### Important Questions

| What is the overall deductible? | $0 | See the chart (starting on page 2) for your costs for services this plan covers. |
| Are there other deductibles for specific services? | No | You don’t have to meet deductibles for specific services, but see the chart (starting on page 2) for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Yes, $1,000 co-payment per individual. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums and health care services this Plan does not cover | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| Is there an overall annual limit on what the plan pays? | No | The chart starting (starting on page 2) describes any limits on what the plan will pay for specific covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of participating providers, see lacare.org | If you use a contracted provider, this plan will pay some or all of the costs of covered services. Be aware that your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, contracted, preferred, or participating for providers in their network. See the chart (starting on page 2) for how this plan pays different providers. |
| Do I need a referral to see a specialist? | Yes. Your Primary Care Physician (PCP) has to refer you. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist. To access behavioral health providers (mental health or substance use disorder), you do not need a referral from your PCP. |
| Are there services this plan doesn’t cover? | Yes | Some of the services this plan doesn’t cover are listed on page 6. See your policy or plan document for additional information about excluded services. |

### Questions:

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**Common Medical Event**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations and Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$5 co-pay/visit</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$2</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>Not covered</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>$5</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
</tbody>
</table>

**If you visit a health care provider's office or clinic**

**If you have a test**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations and Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic test (X-rays, blood work)</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
</tbody>
</table>
# PASC-SEIU Homecare Workers Health Care Plan

**Summary of Benefits and Coverage**: What This Plan Covers & What It Costs | **Coverage for Group**

**Coverage Period**: 2016 – 2017  
**Plan Type**: HMO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations and Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs on Formulary</td>
<td>$5 per prescription</td>
<td>Not covered</td>
<td>Covers up to 30-day supply. 90-day supply for maintenance drugs. Exclusions apply, see your policy or plan document for additional information about excluded services.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.lacare.org">www.lacare.org</a></td>
<td>Brand named drugs on Formulary</td>
<td>$5</td>
<td>Not covered</td>
<td>Covers up to 30-day supply. Exclusions apply, see your policy or plan document for additional information about excluded services.</td>
</tr>
<tr>
<td></td>
<td>Non-Formulary drugs</td>
<td>$5</td>
<td>Not covered</td>
<td>Covered if authorized. Exclusions apply, see your policy or plan document for additional information about excluded services.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$0</td>
<td>Not covered</td>
<td>Exclusions apply, see your policy or plan document for additional information about excluded services.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0</td>
<td>Not covered</td>
<td>Exclusions apply, see your policy or plan document for additional information about excluded services.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$35</td>
<td>Not covered</td>
<td>Waived if admitted to hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0</td>
<td>Not covered</td>
<td>Excludes coverage for transportation by airplane, passenger car, taxi or other form of public transportation.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$5 per visit</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
</tbody>
</table>

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# PASC-SEIU Homecare Workers Health Care Plan for In-Home Supportive Services Workers

**Coverage period 2016 – 2017**

**Summary of Benefits and Coverage:** What This Plan Covers & What It Costs | Coverage for Group

**Plan Type:** HMO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations and Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$0</td>
<td>Not covered</td>
<td>Excludes a private room in a hospital. Personal or comfort items are excluded, unless medically necessary as determined by the plan.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>$0</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/behavioral health outpatient services</td>
<td>Office visits $5 Facility-based services $0</td>
<td>Not covered</td>
<td>Prior authorization required for some facility-based services.</td>
</tr>
<tr>
<td></td>
<td>Mental/behavioral health inpatient services</td>
<td>$0</td>
<td>Not covered</td>
<td>Prior authorization required for some inpatient services.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>Office visits $5 Facility-based services $0</td>
<td>Not covered</td>
<td>Prior authorization required for some facility-based services.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$0</td>
<td>Not covered</td>
<td>Prior authorization required for some inpatient services.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$0</td>
<td>Not covered</td>
<td>New baby after 31 days of birth will not be covered.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$0</td>
<td>Not covered</td>
<td>The plan does not restrict its inpatient hospital care to less than 48 hours following a normal vaginal delivery and not less than 96 hours following a cesarean section delivery.</td>
</tr>
</tbody>
</table>
### PASC-SEIU Homecare Workers Health Care Plan for In-Home Supportive Services Workers

**Summary of Benefits and Coverage:** What This Plan Covers & What It Costs | **Coverage for Group**

**Coverage Period:** 2016 – 2017  
**Plan Type:** HMO

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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$0</td>
<td>Not covered</td>
<td>Custodial care not included</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$5</td>
<td>Not covered</td>
<td>Includes outpatient physical, occupational, speech, and respiratory therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$0</td>
<td>Not covered</td>
<td>Benefit is limited to a maximum of 100 days per benefit year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>$0</td>
<td>Not covered</td>
<td>Equipment for home used as medically necessary.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>$0</td>
<td>Not covered</td>
<td>Limited to individuals who are diagnosed with a terminal illness with a life expectancy of 12 months or less.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental checkup</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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PASC-SEIU Homecare Workers Health Care Plan for In-Home Supportive Services Workers

Summary of Benefits and Coverage: What This Plan Covers & What It Costs

Coverage for Group Coverage Period: 2016–2017

Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Private-duty nursing
- Cosmetic surgery
- Routine dental care (unless medically necessary)
- Acupuncture
- Hearing aids
- Infertility treatment (unless for medically necessary medical conditions)
- Long-term care
- Routine eye care
- Chiropractic care
- Routine foot care
- Habilitation services
- Non-emergency care when traveling outside the U.S.
- Weight-loss programs
- Children’s dental and eye care
- Bariatric surgery (unless medically necessary for the treatment of morbid obesity)
- Other practitioner office visits

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1.888.839.9909. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.3272 or dol.gov/ebsa or the U.S. department of Health and Human Services at 1.877.267.2323 x61565 or cciio.cms.gov

Questions: Call 1.888.839.9909 or visit us at lacare.org

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can call, write, or visit the plan or go to the plan’s website:

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
1.888.839.9909
TDD/TTY Service: 711
lacare.org

Additionally, a consumer assistance program can help you file your appeal. Contact:

California Department of Managed Health Care
California Help Center
980 9th St, Suite #500
Sacramento, CA 95814
888.466.2219
healthhelp.ca.gov
helpline@dmhc.ca.gov

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Language Access Services:

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan’s phone number at 1.800.750.4776. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1.888.466.2219.

IMPORTANTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1-800-750-4776. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1.888.466.2219. (Spanish)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o sa planong pangkalusugan. Upang makakuha ng isang tagapagsalin o magtanong tungkol sa maraming imparan at kahalagang impormasyon sa Tagalog, mangyaring tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1.800.750.4776. Ang isang taon na nakapagsalita ng Tagalog ay maaaring tumulong sa iyong kalusugan. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể nhận được dịch vụ thông dịch miễn phí khi khám tại bác sĩ hoặc khi liên hệ với chương trình bảo hiểm sức khỏe của quý vị. Để nhận được dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt, trước tiên hãy gọi số điện thoại của quý vị theo số 1.800.750.4776. Nếu quý vị cần được giúp đỡ thêm, hãy gọi Trung tâm Hỗ trợ HMO theo số 1.888.466.2219. (Vietnamese)

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,540
- **Patient pays:** $0

**Sample care costs:**

- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive care $40

**Total** $7,540

**Patient pays:**

- Deductibles $0
- Co-pays $0
- Coinsurance $0
- Limits or exclusions $0

**Total** $0

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,400
- **Patient pays:** $0

**Sample care costs:**

- Prescriptions $2,900
- Medical equipment and supplies $1,300
- Office visits and procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive care $100

**Total** $5,400

**Patient pays:**

- Deductibles $0
- Co-pays $0
- Coinsurance $0
- Limits or exclusions $0

**Total** $0
# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.