and the provider network.

Travel time and distance to care

The Alliance must follow travel time and distance standards for your care. Those standards help to make sure you are able to get care without having to travel too long or too far from where you live. Travel time and distance standards are different depending on the county you live in.

If the Alliance is not able to provide care to you within these travel time and distance standards, a different standard called an alternative access standard may be used. To see the Alliance's time and distance standards for where you live, please, visit www.ccah-alliance.org or call Member Services at 800-700-3874 (TTY 800-735-2929).

If you need care from a specialist and that provider is located far from where you live, you can call Member Services at 800-700-3874 (TTY 800-735-2929) to get help finding care with a specialist located closer to you. If the Alliance cannot find care for you with a closer specialist, you can request the Alliance arrange transportation for you to see a specialist even if that specialist is located far from where you live. It is considered far if you cannot get to that specialist within the Alliance's travel time and distance standards for your county, regardless of any alternative access standard the Alliance may use for your ZIP Code.

Initial health assessment (IHA)

The Alliance recommends that, as a new member, you visit your new PCP within the first 120 days for an initial health assessment (IHA). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP may ask you some questions about your health history or may ask you to complete a questionnaire. Your PCP will also tell you about health education counseling and classes that may help you.

When you call to schedule your IHA appointment, tell the person who answers the phone that you are a member of the Alliance. Give your Alliance ID number.

Take your BIC card and your Alliance ID card to your appointment. It is a good idea to take a list of your medications and questions with you to your visit. Be ready to talk with your PCP about your health care needs and concerns.

Be sure to call your PCP's office if you are going to be late or cannot go to your appointment.

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups and health education and counseling. In addition to preventive care, routine care also includes care when you are sick. The Alliance covers routine care from your PCP.

Your PCP will:

- Give you all your routine care, including regular checkups, shots, treatment, prescriptions and medical advice
- Keep your health records
- Refer (send) you to specialists if needed
- Order X-rays, mammograms or lab work if you need them

When you need routine care, you will call your PCP for an appointment. Be sure to call your PCP before you get medical care, unless it is an emergency. For an emergency, call **911** or go to the nearest emergency room.

To learn more about health care and services your plan covers, and what it does not cover, read Chapter 4 in this handbook.

Urgent care

Urgent care is **not** for an emergency or life-threatening condition. It is for services you need to prevent serious damage to your health from a sudden illness, injury or complication of a condition you already have. Urgent care appointments require care within 48 hours. If you are outside Alliance's service area, urgent care services may be covered. Urgent care needs could be a cold, sore throat, fever, ear pain, sprained muscle or maternity services.

For urgent care, call your PCP. If you cannot reach your PCP, call 800-700-3874 (TTY 800-735-2929 or 711). Or you can call the Alliance Nurse Advice Line at 844-971-8907. There is no cost to you and it is available 24 hours a day, 7 days a week. They will ask for your ID number and your date of birth. The Nurse Advice Line will help you decide what to do next.

If you need urgent care out of the area, go to the nearest urgent care facility. You do not need pre-approval (prior authorization). If you need mental health urgent care, call the county Mental Health Plan at the toll-free telephone number that is available 24 hours a day, 7 days a week.

County of Santa Cruz Behavioral Health Services: 1-800-952-2335

Monterey County Behavioral Health: 1-888-258-6029

Merced County Behavioral Health and Recovery Services: 1-888-334-0163

To find all counties' toll-free telephone numbers online, visit www.dhcs.ca.gov/individuals/pages/mhpcontactlist.aspx

Emergency care

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.

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a reasonable layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, your health (or your unborn baby's health) could be in danger, or a body function, body organ or body part could be seriously harmed. Examples include:

- Active labor
- Broken bone
- Severe pain, especially in the chest
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency condition

Do not go to the ER for routine care. You should get routine care from your PCP, who knows you best. If you are not sure if your medical condition is an emergency, call your PCP. You may also call the 24/7 Alliance Nurse Advice Line at 844-971-8907 (toll free).

If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in the Alliance network. If you go to an ER, ask them to call the Alliance. You or the hospital to which you were admitted should call the Alliance within 24 hours after you get emergency care. If you are traveling outside the U.S., other than to Canada or Mexico, and need emergency care, the Alliance will **not** cover your care.

If you need emergency transportation, call **911**. You do not need to ask your PCP or the Alliance first before you go to the ER.

If you need care in an out-of-network hospital after your emergency (post-stabilization care), the hospital will call the Alliance.

Remember: Do not call **911** unless it is an emergency. Get emergency care only for an emergency, not for routine care or a minor illness like a cold or sore throat. If it is an emergency, call **911** or go to the nearest emergency room.

Sensitive care

Minor consent services

If you are under 18 years old, you can go to a doctor without consent from your parents or guardian for these types of care:

- Outpatient mental health (only minors 12 years or older) for:
  - Sexual or physical abuse
  - When you may hurt yourself or others
- Pregnancy
- Family planning/birth control (except sterilization)
- Sexual assault
- HIV/AIDS prevention/testing/treatment (only minors 12 years or older)
- Sexually transmitted infections prevention/testing/treatment (only minors 12 years or older)
- Drug and alcohol abuse treatment (only minors 12 years or older)

The doctor or clinic does not have to be part of the Alliance network and you do not need a referral from your PCP to get these services. For help finding a doctor or clinic giving these services, or for help getting to these services, you can call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You may also call the 24/7 Alliance Nurse Advice Line at 844-971-8907 (toll free).

Minors can talk to a representative in private about their health concerns by calling the 24/7 Alliance Nurse Advice Line at 844-971-8907 (toll free).

Adult sensitive services

As an adult, you may not want to go to your PCP for certain sensitive or private care. If so, you may choose any doctor or clinic for these types of care:

- Family planning
- HIV/AIDS testing
- Sexually transmitted infections

The doctor or clinic does not have to be part of the Alliance network. Your PCP does not have to refer you for these types of service. For help finding a doctor or clinic giving these services, you can call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You may also call the 24/7 Alliance Nurse Advice Line at 844-971-8907 (toll free).

Advance directives

An advance health directive is a legal form. On it, you can list what health care you want in case you cannot talk or make decisions later on. You can list what care you do **not** want. You can name someone, such as a spouse, to make decisions for your health care if you cannot.

You can get an advance directive form at drugstores, hospitals, law offices and doctors' offices. You may have to pay for the form. You can also find and download a free form online. You can ask your family, PCP or someone you trust to help you fill out the form.

You have the right to have your advance directive placed in your medical records. You have the right to change or cancel your advance directive at any time.

You have the right to learn about changes to advance directive laws. The Alliance will tell you about changes to the state law no longer than 90 days after the change.

Where to get care

You will get most of your care from your PCP. Your PCP will give you all of your routine preventive (wellness) care. You will also go to your PCP for care when you are sick. Be sure to call your PCP before you get non-emergency medical care. Your PCP will refer (send) you to specialists if you need them.

To get help with your health questions, you can also call Alliance Nurse Advice Line at 844-971-8907 (toll free).

If you need urgent care, call your PCP. Urgent care is care you need within 48 hours but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain or sprained muscle.

For emergencies, call **911** or go to the nearest emergency room.

Moral objection

Some providers have a moral objection to some services. This means they have a right to **not** offer some covered services if they morally disagree. If your provider has a moral objection, he or she will help you find another provider for the needed services. The Alliance can also work with you to find a provider.

- Some hospitals and other providers do not offer one or more of the services listed below. These services you or your family member might need may be covered under your plan contract:

- Family planning and contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortion

You should get more information before you enroll. Call the new doctor, medical group, independent practice association or clinic that you want. Or call the Alliance at 800-700-3874 (TTY 800-735-2929 or 711) to make sure you can get the health care services you need

Provider Directory

The Alliance Provider Directory lists providers that participate in the Alliance network. The network is the group of providers that work with the Alliance.

The Alliance Provider Directory lists hospitals, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).

The Provider Directory has Alliance network provider names, addresses, phone numbers, business hours and languages spoken. It tells if the provider is taking new patients. It also gives the level of physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars.

You can find the online Provider Directory at www.ccah-alliance.org/choosedoctors.html.

If you need a printed Provider Directory, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

Provider network

The provider network is the group of doctors, hospitals and other providers that work with the Alliance. You will get your covered services through the Alliance network.

If your provider in the network, including a PCP, hospital or other provider, has a moral objection to providing you with a covered service, such as family planning or abortion, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). Go to Chapter 4 for more about moral objections.

If your provider has a moral objection, he or she can help you find another provider who will give you the services you need. The Alliance can also work with you to find a

provider.

In network

You will use providers in the Alliance network for your health care needs. You will get preventive and routine care from your PCP. You will also use specialists, hospitals and other providers in the Alliance network.

To get a Provider Directory of network providers, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You can also find the Provider Directory online at http://www.ccah-alliance.org/choosedoctors.html.

For emergency care, call **911** or go to the nearest emergency room.

Except for emergency care, you may have to pay for care from providers who are out of network.

Out-of-network or Out-of-service area

Out-of-network providers are those that do not have an agreement to work with the Alliance. Except for emergency care, you may have to pay for care from providers who are out of the network. If you need covered health care services, you may be able to get them out of the network at no cost to you as long as they are medically necessary and not available in the network.

If you need help with out-of-network services, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

If you are outside of the Alliance service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

For emergency care, call **911** or go to the nearest emergency room. The Alliance covers out-of-network emergency care. If you travel to Canada or Mexico and need emergency services requiring hospitalization, the Alliance will cover your care. If you are traveling internationally outside of Canada or Mexico and need emergency care, the Alliance will **not** cover your care.

If you need health care services for a California Children's Services (CCS) eligible condition and the Alliance does not have a CCS-paneled specialist in the network who can provide the care you need, you may be able to go to a provider outside of the provider network at no cost to you. To learn more about the CCS program, read the Benefits and Services chapter of this handbook.

If you have questions about out-of-network or out-of-service area care, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). If the office is closed and you want help from a representative, call Alliance Nurse Advice Line at 844-971-8907 (toll free).

Doctors

You will choose your doctor or a primary care provider (PCP) from the Alliance Provider Directory. The doctor you choose must be a participating provider. This means the provider is in the Alliance network. To get a copy of the Alliance Provider Directory, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). Or find it online at http://www.ccah-alliance.org/choosedoctors.html.

You should also call if you want to check to be sure the PCP you want is taking new patients.

If you had a doctor before you were a member of the Alliance, you may be able to keep that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

If you need a specialist, your PCP will refer you to a specialist in the Alliance network.

Remember, if you do not choose a PCP, the Alliance will choose one for you. You know your health care needs best, so it is best if you choose. If you are in both Medicare and Medi-Cal, you do not have to choose a PCP.

If you want to change your PCP, you must choose a PCP from the Alliance Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

Hospitals

In an emergency, call **911** or go to the nearest hospital.

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in the network. The hospitals in the Alliance network are listed in the Provider Directory. Hospital services, other than emergencies, require pre-approval (prior authorization).

Primary care provider (PCP)

You must choose a PCP within 30 days of enrolling in the Alliance. Depending on your age and sex, you may choose a general practitioner, ob/gyn, family practitioner, internist or pediatrician as your primary care provider (PCP). A nurse practitioner (NP), physician assistant (PA) or certified nurse midwife may also act as your PCP. If you choose an NP, PA or certified nurse midwife, you may be assigned a doctor to oversee your care.

You can also choose an Indian Health Service Facility (IHF), Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as your PCP. Depending on the type of the provider, you may be able to choose one PCP for your entire family who are members of the Alliance.

If you do not choose a PCP within 30 days of enrollment, the Alliance will assign you to a PCP. If you are assigned to a PCP and want to change, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). The change happens the first day of the next month.

Your PCP will:

- Get to know your health history and needs
- Keep your health records
- Give you the preventive and routine health care you need
- Refer (send) you to a specialist if you need one
- Arrange for hospital care if you need it

You can look in the Provider Directory to find a PCP in the Alliance network. The Provider Directory has a list of IHFs, FQHCs and RHCs that work with the Alliance.

You can find the Alliance Provider Directory online at www.ccah-alliance.org/choosedoctors.html. Or you can request a Provider Directory to be mailed to you by calling Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

You know your health care needs best, so it is best if you choose your PCP.

It is best to stay with one PCP so he or she can get to know your health care needs. However, if you want to change to a new PCP, you can change anytime. You must choose a PCP who is in the Alliance provider network and is taking new patients.

Your new choice will become your PCP on the first day of the next month after you

make the change.

To change your PCP, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

The Alliance may ask you to change your PCP if the PCP is not taking new patients, has left the Alliance network or does not give care to patients your age. The Alliance or your PCP may also ask you to change to a new PCP if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If the Alliance needs to change your PCP, the Alliance will tell you in writing.

If you change PCPs, you will get a new Alliance member ID card in the mail. It will have the name of your new PCP. Call member services if you have questions about getting a new ID card.

Appointments

When you need health care:

- Call your PCP
- Have your Alliance ID number ready on the call
- Leave a message with your name and phone number if the office is closed
- Take your BIC card and Alliance ID card to your appointment
- Ask for transportation to your appointment, if needed
- Ask for language assistance or interpretation services, if needed
- Be on time for your appointment
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

If you have an emergency, call **911** or go to the nearest emergency room.

Payment

You do **not** have to pay for covered services. In most cases, you will not get a bill from a provider. You may get an Explanation of Benefits (EOB) or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). Tell the Alliance the amount charged, the date of service and the reason for the bill. You are **not** responsible to pay a provider for any amount owed by the Alliance for any covered service. Except for emergency care or urgent care, you may have to pay for care from providers who are not in the network. If you need covered health care

services, you may be able to get them at an out-of-network provider at no cost to you, as long as they are medically necessary and not available in the network.

If you get a bill or are asked to pay a co-pay that you think you did not have to pay, you can also file a claim form with the Alliance. You will need to tell the Alliance in writing why you had to pay for the item or service. The Alliance will read your claim and decide if you can get money back. For questions or to ask for a claim form, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

Referrals

Your PCP will give you a referral to send you to a specialist if you need one. A specialist is a doctor who has extra education in one area of medicine. Your PCP will work with you to choose a specialist. Your PCP's office can help you set up a time to go to the specialist.

Other services that may require a referral include in-office procedures, X-rays and lab work.

Your PCP may give you a form to take to the specialist. The specialist will fill out the form and send it back to your PCP and to the Alliance. The specialist will treat you for as long as he or she thinks you need treatment. The specialist must accept the Alliance's terms and conditions.

If you have a health problem that needs special medical care for a long time, you may need a standing referral. This means you can go to the same specialist more than once without getting a referral each time.

If you have trouble getting a standing referral or want a copy of the Alliance referral policy, call Member Services at 800-700-3874 (TTY 800-735-2929).

You do not need a referral for:

- PCP visits
- Ob/gyn visits
- Urgent or emergency care visits
- Adult sensitive services, such as sexual assault care
- Family planning services (to learn more, call California Family Planning Information and Referral Service at 1-800-942-1054)
- HIV testing and counseling (only minors 12 years or older)
- Treatment for sexually transmitted infections (only minors 12 years or older)
- Acupuncture (the first two services per month; additional appointments will need a referral)

- Chiropractic services (when provided by FQHCs and RHCs)
- Podiatry services (when provided by FQHCs and RHCs)
- Eligible dental services
- Initial mental health assessment
- Routine Vision Exam

Minors also do not need a referral for:

- Outpatient mental health services for:
  - Sexual or physical abuse
  - When you may hurt yourself or others
- Pregnancy care
- Sexual assault care
- Drug and alcohol abuse treatment

Pre-approval

For some types of care, your PCP or specialist will need to ask the Alliance for permission before you get the care. This is called asking for prior authorization, prior approval, or pre-approval. It means that the Alliance must make sure that the care is medically necessary or needed.

Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed disease, illness or injury.

The following services always need pre-approval, even if you receive them from a provider in the Alliance network:

- Hospitalization, if not an emergency
- Services out of the Alliance service area
- Outpatient surgery
- Long-term care at a nursing facility
- Specialized treatments

For some services, you need pre-approval (prior authorization). Under Health and Safety Code Section 1367.01(h)(2), the Alliance will decide routine pre-approvals within 5 working days of when the Alliance gets the information reasonably needed to decide.

For requests in which a provider indicates or the Alliance determines that following the standard timeframe could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function, the Alliance will make an expedited (fast) pre-

approval decision. The Alliance will give notice as quickly as your health condition requires and no later than 72 hours after receiving the request for services.

The Alliance does **not** pay the reviewers to deny coverage or services. If the Alliance does not approve the request, the Alliance will send you a Notice of Action (NOA) letter. The NOA letter will tell you how to file an appeal if you do not agree with the decision.

The Alliance will contact you if the Alliance needs more information or more time to review your request.

You never need pre-approval for emergency care, even if it is out of the network. This includes labor and delivery if you are pregnant.

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you may want a second opinion if you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan and it has not worked.

If you want to get a second opinion, you can choose an in-network provider of your choice. For help choosing a provider, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

The Alliance will pay for a second opinion if you or your network provider asks for it and you get the second opinion from a network provider. You do not need permission from the Alliance to get a second opinion from a network provider.

If there is no provider in the Alliance network to give you a second opinion, the Alliance will pay for a second opinion from an out-of-network provider. The Alliance will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic, severe or serious illness, or face an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, the Alliance will decide within 72 hours.

If the Alliance denies your request for a second opinion, you may appeal. To learn more about appeals, go to page 61 in this handbook.

Women's health specialists

You may go to a women's health specialist within the Alliance network for covered care necessary to provide women's routine and preventive health care services. You do not need a referral from your PCP to get these services. For help finding a women's health

specialist, you can call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You may also call the 24/7 Alliance Nurse Advice Line at 844-971-8907 (toll free).

Timely access to care

Appointment Type	Must Get Appointment Within
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointment that do require pre-approval (prior authorization)	96 hours
Non-urgent primary care appointments	10 business days
Non-urgent specialist	15 business days
Non-urgent mental health provider (non-doctor)	10 business days
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition	15 business days
Telephone wait times during normal business hours	10 minutes
Triage – 24/7 services	24/7 services – No more than 30 minutes
Initial pre-natal care	10 business days

4. Benefits and services

What your health plan covers

This section explains all of your covered services as a member of the Alliance. Your covered services are free as long as they are medically necessary and provided by an in-network provider. Your health plan may cover medically necessary services from an out-of-network provider. But you must ask the Alliance for this. Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed disease, illness or injury.

The Alliance offers these types of services:

- Outpatient (ambulatory) services
- Emergency services
- Hospice and palliative care
- Hospitalization
- Maternity and newborn care
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory and radiology services, such as X-rays
- Preventive and wellness services and chronic disease management
- Mental health services
- Does use disorder treatment services
- Pediatric services
- Vision services
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)
- Long-term services and supports (LTSS)
- CCS-eligible services

Read each of the sections below to learn more about the services you can get.

Medi-Cal benefits

Outpatient (ambulatory) services

- ***Adult Immunizations***

  You can get adult immunizations (shots) from a network pharmacy or network provider without pre-approval. The Alliance covers those shots recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

- ***Allergy care***

  The Alliance covers allergy testing and treatment, including allergy desensitization, hyposensitization or immunotherapy.

- ***Anesthesiologist services***

  The Alliance covers anesthesia services that are medically necessary when you receive outpatient care.

- ***Chiropractic services***

  The Alliance covers chiropractic services, limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to two services per month in combination with acupuncture, audiology, occupational therapy and speech therapy services. The Alliance may pre-approve other services as medically necessary.

  The following members are eligible for chiropractic services:

  - Children under age 21;
  - Pregnant women through the end of the month that includes 60-days following the end of a pregnancy;
  - Residents in a skilled nursing facility, intermediate care facility, or subacute care facility; or
  - All members when services are provided at hospital outpatient departments, Federally Qualified Health Center (FQHC) or Rural Health

Center (RHC).

- ***Dialysis/hemodialysis services***

  The Alliance covers dialysis treatments. The Alliance also covers hemodialysis (chronic dialysis) services if your PCP and the Alliance approve it.

- ***Outpatient surgery***

  The Alliance covers outpatient surgical procedures. Those needed for diagnostic purposes, procedures considered to be elective, and specified outpatient medical procedures require pre-approval (prior authorization).

- ***Physician services***

  The Alliance covers physician services that are medically necessary.

- ***Podiatry (foot) services***

- The Alliance covers podiatry services as medically necessary for diagnosis and medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

- ***Treatment therapies***

  The Alliance covers different treatment therapies, including:

  - Chemotherapy
  - Radiation therapy

Mental health services

- ***Outpatient mental health services***

  - The Alliance covers a member for an initial mental health assessment without requiring pre-approval (prior authorization). You may get a mental health assessment at any time from a licensed mental health provider in the Alliance network without a referral.

  - Your PCP or mental health provider will make a referral for additional mental

health screening to a specialist within the Alliance network to determine your level of impairment. If your mental health screening results determine you are in mild or moderate distress or have impairment of mental, emotional or behavioral functioning, the Alliance can provide mental health services for you. The Alliance covers these mental health services:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purposes of monitoring medication therapy
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation

- For help finding more information on mental health services provided by the Alliance, call Member Services at 800-700-3874 (TTY 800-735-2929).
- If your mental health screening results determine you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider will refer you to the county mental health plan to receive an assessment. To learn more, read “*What your health plan does not cover*” on page 50.

Emergency services

- ***Inpatient and outpatient services needed to treat a medical emergency***

  The Alliance covers all services that are needed to treat a medical emergency that happens in the U.S. or requires you to be in a hospital in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

  - Serious risk to your health; ***or***
  - Serious harm to bodily functions; ***or***
  - Serious dysfunction of any bodily organ or part; ***or***

- In the case of a pregnant woman in active labor, meaning labor at a time 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.

- ***Emergency transportation services***

  The Alliance covers ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico.

Hospice and palliative care

The Alliance covers hospice care and palliative care for children and adults, which help reduce physical, emotional, social and spiritual discomforts.

Hospice care is a benefit that services terminally ill members. It is intervention that focuses mainly on pain and symptom management rather than on a cure to prolong life.

Hospice care includes:

- Nursing services
- Physical, occupational or speech services
- Medical social services
- Home health aide and homemaker services
- Medical supplies and appliances
- Drugs and biological services
- Counseling services
- Continuous nursing services on a 24-hour basis during periods of crisis and as necessary to maintain the terminally ill member at home
- Inpatient respite care for up to five consecutive days at a time in a hospital, skilled nursing facility or hospice facility
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing facility or hospice facility

Palliative care is patient- and family-centered care that improves quality of life by anticipating, preventing and treating suffering. Palliative care does not require the

member to have a life expectancy of six months or less. Palliative care may be provided at the same time as curative care.

Hospitalization

- ***Anesthesiologist services***

  The Alliance covers medically necessary anesthesiologist services during covered hospital stays. An anesthesiologist is a provider who specializes in giving patients anesthesia. Anesthesia is a type of medicine used during some medical procedures.

- ***Inpatient hospital services***

  The Alliance covers medically necessary inpatient hospital care when you are admitted to the hospital.

- ***Surgical services***

  The Alliance covers medically necessary surgeries performed in a hospital.

Maternity and newborn care

The Alliance covers these maternity and newborn care services:

- Breastfeeding education and aids
- Delivery and postpartum care
- Prenatal care
- Birthing center services
- Certified Nurse Midwife (CNM)
- Licensed Midwife (LM)
- Diagnosis of fetal genetic disorders and counseling

Prescription drugs

Covered drugs

Your provider can prescribe you drugs that are on the Alliance preferred drug list (PDL), subject to exclusions and limitations. The Alliance PDL is sometimes called a formulary. Drugs on the formulary are safe and effective for their prescribed use. A group of doctors and pharmacists update this list.

- Updating this list helps make sure the drugs on it are safe and effective.

- If your doctor thinks you need to take a drug that is not on this list, your doctor will need to call the Alliance to ask for pre-approval before you get the drug.

To find out if a drug is on the Alliance formulary or to get a copy of the formulary, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711). You may also find the formulary at www.ccah-alliance.org.

Sometimes Alliance needs to approve a drug before a provider can prescribe it. The Alliance will review and decide these requests within 24 hours.

- A pharmacist or hospital emergency room may give you a 72-hour emergency supply if they think you need it. The Alliance will pay for the emergency supply.
- If the Alliance says no to the request, the Alliance will send you a letter that lets you know why and what other drugs or treatments you can try.

Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with the Alliance. You can find a list of pharmacies that work with the Alliance in the Alliance Provider Directory at http://www.ccah-alliance.org/aspnetforms/MedimpactLocator.aspx. 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. Your provider may also send it to the pharmacy for you. Give the pharmacy your prescription with your Alliance ID card. Make sure the pharmacy knows about all medications you are taking and any allergies you have. If you have any questions about your prescription, make sure you ask the pharmacist.

Rehabilitative and habilitative services and devices

The plan covers:

- ***Audiology (hearing)***

  The Alliance covers audiology services. Outpatient audiology is limited to two services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services. The Alliance may pre-approve (prior authorization) additional services as medically necessary.

- ***Acupuncture***

The Alliance covers acupuncture services to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of needles) are limited to two services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services. The Alliance may pre-approve (prior authorization) additional services as medically necessary.

- ***Behavioral health treatments***

  Behavioral health treatment (BHT) includes services and treatment programs, such as applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual.

  BHT services teach skills using behavioral observation and reinforcement, or through prompting to teach each step of a targeted behavior. BHT services are based on reliable evidence and are not experimental. Examples of BHT services include behavioral interventions, cognitive behavioral intervention packages, comprehensive behavioral treatment and applied behavioral analysis.

  BHT services are available for members who meet eligibility criteria. This means the services must be medically necessary, prescribed by a licensed doctor or psychologist, approved by the plan, and provided in a way that follows the approved treatment plan.

- ***Cancer clinical trials***

  The Alliance covers a clinical trial if it is related to the prevention, detection or treatment of cancer or other life-threatening conditions and if the study is conducted by the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS). Studies must be approved by the National Institutes of Health, the FDA, the Department of Defense or the Veterans Administration.

- ***Cardiac rehabilitation***

  The Alliance covers inpatient and outpatient cardiac rehabilitative services.

- ***Cosmetic Surgery***

  The Alliance does not cover cosmetic surgery to change the shape of normal structures of the body in order to improve appearance.

- ***Durable medical equipment (DME)***

  The Alliance covers the purchase or rental of medical supplies, equipment and other services with a prescription from a doctor. Prescribed DME items may be covered as medically necessary to preserve bodily functions essential to activities of daily living or to prevent major physical disability. The Alliance does not cover comfort, convenience or luxury equipment, features and supplies.

- ***Enteral and parenteral nutrition***

  These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. The Alliance covers enteral and parenteral nutrition products when medically necessary.

- ***Hearing aids***

  The Alliance covers hearing aids if you are tested for hearing loss and have a prescription from your doctor. The Alliance may also cover hearing aid rentals, replacements and batteries for your first hearing aid.

- ***Home health services***

  The Alliance covers health services provided in your home, when prescribed by your doctor and found to be medically necessary.

- ***Medical supplies, equipment and appliances***

  The Alliance covers medical supplies that are prescribed by a doctor.

- ***Occupational therapy***

  The Alliance covers occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction and consultative services. Occupational therapy services are limited to two services per month in combination with acupuncture, audiology, chiropractic and speech therapy services. The Alliance may pre-approve (prior authorization) additional services as medically necessary.

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- ***Orthotics/prostheses***

  The Alliance covers orthotic and prosthetic devices and services that are medically necessary and prescribed by your doctor, podiatrist, dentist, or non-physician medical provider. This includes implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part.

- ***Ostomy and urological supplies***

  The Alliance covers ostomy bags, urinary catheters, draining bags, irrigation supplies and adhesives. This does not include supplies that are for comfort, convenience or luxury equipment or features.

- ***Physical therapy***

  The Alliance covers physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services and application of topical medications.

- ***Pulmonary rehabilitation***

  The Alliance covers pulmonary rehabilitation that is medically necessary and prescribed by a doctor.

- ***Reconstructive Services***

  The Alliance covers surgery to correct or repair abnormal structures of the body to improve or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.

- ***Skilled nursing facility services***

  The Alliance covers skilled nursing facility services as medically necessary if you are disabled and need a high level of care. These services include room and board in a licensed facility with skilled nursing care on a 24-hour per day basis.

- ***Speech therapy***

  The Alliance covers speech therapy that is medically necessary. Speech therapy services are limited to two services per month, in combination with acupuncture, audiology, chiropractic and occupational therapy. the Alliance may pre-approve (prior authorization) additional services as medically necessary.

- ***Transgender Services***

  The Alliance covers transgender services (gender-affirming services) as a benefit when they are medically necessary or when the services meet the criteria for reconstructive surgery.

Laboratory and radiology services

The Alliance covers outpatient and inpatient laboratory and X-ray services when medically necessary. Various advanced imaging procedures are covered based on medical necessity.

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- Health Resources and Service Administration's Bright Futures recommendations
- Preventive services for women recommended by the Institute of Medicine
- Smoking cessation services
- United States Preventive Services Task Force A and B recommended preventive services

Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include some methods of birth control approved by the FDA. The Alliance's PCP and ob/gyn specialists are available for family planning services

For family planning services, you may also choose a doctor or clinic not connected with the Alliance without having to get pre-approval from the Alliance. Services from an out-of-network provider not related to family planning may not be covered. To learn more, call Member Services at 800-700-3874 (TTY 800-735-2929).

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program. It is designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The program lasts one year. It can last for a second year for members who qualify. The program-approved lifestyle supports and techniques include, but are not limited to:

- Providing a peer coach
- Teaching self-monitoring and problem solving
- Providing encouragement and feedback
- Providing informational materials to support goals
- Tracking routine weigh-ins to help accomplish goals

Members must meet program eligibility requirements to join DPP. Call the Alliance to learn more about the program and eligibility

Substance use disorder services

The plan covers:

- Alcohol misuse screenings and behavioral health counseling interventions for alcohol misuse

Pediatric services

The plan covers:

- Early and periodic screening, diagnostic and treatment (EPSDT) services.
    - If you or your child are under 21 years old, the Alliance covers well-child visits. Well-child visits are a comprehensive set of preventive, screening, diagnostic, and treatment services.
    - The Alliance will make appointments and provide transportation to help children get the care they need.
    - Preventive care can be regular health check-ups and screenings to help your doctor find problems early. Regular check-ups help your doctor look for any problems with your medical, dental, vision, hearing, mental health, and any substance use disorders. The Alliance covers screening services (including lead blood level assessment) any time there is a need for them, even if it is not during your regular check-up. Also, preventive care can be shots you or your child need. The Alliance

must make sure that all enrolled children get needed shots at the time of any health care visit.

- When a problem physical or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem. If the care is medically necessary and the Alliance is responsible for paying for the care, then the Alliance covers the care at no cost to you. These services include:
    - Doctor, nurse practitioner, and hospital care
    - Shots to keep you healthy
    - Physical, speech/language, and occupational therapies
    - Home health services, which could be medical equipment, supplies, and appliances
    - Treatment for vision and hearing, which could be eyeglasses and hearing aids
    - Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
    - Case management, targeted case management, and health education
    - Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.
- If the care is medically necessary and the Alliance is not responsible for paying for the care, then the Alliance will help you get the right care you need. These services include:
    - Treatment and rehabilitative services for mental health and substance use disorders
    - Treatment for dental issues, which could be orthodontics
    - Private duty nursing services

Vision services

The plan covers:

- Routine eye exam once every 24 months; the Alliance may pre-approve (prior authorization) additional services as medically necessary.
- Eyeglasses (frames and lens) once every 24 months; contact lens when required for medical conditions such as aphakia, aniridia and keratoconus.

Non-emergency medical transportation (NEMT)

You are entitled to use non-emergency medical transportation (NEMT) when you physically or medically are not able to get to your medical, dental, mental health and substance use disorder appointment by car, bus, train or taxi, and the plan pays for your medical or physical condition. Before getting NEMT, you need to request the service through your doctor, and they will prescribe the correct type of transportation to meet your medical condition.

NEMT is an ambulance, litter van, wheelchair van or air transport. NEMT is not a car, bus or taxi. The Alliance allows the lowest cost NEMT for your medical needs when you need a ride to your appointment. That means, for example, if you can physically or medically be transported by a wheelchair van, the Alliance will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

NEMT must be used when:

- It is physically or medically needed as determined with a written authorization by a doctor; or you are not able to physically or medically use a bus, taxi, car or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle or place of treatment due to a physical or mental disability.
- It is approved in advance by the Alliance with a written authorization by a doctor.

To ask for NEMT services that your doctor has prescribed, please call the Alliance at **800-700-3874 ext. 5577** at least five business days (Monday-Friday) before your appointment. For urgent appointments, please call as soon as possible. Please have your member ID card ready when you call.

Limits of NEMT

There are no limits for receiving NEMT to or from medical, dental, mental health and substance use disorder appointments covered under the Alliance when a provider has prescribed it for you. If the appointment type is covered by Medi-Cal but not through the health plan, your health plan will provide for or help you schedule your transportation.

What does not apply?

Transportation will not be provided if your physical and medical condition allows you to get to your medical appointment by car, bus, taxi or other easily accessible method of

transportation. Transportation will not be provided if the service is not covered by Medi-Cal. A list of covered services is in this Member Handbook.

Cost to member

There is no cost when transportation is authorized by the Alliance.

Non-medical transportation (NMT)

You can use non-medical transportation (NMT) when you are:

- Traveling to and from an appointment for a Medi-Cal service authorized by your provider.
- Picking up prescriptions and medical supplies.

The Alliance allows you to use a car, taxi, bus or other public/private way of getting to your medical appointment for Medi-Cal-covered services. The Alliance provides mileage reimbursement when transportation is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

Before getting approval for mileage reimbursement, you must state to the Alliance by phone, by email or in person that you tried to get all other reasonable transportation choices and could not get one. The Alliance allows the lowest cost NMT type that meets your medical needs.

To request NMT services that your provider authorized, call the Alliance at **800-700-3874** at least seven business days (Monday-Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have your member ID card ready when you call.

Limits of NMT

There are no limits for receiving NMT to or from medical, dental, mental health and substance use disorder appointments when a provider has authorized it for you. If the appointment type is covered by Medi-Cal but not through the health plan, your health plan will provide for or help you schedule your transportation.

What does not apply?

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.

- You need assistance from the driver to and from the residence, vehicle or place of treatment due to a physical or medical condition.
- The service is not covered by Medi-Cal.

Cost to member

There is no cost when transportation is authorized by the Alliance.

Long-term services and supports (LTSS)

The Alliance covers these LTSS benefits for members who qualify:

- Skilled nursing facility services as approved by the Alliance
- Home and Community Based Services as approved by the Alliance

Telehealth services

The Alliance may be able to provide some of your services through telehealth. Telehealth is a way of receiving 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. You can contact the Alliance to determine which types of services the Alliance may be able to provide to you through telehealth.

What your health plan does not cover

Other services you can get through Fee-For-Service (FFS) Medi-Cal

Sometimes the Alliance does not cover services, but you can still get them through FFS Medi-Cal. This section lists these services. To learn more, call Member Services at 800-700-3874 (TTY 800-735-2929 or 711).

Specialty mental health services

County mental health plans provide specialty mental health services (SMHS) to Medi-Cal beneficiaries who meet medical necessity rules. SMHS may include these outpatient, residential and inpatient services:

- Outpatient services:

    - Mental health services (assessments, plan development, therapy, rehabilitation and collateral)
    - Medication support services
    - Day treatment intensive services
    - Day rehabilitation services
    - Crisis intervention services
    - Crisis stabilization services
    - Targeted case management services
    - Therapeutic behavioral services
    - Intensive care coordination (ICC)
    - Intensive home-based services (IHBS)
    - Therapeutic foster care (TFC)
- Residential services:
    - Adult residential treatment services
    - Crisis residential treatment services
- Inpatient services:
    - Acute psychiatric inpatient hospital services
    - Psychiatric inpatient hospital professional services
    - Psychiatric health facility services

To learn more about specialty mental health services the county mental health plan provides, you can call the county. To find all counties' toll-free telephone numbers online, visit https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Substance use disorder services

County mental health plans provide substance use disorder services to Medi-Cal members including outpatient services and residential services. For help finding more information on specialty mental health services provided by the county mental health plan, you can call the county. To locate all counties toll free numbers online, visit http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Dental services

Medi-Cal covers some dental services, including:

- Diagnostic and preventive dental hygiene (such as examinations, X-rays and teeth cleanings)
- Emergency services for pain control
- Tooth extractions

- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planning
- Periodontal maintenance
- Complete and partial dentures
- Orthodontics for children who qualify

If you have questions or want to learn more about dental services, call Denti-Cal at 1-800-322-6384 (TTY 1-800-735-2922). You may also visit the Denti-Cal website at denti-cal.ca.gov.

Services you cannot get through the Alliance or Medi-Cal

There are some services that neither the Alliance nor Medi-Cal will cover, including:

Services received outside of the United States or its territories

You are not covered for services you receive outside of the United States or its territories except for emergency services requiring a hospital stay in either Canada or Mexico.

Other programs and services for people with Medi-Cal

There are other programs and services for people with Medi-Cal, including:

- Organ and tissue donation
- Whole Child Model (WCM) Program

Organ and tissue donation

Anyone can help save lives by becoming an organ or tissue donor. If you are between 15 and 18 years old, you can become a donor with the written consent of your parent or guardian. You can change your mind about being an organ donor at any time. If you want to learn more about organ or tissue donation, talk to your PCP. You can also visit the United States Department of Health and Human Services website at organdonor.gov.

- Health promotion
- Comprehensive transitional care
- Individual and family support services
- Referral to community and social supports

The Whole Child Model/California Children's Services (CCS)

CCS is a state program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems and who meet the CCS program rules. If the Alliance or your child's PCP believes your child has a CCS condition, he or she will be referred to the CCS program.

CCS program staff will decide if your child qualifies for CCS services. If your child qualifies to get this type of care, CCS approved providers will treat him or her for the CCS condition. The services will be covered by the Alliance.

CCS covers children with health conditions such as:

- Congenital heart disease
- Cancers
- Tumors
- Hemophilia
- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts
- Cerebral palsy
- Seizures under certain circumstances
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

The Alliance will cover all of your child's CCS services. The only exceptions are services received through CCS Medical Therapy Program. These services are covered by your county CCS program.

If you have questions about your child's eligibility for CCS, call your local county CCS office:

Merced County	Monterey County	Santa Cruz County
209-381-1114	831-755-4747	831-763-8000

Care coordination

The Alliance offers services to help you coordinate your health care needs at no cost to you. If you have questions or concerns about your health or the health of your child, call Member Services at 800-700-3874 (TTY 800-735-2929).

5. Rights and responsibilities

As a member of the Alliance, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of the Alliance.

Your rights

The Alliance members have these rights:

- To be treated with respect, 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.
- To be able to choose a primary care provider within the Alliance's network.
- 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 received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer or limit services or benefits.
- To receive oral interpretation services for their language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To disenroll upon request. Members that can request expedited disenrollment include, but are not limited to, those receiving services under the Foster Care or Adoption Assistance Programs and those with special health care needs.
- To access Minor Consent Services.
- To receive written member-informing materials in alternative formats (such as braille, large-size print and audio format) 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 be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the Alliance, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Service Facilities, midwifery services, Rural Health Centers, sexually transmitted disease services and Emergency Services outside the Alliance's network pursuant to the federal law.

Your responsibilities

The Alliance members have these responsibilities:

- Know the Alliance's rules and follow them.
- Tell your doctor about your health conditions, both now and in the past.
- Keep your appointments. If you have to cancel an appointment, let the office know 24 hours before you were scheduled to see the doctor.
- Be kind and polite to your doctors, their staff and to Alliance staff.
- Keep your Alliance ID and Medi-Cal BIC cards with you at all times and show your cards when you get care.
- Follow the rules of any other health insurance you have.
- Use the emergency room only for emergency care.
- Call your county Medi-Cal office if you move or change your phone number. If you receive Supplemental Security Income (SSI), call the local Social Security Office.
- Call your local county services office to update any other health insurance you have or no longer have. To update other insurance information by phone, call:

▪ Merced County **209-385-3000**	Monterey County **877-410-8823**	Santa Cruz County **888-421-8080**

To update other insurance information online, go to the California Department of Health Care Services (DHCS) website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx

Notice of Privacy Practices

Effective Date: January 1, 2019

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.ccah-alliance.org

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 Healthcare 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	Marketing purposes. Sale of your information.

unless you give us written permission:	Psychotherapy notes. Substance abuse treatment records.

Our Uses and Disclosures

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

Help manage the health care treatment you receive	▪ We can use your health information and share it with professionals who are treating you.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can make sure the services are medically necessary and are covered benefits.
Run our organization	▪ We can use and disclose your information to run our organization and contact you when necessary. ▪ We can also use and disclose your information to contractors (Business Associates) who help us with certain functions. They must sign an agreement to keep your information confidential before we share it with them. ▪ **We are not allowed to use genetic**	**Example:** We use health information about you to develop better services for you. **Example:** We share your name and address with a contractor to print and mail our member identification cards.

	information to decide whether we will give you coverage and the price of that coverage.	
Pay for your health services	▪ We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you with any other health insurance plan you have to coordinate payment for your health care.
Administer your plan	▪ We may disclose your health information to your health plan sponsor for plan administration.	**Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

Help with public health and safety issues	▪ We can share health information about you for certain situations such as: ▪ Preventing disease ▪ Helping with product recalls ▪ Reporting adverse reactions to medications ▪ Reporting suspected abuse, neglect, or

	domestic violence ▪ Preventing or reducing a serious threat to anyone's health or safety.
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 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.ccah-alliance.org**

How to File a Complaint

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

you receive as an Alliance member.

Contact us:

Central California Alliance for Health – Privacy Officer

1600 Green Hills Road, Suite 101

Scotts Valley, CA 95066

1 (800) 700-3874 (toll-free)

1 (877) 548-0857 (TDD – for hearing impaired)

If you are a Medi-Cal member, you may also file a complaint with the California Department of Health Care Services:

Privacy Officer

c/o Office of HIPAA Compliance

Department of Health Care Services

P.O. Box 997413, MS 4722

Sacramento, CA 95899-7413

Telephone: 916-445-4646

Email: privacyofficer@dhcs.ca.gov

Fax: (916) 440-7680

You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights:

200 Independence Avenue SW

Washington, DC 20211

calling 1 (877) 696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all

information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are state and federal laws about the Medi-Cal program. Other federal and state laws may apply too.

Notice about Medi-Cal as a payer of last resort

Sometimes someone else has to pay first for the services the Alliance provides you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

DHCS has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. If you are injured, and someone else is liable for your injury, you or your legal representative must notify DHCS within 30 days of filing a legal action or a claim. Submit your notification online:

- Personal Injury Program at http://dhcs.ca.gov/PI
- Workers Compensation Recovery Program at http://dhcs.ca.gov/WC

To learn more, call 1-916-445-9891.

The Medi-Cal program complies with state and federal laws and regulations relating to the legal liability of third parties for health care services to beneficiaries. The Alliance will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

You must apply for and keep other health coverage (OHC) that is available to you for free or is state-paid coverage. If you do not apply for or keep no-cost or state-paid OHC, your Medi-Cal benefits and/or eligibility will be denied or stopped. If you do not report changes to your OHC promptly, and because of this, receive Medi-Cal benefits that you are not eligible for, you may have to repay DHCS.

Notice about estate recovery

The Medi-Cal program must seek repayment from the estates of certain deceased Medi-Cal members from payments made, including managed care premiums, nursing facility services, home and community-based services, and related hospital and prescription drug services provided to the deceased Medi-Cal member on or after the member's 55th birthday. If a deceased member does not leave an estate or owns nothing when they die, nothing will be owed.

To learn more about the estate recovery, call 1-916-650-0490. Or get legal advice.

Notice of Action

The Alliance will send you a Notice of Action (NOA) letter any time the Alliance denies, delays, terminates or modifies a request for health care services. If you disagree with the plan's decision, you can always file an appeal with the Alliance.

6. Reporting and solving problems

There are two kinds of problems that you may have with the Alliance:

- A **complaint** (or **grievance)** is when you have a problem with the Alliance or a provider, or with the health care or treatment you got from a provider
- An **appeal** is when you don't agree with the Alliance's decision not to cover or change your services

You can use the Alliance grievance and appeal process to let us know about your problem. This does not take away any of your legal rights and remedies. We will not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all members.

You should always contact the Alliance first to let us know about your problem. Call us between at between 8:00 a.m. and 5:30 p.m. Monday through Friday at **800-700-3874 (TTY 800-735-2929 or 711)** to tell us about your problem. This will not take away any of your legal rights and remedies. We will not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all members.

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can also help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609.

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call Member Services at 800-700-3874 (TTY 800-735-2929).

To report incorrect information about your additional health insurance, please call Medi-Cal Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-800-541-5555.

Complaints

A complaint (or grievance) is when you have a problem or are unhappy with the services you are receiving from the Alliance or a provider. There is no time limit to file a complaint. You can file a complaint with us at any time by phone, in writing or online.

- **By phone:** Call the Alliance at **800-700-3874 (TTY 800-735-2929)** between 8:00 a.m. and 5:30 p.m. Monday through Friday. Give your health plan ID number, your name and the reason for your complaint.
- **By mail:** Call the Alliance at **800-700-3874 (TTY 800-735-2929 or 711)** and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the reason for your complaint. Tell us what happened and how we can help you.

  Mail the form to:

  Grievance Department

  1600 Green Hills Road, Suite 101,

  Scotts Valley, CA 95066

  Your doctor's office will have complaint forms available.
- **Online:** Visit the Alliance website. Go to www.ccah-alliance.org.

If you need help filing your complaint, we can help you. We can give you free language services. Call Member Services at 800-700-3874 (TTY 800-735-2929).

Within 5 days of getting your complaint, we will send you a letter letting you know we received it. Within 30 days, we will send you another letter that tells you how we resolved your problem. If you call the Alliance about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and your grievance is resolved by the end of the next business day, you may not receive a letter.

If you want us to make a fast decision because the time it takes to resolve your complaint would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call us at Member Services at 800-700-3874 (TTY 800-735-2929). We will make a decision within 72 hours of receiving your complaint.

Appeals

An appeal is different from a complaint. An appeal is a request for the Alliance to review and change a decision we made about coverage for a requested service. If we sent you a Notice of Action (NOA) letter telling you that we are denying, delaying, changing or ending a service, and you do not agree with our decision, you can file an appeal. Your PCP can also file an appeal for you with your written permission.

You must file an appeal within 60 calendar days from the date on the NOA you received. If you are currently getting treatment and you want to continue getting treatment, then you must ask for an appeal within 10 calendar days from the date the NOA was delivered to you, or before the date the Alliance says services will stop. When you request the appeal, please tell us that you want to continue receiving services.

You can file an appeal by phone, in writing or online:

- **By phone:** Call the Alliance at **800-700-3874 (TTY 800-735-2929 or 711)** between 8:00 a.m. and 5:30 p.m., Monday through Friday. Give your name, health plan ID number and the service you are appealing.
- **By mail:** Call the Alliance at **800-700-3874 (TTY 800-735-2929 or 711)** and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the service you are appealing.

  Mail the form to:

  Grievance Department
  1600 Green Hills Road, Suite 101,
  Scotts Valley, CA 95066

  Your doctor's office will have appeal forms available.
- **Online:** Visit the Alliance website. Go to www.ccah-alliance.org.

If you need help filing your appeal, we can help you. We can give you free language services. Call Member Services at 800-700-3874 (TTY 800-735-2929).

Within 5 days of getting your appeal, we will send you a letter letting you know we received it. Within 30 days, we will tell you our appeal decision.

If you or your doctor wants us to make a fast decision because the time it takes to resolve your appeal would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call Member Services at 800-700-3874 (TTY 800-735-2929). We will make a decision within 72

hours of receiving your appeal.

What to do if you do not agree with an appeal decision

If you filed an appeal and received a letter from the Alliance telling you we did not change our decision, or you never received a letter telling you of our decision and it has been past 30 days, you can:

- Ask for a **State Hearing** from Department of Social Services (DSS), and a judge will review your case.

State Hearings

A A State Hearing is a meeting with people from the DSS. A judge will help to resolve your problem. You can ask for a State Hearing only if you have already filed an appeal with the Alliance and you are still not happy with the decision or if you have not received a decision on your appeal after 30 days, and you have not requested an IMR.

You must ask for a State Hearing within 120 days from the date on the notice telling you of the appeal decision. Your PCP can ask for a State Hearing for you with your written permission and if he or she gets approval from DSS. You can also call DSS to ask the State to approve your PCP's request for a State Hearing.

You can ask for a State Hearing by phone or mail.

- **By phone:** Call the DSS Public Response Unit at 1-800-952-5253 (TTY 1-800-952-8349).
- **By mail**: Fill out the form provided with your appeals resolution notice. Send it to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, MS 09-17-37
  Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call Member Services at 800-700-3874 (TTY 800-735-2929).

At the hearing, you will give your side. We will give our side. It could take up to 90 days for the judge to decide your case. The Alliance must follow what the judge decides.

If you want the DSS to make a fast decision because the time it takes to have a State

Hearing would put your life, health or ability to function fully in danger, you or your PCP can contact the DSS and ask for an expedited (fast) State Hearing. DSS must make a decision no later than 3 business days after it gets your complete case file from the Alliance.

Fraud, waste and abuse

If you suspect that a provider or a person who gets Medi-Cal has committed fraud, waste or abuse, it is your right to report it.

Provider fraud, waste and abuse includes:

- Falsifying medical records
- Prescribing more medication than is medically necessary
- Giving more health care services than medically necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service

Fraud, waste and abuse by a person who gets benefits includes:

- Lending, selling or giving a health plan ID card or Medi-Cal Benefits Identification Card (BIC) to someone else
- Getting similar or the same treatments or medicines from more than one provider
- Going to an emergency room when it is not an emergency
- Using someone else's Social Security number or health plan ID number

To report fraud, waste and abuse, write down the name, address and ID number of the person who committed the fraud, waste or abuse. Give as much information as you can about the person, such as the phone number or the specialty if it is a provider. Give the dates of the events and a summary of exactly what happened.

Send your report to:

Member Services Department
1600 Green Hills Road, Suite 101,
Scotts Valley, CA 95066

Or call Member Services at **1-800-700-3874 (TTY 1-800-735-2929 or 711).**

7. Important numbers and words to know

Important phone numbers

- Alliance Member Services: 1-800-700-3874 (TTY 1-800-735-2929 or 711).
- Alliance Nurse Advice Line: 1-844-971-8907
- Alliance Transportation Coordinators: 1-800-700-3874
- Alliance Case Management: 1-800-700-3874 ext.5512
- Alliance Health Education: 1-800-700-3874 ext.5580
- To request interpreter services: 1-800-700-3874 ext. 5580
- Beacon Health Options (for mental health services): 1-855-765-9700
- Vision Services Plan (for routine vision services): 1-800-877-7195
- Denti-Cal Program (for dental services): 1-800-322-6384

Words to know

Active labor: The period of time when a woman is in the three stages of giving birth and either cannot be safely transferred in time to another hospital before delivery or a transfer may harm the health and safety of the woman or unborn child.

Acute: A medical condition that is sudden, requires fast medical attention and does not last a long time.

Appeal: A member's request for the Alliance to review and change a decision made about coverage for a requested service.

Benefits: Health care services and drugs covered under this health plan.

California Children's Services (CCS): A program that provides services for children up to age 21 with certain diseases and health problems.

California Health and Disability Prevention (CHDP): A public health program that reimburses public and private health care providers for early health assessments to

detect or prevent disease and disabilities in children and youth. The program helps children and youth who qualify have access to regular health care. Your PCP can provide CHDP services.

Case manager: Registered nurses or social workers who can help you understand major health problems and arrange care with your providers.

Certified Nurse Midwife (CNM): An individual licensed as a Registered Nurse and certified as a nurse midwife by the California Board of Registered Nursing. A certified nurse midwife is permitted to attend cases of normal childbirth.

Chronic condition: A disease or other medical problem that cannot be completely cured or that gets worse over time or that must be treated so you do not get worse.

Clinic: A facility that members can select as a primary care provider (PCP). It can be either a Federally Qualified Health Center (FQHC), community clinic, Rural Health Clinic (RHC), Indian Health Service Facility or other primary care facility.

Community-based adult services (CBAS): Outpatient, facility-based services for skilled nursing care, social services, therapies, personal care, family and caregiver training and support, nutrition services, transportation, and other services for members who qualify.

Complaint: A member's verbal or written expression of dissatisfaction about the Alliance, a provider, or the quality of care or quality of services provided. A complaint is the same as a grievance.

Continuity of care: The ability of a plan member to keep getting Medi-Cal services from their existing provider for up to 12 months, if the provider and the Alliance agree.

Coordination of Benefits (COB): The process of determining which insurance coverage (Medi-Cal, Medicare, commercial insurance or other) has primary treatment and payment responsibilities for members with more than one type of health insurance coverage.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Enrolled recipients choose their health care provider from among all COHS providers.

Copayment: A payment you make, generally at the time of service, in addition to the insurer's payment.

Coverage (covered services): The health care services provided to members of the Alliance, subject to the terms, conditions, limitations and exclusions of the Medi-Cal contract and as listed in this Evidence of Coverage (EOC) and any amendments.

DHCS: The California Department of Health Care Services. This is the State office that oversees the Medi-Cal program.

Disenroll: To stop using this health plan because you no longer qualify or change to a new health plan. You must sign a form that says you no longer want to use this health plan or call HCO and disenroll by phone.

Durable medical equipment (DME): Equipment that is medically necessary and ordered by your doctor or other provider. The Alliance decides whether to rent or buy DME. Rental costs must not be more than the cost to buy. Repair of medical equipment is covered.

Early and periodic screening, diagnosis and treatment (EPSDT): EPSDT services are a benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early.

Emergency medical condition: A medical or mental condition with such severe symptoms, such as active labor (go to definition above) or severe pain, that someone with a prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger
- Cause impairment to a body function
- Cause a body part or organ to not work right

Emergency room care: An exam performed by a doctor (or staff under direction of a doctor as allowed by law) to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.

Emergency medical transportation: Transportation in an ambulance or emergency vehicle to an emergency room to receive emergency medical care.

Enrollee: A person who is a member of a health plan and receives services through the plan.

Excluded services: Services not covered by the Alliance; non-covered services.

Family planning services: Services to prevent or delay pregnancy.

Federally Qualified Health Center (FQHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an FQHC.

Fee-For-Service (FFS): This means you are not enrolled in a managed care health

plan. Under FFS, your doctor must accept "straight" Medi-Cal and bill Medi-Cal directly for the services you got.

Follow-up care: Regular doctor care to check a patient's progress after a hospitalization or during a course of treatment.

Formulary: A list of drugs or items that meet certain criteria and are approved for members.

Fraud: An intentional act to deceive or misrepresent by a person who knows the deception could result in some unauthorized benefit for the person or someone else.

Freestanding Birth Centers (FBCs): Health facilities where childbirth is planned to occur away from the pregnant woman's residence that are licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan. These facilities are not hospitals.

Grievance: A member's verbal or written expression of dissatisfaction about the Alliance, a provider, or the quality of care or services provided. A complaint is the same as a grievance.

Habilitation services and devices: Health care services that help you keep, learn or improve skills and functioning for daily living.

Health Care Options (HCO): The program that can enroll you in or disenroll you from the health plan.

Health care providers: Doctors and specialists such as surgeons, doctors who treat cancer or doctors who treat special parts of the body, and who work with the Alliance or are in the Alliance network. The Alliance network providers must have a license to practice in California and give you a service the Alliance covers.

You usually need a referral from your PCP to go to a specialist.

You do **not** need a referral from your PCP for some types of service, such as family planning, emergency care, ob/gyn care or sensitive services.

Types of health care providers:

- Audiologist is a provider who tests hearing.
- Certified nurse midwife is a nurse who cares for you during pregnancy and childbirth.
- Family practitioner is a doctor who treats common medical issues for people of all ages.

- General practitioner is a doctor who treats common medical issues.
- Internist is a doctor with special training in internal medicine, including diseases.
- Licensed vocational nurse is a licensed nurse who works with your doctor.
- A counselor is a person who helps you with family problems.
- Medical assistant or certified medical assistant is a non-licensed person who helps your doctors give you medical care.
- Mid-level practitioner is a name used for health care providers, such as nurse-midwives, physician assistants or nurse practitioners.
- Nurse anesthetist is a nurse who gives you anesthesia.
- Nurse practitioner or physician assistant is a person who works in a clinic or doctor's office who diagnoses, treats and cares for you, within limits.
- Obstetrician/gynecologist (ob/gyn) is a doctor who takes care of a woman's health, including during pregnancy and birth.
- Occupational therapist is a provider who helps you regain daily skills and activities after an illness or injury.
- Pediatrician is a doctor who treats children from birth through the teen years.
- Physical therapist is a provider who helps you build your body's strength after an illness or injury.
- Podiatrist is a doctor who takes care of your feet.
- Psychologist is a person who treats mental health issues but does not prescribe drugs.
- Registered nurse is a nurse with more training than a licensed vocational nurse and who has a license to do certain tasks with your doctor.
- Respiratory therapist is a provider who helps you with your breathing.
- Speech pathologist is a provider who helps you with your speech.

Health insurance: Insurance coverage that pays for medical and surgical expenses by repaying the insured for expenses from illness or injury or paying the care provider directly.

Home health care: Skilled nursing care and other services given at home.

Home health care providers: Providers who give you skilled nursing care and other services at home.

Hospice: Care to reduce physical, emotional, social and spiritual discomforts for a member with a terminal illness (not expected to live for more than 6 months).

Hospital: A place where you get inpatient and outpatient care from doctors and nurses.

Hospitalization: Admission to a hospital for treatment as an inpatient.

Hospital outpatient care: Medical or surgical care performed at a hospital without admission as an inpatient.

Inpatient care: When you have to stay the night in a hospital or other place for the medical care you need.

Long-term care: Care in a facility for longer than the month of admission.

Managed care plan: A Medi-Cal plan that uses only certain doctors, specialists, clinics, pharmacies and hospitals for Medi-Cal recipients enrolled in that plan. The Alliance is a managed care plan.

Medical home: A model of care that will provide better health care quality, improve self-management by members of their own care and reduce avoidable costs over time.

Medically necessary (or medical necessity): Medically necessary care are important services that are reasonable and protect life. This care is needed to keep patients from getting seriously ill or disabled. This care reduces severe pain by treating the disease, illness or injury. For members under the age of 21, Medi-Cal services includes care that is medically necessary to fix or help a physical or mental illness or condition, including substance use disorders, as set forth in Section 1396d(r) of Title 42 of the United States Code.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

Member: Any eligible Medi-Cal member enrolled with the Alliance who is entitled to receive covered services.

Mental health services provider: Licensed individuals who provide mental health and behavioral health services to patients.

Midwifery services: Prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn, provided by certified nurse midwives (CNM) and licensed midwives (LM).

Network: A group of doctors, clinics, hospitals and other providers contracted with the Alliance to provide care.

Network provider (or in-network provider): Go to “Participating provider.”

Non-covered service: A service that the Alliance does not cover.

Non-emergency medical transportation (NEMT): Transportation when you cannot get

to a covered medical appointment by car, bus, train or taxi. The Alliance pays for the lowest cost NEMT for your medical needs when you need a ride to your appointment.

Non-formulary drug: A drug not listed in the drug formulary.

Non-medical transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by your provider.

Non-participating provider: A provider not in the Alliance network.

Other health coverage (OHC): Other health coverage (OHC) refers to private health insurance. Services may include medical, dental, vision, pharmacy and/or Medicare supplemental plans (Part C & D).

Orthotic device: A device used as a support or brace affixed externally to the body to support or correct an acutely injured or diseased body part and that is medically necessary for the medical recovery of the member.

Out-of-area services: Services while a member is anywhere outside of the service area.

Out-of-network provider: A provider who is not part of the Alliance network.

Outpatient care: When you do not have to stay the night in a hospital or other place for the medical care you need.

Outpatient mental health services: Outpatient services for members with mild to moderate mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory, supplies and supplements

Palliative care: Care to reduce physical, emotional, social and spiritual discomforts for a member with a serious illness.

Participating hospital: A licensed hospital that has a contract with the Alliance to provide services to members at the time a member receives care. The covered services that some participating hospitals may offer to members are limited by the Alliance's utilization review and quality assurance policies or the Alliance's contract with the hospital.

Participating provider (or participating doctor): A doctor, hospital or other licensed

health care professional or licensed health facility, including sub-acute facilities that have a contract with the Alliance to offer covered services to members at the time a member receives care.

Physician services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while you are admitted in a hospital that are charged in the hospital bill.

Plan: Go to “Managed care plan.”

Post-stabilization services: Services you receive after an emergency medical condition is stabilized.

Pre-approval (or prior-authorization): Your PCP must get approval from the Alliance before you get certain services. The Alliance will only approve the services you need. the Alliance will not approve services by non-participating providers if the Alliance believes you can get comparable or more appropriate services through the Alliance providers. A referral is not an approval. You must get approval from the Alliance.

Premium: An amount paid for coverage; cost for coverage.

Prescription drug coverage: Coverage for medications prescribed by a provider.

Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed, unlike over-the-counter (OTC) drugs that do not require a prescription.

Preferred drug list (PDL): A chosen list of drugs approved by this health plan from which your doctor may order for you. Also called a formulary.

Primary care: Go to “Routine care.”

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need. Some care needs to be approved first, unless:

- You have an emergency.
- You need ob/gyn care.
- You need sensitive services.
- You need family planning care.

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner

- Ob/gyn
- FQHC or RHC
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (pre-approval): A formal process requiring a health care provider to get approval to provide specific services or procedures.

Prosthetic device: An artificial device attached to the body to replace a missing body part.

Provider Directory: A list of providers in the Alliance network.

Psychiatric emergency medical condition: A mental disorder in which the symptoms are serious or severe enough to cause an immediate danger to yourself or others or you are immediately unable to provide for or use food, shelter or clothing due to the mental disorder.

Public health services: Health services targeted at the population as a whole. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified provider: Doctor qualified in the area of practice appropriate to treat your condition.

Reconstructive surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors, or disease.

Referral: When your PCP says you can get care from another provider. Some covered care services require a referral and pre-approval.

Routine care: Medically necessary services and preventive care, well child visits, or care such as routine follow-up care. The goal of routine care is to prevent health problems.

Rural Health Clinic (RHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an RHC.

Sensitive services: Medically necessary services for family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions.

Serious illness: A disease or condition that must be treated and could result in death.

Service area: The geographic area the Alliance serves. This includes the counties of Merced, Monterey and Santa Cruz.

Skilled nursing care: Covered services provided by licensed nurses, technicians and/or therapists during a stay in a Skilled Nursing Facility or in a member's home.

Skilled nursing facility: A place that gives 24-hour-a-day nursing care that only trained health professionals may give.

Specialist (or specialty doctor): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a referral from your PCP to go to a specialist.

Specialty mental health services:

- Outpatient services:
  - Mental health services (assessments, plan development, therapy, rehabilitation and collateral)
  - Medication support services
  - Day treatment intensive services
  - Day rehabilitation services
  - Crisis intervention services
  - Crisis stabilization services
  - Targeted case management services
  - Therapeutic behavioral services
  - Intensive care coordination (ICC)
  - Intensive home-based services (IHBS)
  - Therapeutic foster care (TFC)
- Residential services:
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services:
  - Acute psychiatric inpatient hospital services
  - Psychiatric inpatient hospital professional services
  - Psychiatric health facility services

Terminal illness: A medical condition that cannot be reversed and will most likely

cause death within one year or less if the disease follows its natural course.

Triage (or screening): The evaluation of your health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of your need for care.

Urgent care (or urgent services): Services provided to treat a non-emergency illness, injury or condition that requires medical care. You can get urgent care from an out-of-network provider if network providers are temporarily not available or accessible.