



PASC - SEIU Homecare Workers Health Care Plan

for In-Home Supportive Services Workers

A Helpful Guide to Your Health Care Benefits

Una guía útil para sus beneficios de atención de la salud

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您的健康護理福利指南

2016 / 2017



Thank you for your membership with L.A. Care Health Plan.

When you join, and then every year, you will get this package of important information in the mail. It is about your health coverage. We need you to read and understand it.

This Member Handbook you are reading contains the Evidence of Coverage and Disclosure Form (EOC). It has the terms and conditions of your health care benefits, summarizes the L.A. Care Health Plan (L.A. Care) policies and rules, and tells you how to get health care. The Member Handbook is broken down into the following sections:

- **Combined Evidence of Coverage and Disclosure Form..... 3**
- **How to Get Your Prescription Drugs.....55**
- **Stay Healthy – Preventive Health Guidelines for Adults.....57**
- **Notice of Privacy Practices61**
- **Nurse Advice Line – List of Audio Health Topics65**

The information listed below can be found in this Member Handbook:

Basic Information

- What benefits and services are covered
- What benefits and services are not covered
- How your health plan makes decisions about when new treatments will become benefits
- What care you can and cannot get when you are out of Los Angeles County or the L.A. Care network
- How to access care when you are out of Los Angeles County
- How to change or get care from your primary care physician (PCP)
- How to get information about doctors
- How to get a referral for special care or to go to the hospital
- What to do when you need care right away or when the office is closed
- What to do if you have an emergency
- How to get prescriptions filled, other pharmacy program information and updates
- Co-payments and other charges
- What to do if you get a bill
- How to keep you and your family healthy guide

L.A. Care has the following Special Programs:

- Quality Improvement Programs to tell us how we can improve quality of care, safety and services for our members. These Programs tell us how to measure our progress so that we can meet our goals and provide quality services and decide what we may need to change
- Case Management Programs for members who have difficult medical problems
- Programs to better manage diseases, like diabetes and/or asthma

How Decisions Are Made About Your Care

- How our doctors and staff make decisions about your care based only on need and benefits. We do not encourage doctors to provide less care than you need and doctors are not paid to deny care.
- How to reach us if you want to know more about how decisions are made about your care
- How to appeal a decision about your care

Member Issues

- Your rights and responsibilities as a health plan member
- How to complain when you are unhappy
- What to do if you are disenrolled from your plan
- How L.A. Care protects and uses your personal health information

You may view this Member Handbook before enrollment in a program. Be sure to see our website lacare.org, or call us at **1.888.839.9909** if you would like paper copies.



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

Combined Evidence of Coverage and Disclosure Form (Member Handbook)

2016 - 2017

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Customer Service



Welcome!

Welcome to **L.A. Care Health Plan** (L.A. Care). L.A. Care Health Plan is a public entity whose official name is Local Initiative Health Authority for Los Angeles County. L.A. Care is an independent publicly managed care health plan licensed by the state of California. L.A. Care works with doctors, clinics, hospitals and other providers to offer you quality health care services.

Health Information Privacy

At L.A. Care, we value the trust you have in us. We want to keep you as an L.A. Care member. That's why we want to share with you the steps L.A. Care takes to keep health information about you and your family private.

To keep health information about you private, L.A. Care:

- Uses secure computer systems
- Handles health information the right way, every time
- Reviews the way it handles health information
- Follows all laws about the privacy of health information

All L.A. Care staff who have access to your health information are trained on privacy laws. They follow L.A. Care guidelines and sign an agreement that they will keep all health information private. L.A. Care does not give out health information to any person or group who does not have a right to it by law.

L.A. Care needs some information about you so that we can provide good health care services. This information includes:

- Name
- Gender
- Date of birth
- Language you speak
- Race/ethnicity
- Home address
- Home or work telephone number
- Health history

L.A. Care may get this information from any of these sources:

- You
- Another health plan
- Your doctor
- PASC-SEIU
- Your health records

Before L.A. Care gives your health information to another person or group, we need your written consent. This may happen when:

- A court, arbitrator, or similar agency needs your health information
- A subpoena or search warrant is requested
- A coroner needs your health information
- Your health information is needed by law

L.A. Care may give your health information to another health plan or group to:

- Make a diagnosis or treatment
- Make payment for your health care
- Review the quality of your health care

Sometimes, we may also give your health information to:


- Groups who license health care providers
- Public agencies
- Investigators
- Probate courts
- Organ donation groups
- Federal or state agencies as required by law
- Disease management programs

If you have any questions or want to know more about how L.A. Care protects your health information, please call **L.A. Care Member Services** at **1.888.839.9909**.

Identification Card (ID Card)

You will receive an ID card that shows you are an L.A. Care member. Keep your member ID card with you at all times. Show the member ID card to the doctor, pharmacy, hospital or other health care provider when you seek care.



 **Never let anyone use your L.A. Care ID card. Letting someone else use your L.A. Care ID card with your knowledge is fraud.**

The Provider Directory

The Provider Directory is a list of all doctors, hospitals, pharmacies, and behavioral health services in L.A. Care's network. The Provider Directory lists the languages spoken at each provider's office. New members should have received the Provider Directory in their welcome packet with this Member Handbook. You can also request the Provider Directory by calling **L.A. Care Member Services** at **1.888.839.9909** or you can visit L.A. Care's website, **lacare.org**, to find a provider.

You may also get a list on the availability, education, and board certification of a participating provider in the area of your choice by calling L.A. Care.

Some hospitals and other providers may have a moral objection to provide some services. Some hospitals and other providers may not offer one or more of the following services that may be covered under your plan contract, or that you or your family member might need. These services may include:

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

Call your prospective doctor, medical group, independent practice association, or clinic, or call Member Services at **1.888.839.9909** to ensure that you can obtain the health care services that you need.

Language and Interpreting Services

You have the right to receive all member materials in any of the following languages: Spanish, Armenian, Chinese, and English.

L.A. Care provides free interpreting services for those members who speak a different language than their health care provider. Interpreting services are available 24 hours a day, 7 days a week, including weekends and holidays. You may call L.A. Care at **1.888.839.9909** to request an interpreter for your doctor's visit. You should not use your family members or friends to interpret for you. Minors should not be used to interpret. You have the right to file a grievance with L.A. Care if your language needs are not met. You can also file a grievance if you believe your cultural needs were not met. If you have any questions, please call L.A. Care.

Hearing Impaired Services

If you are deaf or hard-of-hearing, you can call L.A. Care's Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) toll-free at **711**. You may also ask for free sign language interpreting services for your health visits.

Vision Impaired Services

You may ask for this document and other materials in audio and large print formats. Please call L.A. Care if you have any questions, at **1.888.839.9909**.

Health Care Access for Patients with Disabilities

L.A. Care sees to it that *provider* offices may be accessed by the disabled. If you cannot find a *provider* who meets your needs, please call L.A. Care. If you believe that L.A. Care or its Participating Provider Groups (PPGs) have not met your *disability* access needs, you may file a *grievance* with L.A. Care..

Service Area

You must live or work in Los Angeles County (including Catalina Island) in order to receive services through L.A. Care. You must choose a Primary Care Physician (PCP) in Los Angeles County. The only benefits available to you without returning to our service area (Los Angeles County) are emergency care and out-of-area urgent care. Please see the “Emergency Services” section under “Emergency and Urgent Care Services” for more details.

Timely Access to Non-Emergency Health Care Services

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

Please contact L.A. Care’s Nurse Advice Line at **1-800.249.3619**, 24 hours a day, 7 days a week to access triage or screening services, at no cost to you. Hearing- or speech- impaired members can contact L.A. Care’s Nurse Advice Line through the California Telecommunications Relay Service at **711** (TTY) or **1-800-854-7784** (speech-to-speech).

For emergencies, always call 911 or your local emergency services. You do not have to call the L.A. Care Nurse Advice Line before getting emergency care.

Helpful information at **lacare.org** on the Internet

Do you use the Internet? Our website **lacare.org** is a great resource. You can:

- Find a doctor
- Learn about your benefits
- Learn more about privacy rights
- Find out about your rights and responsibilities
- File a complaint (called a “grievance”)

You can check your eligibility for medical coverage. You can even request to change your doctor or medical group. Since this information is private, you will need to log in. Go to **lacare.org** and then click “**Member Sign In**” to create an account. (Be sure to have your member ID card ready as we ask for your member ID number.)

Member Bill of Rights



As a Member of L.A. Care Health Plan, you have a right to...

Respectful and courteous treatment. You have the right to be treated with respect, dignity and courtesy from L.A. Care providers and staff. You have the right to be free of restraint (including physical and mechanical restraints and drugs), used as a means of coercion, discipline, convenience or retaliation. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, health status, claims experience, medical history, genetic information, information of insurability, or geographic location within the service area.

Privacy and confidentiality. You have the right to have a private relationship with your provider and to have your medical record kept confidential. You also have the right to receive a copy of and request corrections to your medical record. If you are a minor, you have the right to certain services that do not need your parent's consent.

Choice and involvement in your care. You have the right to receive information about L.A. Care and our services, doctors and other providers. You have the right to choose your Primary Care Physician (doctor) from the doctors and clinics listed in L.A. Care's Provider Directory. You also have the right to get appointments within a reasonable amount of time. You have the right to talk with your doctor about any care your doctor provides or recommends. You have the right to a second opinion. You have the right to information about treatment and to talk candidly to your doctor about appropriate or medically necessary treatment options for your condition, regardless of the cost or what your benefits are. You have the right to say "no" to treatment. You have the right to decide in advance how you want to be cared for in case you have a life-threatening illness or injury.

Receive timely customer service. You have the right to wait no more than 10 minutes to speak to a customer service representative during L.A. Care's normal business hours.

Voice your concerns. You have the right to complain about L.A. Care, our providers, or the care you get without fear of losing your benefits. L.A. Care will help you with the process. If you do not agree with a decision, you have the right to ask for a review. You have the right to disenroll from L.A. Care whenever you want.

Service outside of L.A. Care's provider network. You have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside L.A. Care's provider network. You have the right to receive emergency treatment whenever and wherever you need it.

Service and information in your language. You have the right to request an interpreter at no charge instead of using a family member or a friend to interpret for you. You should not use children to interpret for you. You have the right to request the Member Handbook and other information in English, Spanish, Armenian or Chinese, large print or audio.

As a Member of L.A. Care Health Plan, you have a responsibility to...

Act courteously and respectfully. You are responsible for treating your L.A. Care doctor and all our providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.

Give up-to-date, accurate and complete information. You are responsible for giving correct information to all of your providers. You are responsible for getting regular checkups and telling your doctor about health problems before they become serious. You are responsible for notifying L.A. Care as soon as possible if you are billed by mistake by a provider.

Follow your doctor's advice and take part in your care. You are responsible for talking over your health care needs with your doctor and following the treatment you both agree on.



Use the Emergency Room only in an emergency.

You are responsible for using the emergency room in cases of an emergency or as directed by your doctor or L.A. Care's 24-hour, free Nurse Advice Line. If you are not sure you have an emergency, you can call your doctor or call our free Nurse Advice Line at **1.800.249.3619**.

Report wrongdoing. You are responsible for reporting health care fraud or wrongdoing to L.A. Care. You can report without giving your name by calling the L.A. Care Compliance Helpline toll-free at 1.800.400.4889.

How to Get Care



Please read the following information so that you will know how and where to get care.

Primary Care Physician (PCP)

All L.A. Care members must have a Primary Care Physician (PCP). The name and phone number of your PCP is found on your L.A. Care member ID card. Except for emergency services, your PCP will arrange for all of your health care needs, refer you to specialists, and make hospital arrangements.

Each PCP works with a Participating Provider Group (PPG), which is another name for a medical group. Each PPG works with certain specialists, hospitals and other health care providers. The PCP you choose determines which health care providers are available to you.

Scheduling Appointments

Step 1: Call your PCP

Step 2: Explain why you called

Step 3: Ask for an appointment

Your PCP's office will tell you when to come in and how much time you will need with your PCP. (Please see the "Summary of Benefits" section to know which services require co-payments).

Clinic/doctor appointments are generally available Monday through Friday between 8 a.m. and 4:30 p.m. Evening and Saturday clinic/doctor office appointments may be available at some L.A. Care sites. Please see the provider directory for more information about each clinic/doctor.

If you need medical advice during clinic/doctor office hours, you may call your PCP and speak to her/him. You can also call the Nurse Advice Line number that is on your member ID card. We are available to you 24 hours a day, 7 days a week, to help answer your health care questions and have your health concerns and symptoms reviewed by a registered nurse. This service is free of charge and available to you in your language. The PCP or L.A. Care Health Plan nurse will answer your questions and help you decide if you need to come into the clinic/doctor's office.

If you cannot come in for your appointment, you should call as far ahead as possible to let the clinic/doctor's office know. You can schedule another appointment at that time. Waiting time for an appointment may be extended if the provider determines that a longer waiting time will not have a detrimental impact on your health. The rescheduling time of appointments shall be appropriate for your health care needs and shall ensure continuity of care.

L.A. Care shall provide or arrange triage or screening services by telephone, 24 hours a day, 7 days a week. Telephone triage or screening services waiting time shall not exceed 30 minutes.

L.A. Care shall ensure that all health care providers have an answering service or answering machine during non-business hours that provide urgent or emergency care instructions to contact an on-call health care provider.

A PCP will be assigned to you

When you join L.A. Care, we will assign you to the nearest PCP available to your home, based on the following:

- The language you speak
- Specialty care most appropriate for your age.

Within two weeks of enrollment, you will receive a member ID card with the PCP name, clinic name and phone number for you to call to schedule an appointment. If needed, you can either choose to schedule an appointment with a PCP at your assigned clinic or you can select another PCP.

How to change your PCP

If you would like to change your PCP or clinic, call L.A. Care at **1.888.839.9909**. Review the PASC-SEIU Homecare Workers Health Care Plan Provider/Pharmacy Directory to choose a PCP from the list of providers. You will find the names of PCPs along with their address, telephone number, specialty, and the languages they speak.

PCPs are listed in two ways to help you find the one who is right for you:

- By City in alphabetical order – If you know the name of the city you would like.
- By Clinic – If you know the name of the clinic.

Some things to think about when choosing a PCP:

- Is the PCP close to home or work?
- Is it easy to get to the PCP or clinic by using public transportation?
- Does the PCP speak your language?

Your request must be received by the 20th day of the month to be effective the first day of the next month. If the request is received after the 20th day of the month, it will be effective one month later.

If your new PCP works with a different clinic or PPG than was originally assigned to you, this may also change the hospitals, specialists and other health care providers from whom you may receive health care.

Referrals and Prior Authorizations

A referral is a request for health care services that are not usually provided by your PCP. All health care services, not including emergency services, must be approved by your PCP before you receive them. This is called prior authorization. Prior authorization is required for some in-network and out-of-network providers.

There are different types of referral requests with different timeframes to obtain authorization for the referral as follows:

- Routine or regular referral – 5 business days
- Urgent referral – 24 to 48 hours
- Emergency referral – same day

Please call L.A. Care if you do not get a response within the above time frames.

The following services do not require a prior authorization.

- Emergency services (go to Emergency Care Services section for more information)
- Preventive health services (including immunizations)
- Obstetrician and gynecological services in-network

All health care services are reviewed, approved, or denied according to medical necessity. Call L.A. Care if you would like a copy of the policies and procedures used to decide if a service is medically necessary. The number is **1.888.839.9909**.

Referrals to Specialty Physicians

Specialists are doctors with training, knowledge and practice in one area of medicine. For example, a cardiologist is a heart specialist, who has years of special training to deal with heart problems.

Your PCP will ask for prior authorization if he or she thinks you should see a specialist.

Services from non-physician providers

You may get services from non-physician providers who work in your PCP's office.

Non-physician providers may include, but are not limited to, clinical social workers, family therapists, nurse practitioners and physician assistants.

Standing Referrals

You may have a chronic, life-threatening or disabling condition or disease such as HIV/AIDS. If so, you may need to see a specialist or qualified health care professional for a long period of time. Your PCP may suggest, or you may ask for, what is called a standing referral.

A standing referral to a specialist, or qualified health care professional, requires prior authorization. With a standing referral, you will not need authorization each time you need to visit the specialist or qualified health care professional. You may ask for a standing referral to a specialist that works with your PCP or with a contracted specialty care center.

The specialist or qualified health care professional will develop a treatment plan for you. The treatment plan will indicate how often you need to be seen. Once the treatment plan is approved, the specialist or qualified health care professional will be authorized to provide health care services. The specialist will provide health care services in his or her area of expertise and training based on the treatment plan.

Second Opinions

You have the right to ask for and get a second opinion. L.A. Care shall authorize your request in an expeditious manner. If your situation is urgent, L.A. Care shall authorize your request within 72 hours.

What is a second opinion?

A second opinion is a visit with another doctor when you:

- question a diagnosis, or
- do not agree with the PCP’s treatment plan, or
- would like to confirm the treatment plan.

The second opinion must be from a qualified health care professional in L.A. Care’s or your PPG’s network. If there is no qualified health care professional in the network, L.A. Care or your PPG will make arrangements for one.

What do you need to do?

Step 1: Talk to L.A. Care or your PCP and let him/her know you would like to see another doctor and the reason why.

Step 2: Your PCP or L.A. Care will refer you to a qualified health care professional.

Step 3: Call the second opinion doctor to make an appointment.

If you do not agree with the second opinion, you may file a grievance with L.A. Care. Refer to the “Grievance and Appeals” section for more information.

Behavioral Health Services

Behavioral health services include mental health and substance use disorder services. This may include treatment for behavioral health problems such as anxiety, depression, substance use disorders, etc. Your PCP will provide you with some outpatient behavioral health services and screening within the scope of their training and practice. When you need behavioral health services beyond your PCP’s training and practice you will be directed to behavioral health specialists. You or your PCP can call the Behavioral Health Hotline at 1.877.344.2858/TTY 1.800.735.2921 to get an appointment. Most outpatient behavioral health services do not require prior authorization.

The following Behavioral Health Services do not require a prior authorization:

- Emergency Care Services
- Individual and Group Therapy
- Medication Management
- Opioid Replacement Therapy
- Diagnostic Evaluation
- Crisis Intervention

For more information on services accessible without a prior authorization and the general process for obtaining prior authorization for all other Behavioral Health services, please call the Behavioral Health Hotline at 1.877.344.2858/TTY 1.800.735.2921.

To access Behavioral Health Providers (mental health or substance use disorder) you do not need a referral from your PCP.

How to Find a Pharmacy

L.A. Care works with many pharmacies. The drugs prescribed by your PCP or specialist must be filled at one of these pharmacies. You can receive a 90-day supply of maintenance medications at certain local pharmacies. Ask your doctor to write a 90-day prescription.

To find a pharmacy near you:

- Look in the Participating Pharmacies section of the Provider Directory to find a pharmacy in your neighborhood. You can also visit the L.A. Care Web site at lacare.org.

You can also click on *How to Get Your Prescriptions Filled* for more information.

Be sure to show your L.A. Care member ID card when you fill your prescriptions at the pharmacy.

What drugs are covered?

L.A. Care uses a formulary of approved drugs. The Formulary is a list of drugs that are generally accepted in the medical community as safe and effective for your diagnosis. The Formulary is reviewed and approved by a committee of L.A. Care’s participating physicians and

pharmacists on a quarterly basis. You may call L.A. Care to ask for a copy of the Formulary or to ask if a specific drug or drugs are included. You can also view the Formulary on L.A. Care's Web site, lacare.org

Your doctor will prescribe drugs from the Formulary. A drug may be included on the Formulary, but your doctor may still not prescribe that drug, depending on your health status. L.A. Care covers generic versions of any prescribed drug and brand name drugs, as necessary. Members are responsible for the pharmacy co-payment.

You may call L.A. Care to ask for a copy of the Formulary in Spanish, Armenian and Chinese or in an alternate format such as large print or audio.

The L.A. Care formulary includes:

- Approved prescription drugs
- Diabetic supplies: Insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices
- Pen delivery systems such as EpiPens
- Inhaler extender devices
- Emergency Contraceptive Drugs: You may get emergency contraceptive drugs from your doctor or pharmacy with a prescription from your doctor. You may also get emergency contraceptive drugs from a certified pharmacist without a prescription.

For information on pharmacies offering emergency contraceptive drugs from registered pharmacists without a prescription, please call L.A. Care Member Services at **1.888.839.9909**.

Emergency contraceptive drugs may also be covered when you receive emergency care services. You may receive emergency care services from doctors, hospitals, pharmacies or other health care professionals whether or not they are contracted with L.A. Care Health Plan.

Non-formulary drugs

Sometimes, the doctor may prescribe a drug that is not on the Formulary. This will require that the doctor get authorization from L.A. Care. To decide if the non-formulary drug will be covered, L.A. Care may ask the doctor and/or pharmacist for more information. L.A. Care will reply to the doctor and/or pharmacist within 24 hours, or one (1) business day, after getting the requested medical information.

The doctor or pharmacist will let you know if the drug is approved. After approval, you can get the drug at a pharmacy in your network.

If the non-formulary drug is denied, you have the right to file a grievance. (Please see the "Grievance and Appeals" section for more information.)

Pharmacy Home

Some L.A. Care members may be chosen to enroll in the Pharmacy Home Program. The Pharmacy Home Program will help members handle their controlled medications safely.

You may be chosen to enroll in this program if:

- **You received prescriptions for controlled medications from three (3) or more providers.**
- **You filled prescriptions for controlled medications at three (3) or more pharmacies within the past 90-day period.**

A Pharmacy Home is a pharmacy that works with L.A. Care where you will get **all your prescriptions for controlled medications filled**. If you are chosen to enroll in the program, L.A. Care will give you a written notice. You are able to choose one pharmacy that works with L.A. Care as your Pharmacy Home. If you do not choose a Pharmacy Home, L.A. Care will choose a pharmacy closest to you. In an emergency, you may get your prescriptions filled at another pharmacy. L.A. Care will let your doctor know when you are enrolled in the program.

L.A. Care will excuse you from the Pharmacy Home Program if:

You are in hospice care or have cancer;

Being in the Pharmacy Home Program causes you trouble in finding care or causes an unnecessary health risk;

Other reasons will be considered on a case by case basis.

If you are unhappy about your selection for or participation in the Pharmacy Home Program, you can file a grievance. To file a grievance, please see the "Complaints: What should I do if I am unhappy?" section in this Member Handbook.

Emergency and Urgent Care Services

Urgent care services

There is a difference between needing care urgently and an emergency. Urgent care is when a condition, illness or injury is not life-threatening, but needs medical care right away. Many of L.A. Care’s doctors have urgent care hours in the evening and on weekends.

How to get urgent care

1. Call your PCP. You may speak to an operator who answers calls for your PCP’s office when closed (like after normal business hours, on the weekends or holidays).
2. Ask to speak to your PCP or the doctor on call. A doctor will call you back. If your PCP is not available, another doctor may answer your call. A doctor is available by phone 24 hours a day, 7 days a week, and also on the weekends and holidays.
3. Tell them about your condition and follow their instructions.

If you are outside of Los Angeles County, you do not need to call your PCP or get prior authorization before getting urgent care services. Be sure to let your PCP know about this care. You may need follow-up care from your PCP.

Emergency services

Emergency services are covered 24-hours a day, seven days a week, anywhere. Emergency care is a service that a member reasonably believes is necessary to stop or relieve:

- sudden serious illnesses or symptoms
- injury or conditions requiring immediate diagnosis and treatment

Emergency services and care include ambulance services, medical screening, exam and evaluation by a doctor or appropriate personnel. Emergency services include both physical and psychiatric emergency conditions, and active labor.

Examples of emergencies include but are not limited to:

- Having trouble breathing
- Seizures (convulsions)
- Lots of bleeding
- Unconsciousness/blackouts (will not wake up)
- In a lot of pain (including chest pain)

- Swallowing of poison or medicine overdose
- Broken bones
- Head injury
- Eye injury
- Thoughts or actions about hurting yourself or someone else

If you think you have a health emergency, call 911. You are not required to call your doctor before you go to the emergency room. Do not use the emergency room for routine health care.

What to do in an emergency:

Call 911 or go to the nearest emergency room if you have an emergency. Emergency care is covered at all times and in all places.

What to do if you are not sure if you have an emergency:

If you are not sure whether you have an emergency or require urgent care, please contact L.A. Care’s Nurse Advice Line at **1.800.249.3619** to access triage or screening services, 24 hours a day, 7 days a week.

Post stabilization and follow-up care after an emergency

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

If the hospital where you received emergency services is not part of L.A. Care Health Plan’s contracted network (“non-contracted hospital”), the non-contracted hospital will contact L.A. Care to get approval for you to stay in their hospital.

If L.A. Care approves your continued stay in the non-contracted hospital, you will not have to pay for services.

If L.A. Care has notified the non-contracting hospital that you can safely be moved to one of L.A. Care’s contracted hospitals, L.A. Care will arrange for and pay for you to be moved from the non-contracted hospital to a contracted hospital.

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

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get L.A. Care's contact information to ask for approval to provide services once you are stable.

If you feel that you were improperly billed for post-stabilization services that you received from a non-contracted hospital, please contact L.A. Care Member Services at 1.888.839.9909.

Non-Qualified Services

Non-qualified services are any non-emergency services received in the emergency room. L.A. Care will review all emergency room services provided to members based on the reasonable person's definition of emergency services. The member must pay for the cost of any non-qualified services. (Please refer to the "Emergency Services" section for more information.)

Continuity of Care

We will send you a letter in the mail if your primary care physician (PCP) stops working with L.A. Care. The letter will be sent to you 60 days before the date your PCP stops working with L.A. Care. You can ask to keep seeing this doctor (including specialists and hospitals), if the doctor agrees to continue to treat you and has been treating you for anything listed below:

- Acute condition – For the duration of the condition.
- Serious chronic (long-term) condition – For a period of time necessary to complete a course of treatment and arrange for a safe transfer to another provider.
- Pregnancy – Includes care for the term of the pregnancy and immediate postpartum care thereafter.
- Terminal illnesses/conditions – For the length of the illness.
- Care of a newborn child from birth to age 36 months – For up to 12 months.

- You have a surgery or other procedure that has been authorized by the plan as part of a documented course of treatment.

New members can also ask to keep seeing their current doctor or hospital for these conditions if they have just joined L.A. Care.

If you have one of the conditions listed above, ask your doctor if you can keep seeing him/her. You can also call L.A. Care Member Services at **1.888.839.9909** and ask how to request continuity of care.

You need to know that the continuity of care benefit will not apply to you if:

- (1) You are a new member in L.A. Care and your old health plan offered to let you keep receiving care from an out-of-network provider.

OR

- (2) You had the choice to keep receiving care from your previous provider, but you decided to change health plans.

Doctors who are not contracted with L.A. Care may be required to agree to the same terms and conditions as contracted providers. If the doctor does not agree, L.A. Care is not required to provide the services through that doctor.

Grievance & Appeals



L.A. Care Grievance Process

Complaints: What should I do if I am unhappy?

If you are not happy, are having problems or have questions about the service or care given to you, you can contact your PCP doctor and let your PCP know. Your PCP doctor may be able to help you or answer your questions. However, you may file a grievance with L.A. Care at any time and do not have to contact your PCP doctor before filing a grievance with L.A. Care.

What is a grievance?

A grievance is a complaint. This complaint is written down and tracked. You might be unhappy with the health care services you get or how long it took to get a service, and have the right to complain. Some examples are complaints about:

- The service or care your PCP or other providers give you
- The service or care your PCP's medical group gives you
- The service or care your pharmacy gives you
- The service or care your hospital gives you
- The service or care L.A. Care gives you

How to File a Grievance

You have many ways to file a grievance. You can do any of the following:

- Write, visit or call L.A. Care. You may also file a grievance online through L.A. Care's website at lacare.org.

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

- Fill out a grievance form at your doctor's office

L.A. Care can help you fill out the grievance form. Or, we can send you a form for you to fill out and send

back to us. Within five calendar days of receiving your grievance, you will get a letter from L.A. Care saying we have your grievance and are working on it.

Then, within 30 calendar days of receiving your grievance, L.A. Care will send you a letter explaining how the grievance was resolved.

Filing a grievance does not affect your medical benefits. If you file a grievance, you may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call L.A. Care.

If you need interpreter services, we will work with you to make sure we can communicate with you in a language you understand.

For members with hearing or speech loss, you can call L.A. Care's Member Services TTY/TDD line **711**. You may call the TTY/TDD Statewide access number at 1.888.877.5379 (Sprint) or 1.800.735.2921 voice (MCI). Members and providers can also dial **711** on their phones to call the California Relay Service directly.

If you do not agree with the outcome of your grievance

If you do not hear from L.A. Care within 30 calendar days, or you do not agree with the decision about your grievance, you may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" section.

How to file a grievance for health care services denied or delayed as not medically necessary

If you believe a health care service has been wrongly denied, changed or delayed by L.A. Care because it was found not medically necessary, you may file a grievance. This is known as a disputed health care service.

Within five calendar days of receiving your grievance, you will get a letter from L.A. Care saying we have received your grievance and that we are working on it. The letter will also let you know the name of the

person working on your grievance. Then, within 30 calendar days, you will receive a letter explaining how the grievance was resolved.

Filing a grievance does not affect your medical benefits. If you file a grievance, you may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call L.A. Care.

If you do not agree with the outcome of your grievance for health care services denied or delayed as not medically necessary

If you do not hear from L.A. Care within 30 calendar days, or you do not agree with the decision about your grievance, you may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section.

How to File a Grievance for Urgent Cases

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

In urgent cases, you can request an “expedited review” of your grievance. You will receive a call and/or a letter about your grievance within 24 hours. A decision will be made by L.A. Care within three calendar days (or 72 hours) from the day your grievance was received.

You have the right to file an urgent grievance with DMHC without filing a grievance with L.A. Care. For information on how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section.

If you do not agree with the outcome of your grievance for urgent cases

If you do not hear from L.A. Care within three calendar days (or 72 hours), or you do not agree with the decision about your grievance, you may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section.

Independent Medical Review

You may request an Independent Medical Review (IMR) from DMHC. You have up to six months from the date of denial to file an IMR. You will receive information on how to file an IMR with your denial letter. You may reach DMHC toll-free at 1.888.HMO.2219 or 1.888.466.2219.

There are no fees for an IMR. You have the right to provide information to support your request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process may cause you to lose certain legal rights to pursue legal action against the plan.

When to file an Independent Medical Review (IMR)

You may file an IMR if you meet the following requirements:

- Your doctor says you need a health care service because it is medically necessary and it is denied; or
- You received urgent or emergency services determined to be necessary and they were denied; or
- You have seen a network doctor for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
- The disputed health care service is denied, changed or delayed by L.A. Care based in whole or in part on a decision that the health care service is not medically necessary, and
- You have filed a grievance with L.A. Care and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 days.

You must first go through the L.A. Care grievance process, before applying for an IMR. In special cases, the DMHC may not require you to follow the L.A. Care grievance process before filing an IMR.

The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision on whether or not the care is medically necessary. You will receive a copy of the IMR decision from DMHC. If it is decided that the service is medically necessary, L.A. Care will provide the health care service.

Non-urgent cases

For non-urgent cases, the IMR decision must be made within 30 days. The 30-day period starts when your application and all documents are received by DMHC.

Urgent cases

If your grievance is urgent and requires fast review, you may bring it to DMHC’s attention right away. You will not be required to participate in the health plan grievance process.

For urgent cases the IMR decision must be made within three calendar days from the time your information is received.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

Independent Medical Review for Denials of Experimental/ Investigational Therapies

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

- We will notify you in writing of the opportunity to request an IMR of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in L.A. Care’s grievance process prior to seeking an IMR of our decision to deny coverage of an experimental/ investigational therapy.
- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the IMR decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against the health plan, you should first telephone the health plan at **1.888.839.9909** (TTY for the hearing impaired at **711**) and use the health plan’s grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an

emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number (1.888.HMO.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired. The department’s Internet website **hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

L.A. Care Health Plan’s grievance process and DMHC’s complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

L.A. Care will help you with interpreter services if you speak a language other than English. You may use the toll-free TTY/TDD numbers listed under “How to File a Grievance” if you are a non-hearing member. With your written consent, your doctor may also file an appeal on your behalf.

Eligibility and Enrollment***Requirements for member eligibility***

In order to be eligible to participate in the PASC-SEIU Plan you must be all of the following:

- Live or work in Los Angeles County.
- Meet all of the employer’s eligibility requirements

Starting date of coverage

You will receive a notice from L.A. Care letting you know when you are approved for the program and when coverage will begin.

Generally, coverage begins the first month after eligibility for the program is determined by Personal Assistance Service Council (PASC).

Notification of eligibility changes

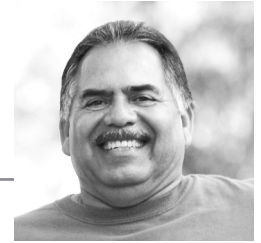
You must meet and continue to meet all of the employer’s eligibility requirements throughout the

period of coverage. You should contact PASC for questions regarding the eligibility requirements.

L.A. Care is required to notify the County's In-Home Supportive Services (IHSS) Program staff when a PASC-SEIU Plan member has:

- A conditions that may prevent or hinder her/him from performing her/his duties such as hospitalization, dialysis, diagnosis of a terminal illness, or any other situation where she/he is under medical care which prevents her/him from caring for an IHSS consumer.
- Died or whose ability to care for an IHSS consumer is questionable, as determined by a medical professional.

Payment Responsibilities



Monthly Premium

The monthly premium is as follows:

Enrollees	Gross Monthly Premium
PASC-SEIU Worker Only	\$1.00

Your premium or co-payment rates will not change unless:

- Authorized or required in the PASC contract
- L.A. Care or PASC notifies you of any change.

If there are any premium or coverage changes to your plan, you will receive written notice at least 60 days prior to the effective date.

Except for any co-payments, L.A. Care pays for all covered medical costs approved by your PCP or for an emergency. You should not get a bill for any services covered by L.A. Care. Please call L.A. Care right away if you receive a medical bill. L.A. Care Health Plan will make sure the doctor stops sending you a bill.

Co-payments

A \$5 co-payment is required for some health care services.

A \$35 co-payment is required for emergency services. This is waived if you are admitted to the hospital.

Please refer to the “Summary of Benefits” section for a listing of services and co-payments.

Annual Co-payment Maximum

The annual co-payment maximum amount for the PASC-SEIU program is \$1,000. The annual co-payment maximum is the highest total co-payment amount you are required to pay during one benefit year. All co-payments count toward the annual maximum, including prescription drug co-payments.

Step 1: Save your receipts.

Step 2: Call us when the receipts total \$1,000. You may not have to pay co-payments for the rest of the benefit year.

Member Liability

Members must pay required co-payments. Other than required co-payments, participating providers may not ask for payments from or assert a lien on a member for covered services. If you think you are being asked to pay a co-payment that you feel you should not have to pay, please call the L.A. Care Compliance Helpline at 1.800.400.4889.

Please see “Third Party Liability,” in the “General Information” section for more information on member liability.

Members are only eligible to get health care services that are covered services in the PASC-SEIU Plan. Even if your doctor recommends that you get health care services that are not covered services, these health care services are not covered plan benefits for members. Members are only able to get covered services as described in this Member Handbook. If you have any questions about what are covered services, please call L.A. Care Member Services at **1.888.839.9909**.

Summary of Benefits



Services are covered only if they are medically necessary.

The table below is a summary of your PASC-SEIU Plan covered benefits and co-payments. Only services described as plan benefits in the Member Handbook are covered by L.A. Care. Services are covered only according to the procedures described in this Member Handbook, including all authorizations and referrals.

Your PCP must arrange and approve all your care before you receive services. Exception: Emergency room and out-of-area urgent care services do not require prior authorization. All health care services are reviewed,

approved or denied according to medical necessity. It is important that you learn about your benefits before you need them. Please call L.A. Care Member Services at **1.888.839.9909** if you have any questions.

Services described in the table below are brief descriptions. For a full explanation of your benefits, please see the pages following this table.

Benefits	Covered Services	Member Pays
<i>Asthma Care</i>	Coverage for medically necessary supplies and equipment relating to the management and treatment of asthma, including inhaler spacers, nebulizers (including face masks and tubing), peak flow meters and education on the proper use of these items. Members identified with asthma are enrolled in the <i>L.A. Cares About Asthma</i> ® disease management program that includes educational mailings and phone condition monitoring by a nurse for high-severity members. For inquiries on the program or to opt out of the program, members can contact: 1.888.200.3094 (TTY/TDD 711) Monday through Friday 8 a.m. to 4 p.m. or email: asthmadm@lacare.org	No co-payment
<i>Blood and Blood Products</i>	Inpatient and outpatient processing, storage, and administration and collection, and storage of autologous blood, when medically necessary.	No co-payment
<i>Cancer Clinical Trials</i>	Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial and member meets certain requirements	\$5 per visit Co-payment for prescriptions as described in the "Prescription Drug Program"
<i>Cataract Spectacles and Lenses</i>	Cataract spectacles and lenses, cataract contact lenses or intraocular lenses that replace the natural lens of the eye after cataract surgery	No co-payment

Benefits	Covered Services	Member Pays
<i>Confidential HIV and STD Testing</i>	Testing available from L.A. County Department of Health Services, family planning services providers, your doctor, or prenatal clinics; no prior authorization required.	No co-payment
<i>Dental Services</i>	Only when medically necessary; no coverage for routine dental services (e.g., cleaning, cosmetic) Routine dental coverage is offered separately and paid through a monthly payroll deduction to SEIU. For information, contact SEIU at 1.877.698.5829.	No co-payment
<i>Diabetic Care</i>	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary, even if the items are available without prescription. Training and health education for diabetes self-management. Family education for self-management. Members identified with diabetes are enrolled in the <i>L.A. Cares About Diabetes</i> ® disease management program that includes educational mailings and phone condition monitoring by a nurse for high-severity members. For inquiries on the program or to opt out of the program, members can contact: 1.877.796.5878 (TTY/TDD 711) Monday through Friday, 8 a.m. to 4 p.m. or email diabetesdm@lacare.org.	No co-payment
<i>Diagnostic, X-Ray and Laboratory Services</i>	Therapeutic radiological services, ECG, EEG, mammography, other outpatient diagnostic laboratory and radiology tests	No co-payment
<i>Durable Medical Equipment</i>	Equipment for home used as medically necessary	No co-payment
<i>Emergency Care Services</i>	Health care services which a reasonable person would consider necessary to relieve a serious illness or symptom, injury, severe pain, thoughts or actions about hurting yourself or someone else or condition requiring immediate diagnosis. Offered 24 hours a day, seven days a week.	\$35 per visit (waived if admitted to hospital)
<i>Emergency Contraception</i>	FDA-approved contraceptive drugs and devices	No co-payment

Benefits	Covered Services	Member Pays
<i>Eye Exam/Vision Services</i>	No coverage for routine vision services (eyeglasses and contact lenses)	
<i>Family Planning Services</i>	Voluntary family planning services	No co-payment
<i>Health Education Services</i>	Effective health education services and materials. This includes education on personal health behavior and health care, and recommendations regarding the optimal use of health care.	No co-payment
<i>Home Health Care Services</i>	Services provided at the home by health care personnel Medically necessary skilled care; does not cover custodial care	No co-payment
<i>Hospice</i>	Medically necessary skilled care; counseling; medical supplies; short-term inpatient care; pain control and symptom management; bereavement services; physical, speech and occupational therapies; medical social services; and respite care.	No co-payment
<i>Hospital Services – Inpatient</i>	Room and board, nursing care and all medically necessary ancillary services <ul style="list-style-type: none"> • anesthesia • dialysis • obstetrical care and delivery (including Caesarean section) 	No co-payment
<i>Hospital Services – Outpatient</i>	Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility <ul style="list-style-type: none"> • ambulatory surgery • specialty care consultations/visits • therapeutic radiology, chemotherapy, renal dialysis • physical, occupational and speech therapy performed on an outpatient basis • emergency health care services (waived if the member is hospitalized) 	No co-payment No co-payment No co-payment \$5 per visit \$35 per visit
<i>Human Papillomavirus Screening & Vaccine (HPV)</i>	Screening test for cervical cancer available to all female members ages 9 through 26	No co-payment
<i>Medical Nutrition Therapy</i>	Treatment of diagnosed medical conditions (uncontrolled diabetes, obesity, underweight or pre-end-stage renal disease) through dietary interventions. Requires physician order.	No co-payment

Benefits	Covered Services	Member Pays
<i>Medical Transportation</i>	Ambulance transportation in an emergency or when medically necessary	No co-payment
<i>Mental Health Care – Inpatient</i>	<p>Prior authorization is required for the following inpatient, in-network services:</p> <ul style="list-style-type: none"> • Adult Residential Treatment Services • Psychiatric Inpatient Hospital Services • 23-hour Observation • Crisis Residential Treatment Services <p>Call L.A. Care’s toll free Behavioral Health Hotline at 1.877.344.2858. We will help you find the kind of help that is right for you.</p>	No co-payment
<i>Mental Health - Outpatient Facility-Based Services</i>	<p>Services outside of an office setting, such as a treatment center or home, that involve daily or weekly treatment delivered over several hours.</p> <p>Prior authorization is required for the following outpatient, in-network services:</p> <ul style="list-style-type: none"> • Acute Partial Hospitalization • Intensive Outpatient • Behavioral Health Treatment for Autism Spectrum Disorders (includes Asperger’s Syndrome, Autism and Pervasive Developmental Disorder) • Transcranial Magnetic Stimulation (TMS) • Outpatient Electroconvulsive Therapy (ECT) • Intensive Day Treatment <p>Call L.A. Care’s toll free Behavioral Health Hotline at 1.877.344.2858. We will help you find the kind of help that is right for you.</p>	No co-payment
<i>Physical, Occupational and Speech Therapy</i>	<p>Outpatient Inpatient</p> <p>Therapy may be provided in a medical office or other appropriate outpatient setting</p>	<p>\$5 per visit No co-payment</p>
<i>Pregnancy and Maternity Care</i>	Prenatal and postpartum care	No co-payment

Benefits	Covered Services	Member Pays
<i>Prescription Drug Program</i>	Drugs prescribed by a licensed practitioner <ul style="list-style-type: none"> • 30-day supply for generic drugs. See limitations for brand name drugs under “Plan Benefits.” • 90-day supply of maintenance drugs – generic only • Prescription drugs provided in an inpatient setting • Drugs administered in the doctor’s office or in an outpatient facility • FDA-approved contraceptive drugs and devices • Respiratory devices for the management and treatment of asthma Call Member Services for mail order form or for a list of participating pharmacies at 1.888.839-9909 .	\$5 per prescription \$5 per prescription No co-payment No co-payment No co-payment No co-payment
<i>Preventive Care Services</i>	<ul style="list-style-type: none"> • Periodic health exams • Immunizations, STD tests, and cytology exams on a reasonable periodic basis • Vision/Hearing Screening • Cancer Screening • Health Education • Well-Child Care – limited to first 31 days of life 	\$5 per visit No co-payment No co-payment No co-payment No co-payment No co-payment
<i>Professional Services</i>	<ul style="list-style-type: none"> • Outpatient Visit Urgent care; office visit, or home visit • Specialty care consultations/visits • Chemotherapy, dialysis, surgery, anesthesiology, or radiation • Inpatient Visit Licensed hospital, skilled nursing facility, hospice, mental health facility 	\$5 per visit \$2 per visit No co-payment No co-payment
<i>Prosthetics and Orthotics</i>	Prosthetics and orthotics as prescribed by L.A. Care providers	No co-payment
<i>Reconstructive Surgery</i>	Reconstructive surgery repairs abnormal body parts, improves body function, or brings back a normal look.	No co-payment

Benefits	Covered Services	Member Pays
<i>Skilled Nursing Care</i>	Services provided in a licensed skilled nursing facility. Benefit is limited to a maximum of 100 days per benefit year.	No co-payment
<i>Substance Use Disorder Treatment Outpatient–Facility-Based Services</i>	<p>Prior authorization is required for the following in-network services:</p> <ul style="list-style-type: none"> • Acute Partial Hospitalization • Intensive Outpatient <p>Call L.A. Care’s toll-free Behavioral Health Hotline at 1.877.344.2858. We will help you find the kind of help that is right for you.</p>	No co-payment
<i>Substance Use Disorder Treatment – Inpatient Care</i>	<p>Prior authorization is required for the following inpatient, in-network services:</p> <ul style="list-style-type: none"> • Inpatient Acute Detoxification • Inpatient Rehabilitation • Residential Detoxification • 23-Hour Observation <p>Call L.A. Care’s toll-free Behavioral Health Hotline at 1.877.344.2858. We will help you find the kind of help that is right for you.</p>	No co-payment
<i>Substance Use Disorder Treatment – Outpatient Visits</i>	<p>Services obtained during a provider office visit, outpatient hospital visit, or urgent care visit. This includes:</p> <ul style="list-style-type: none"> • Opioid Replacement Therapy • Diagnostic Evaluation • Crisis Intervention • Individual and Group Therapy <p>Call L.A. Care’s toll-free Behavioral Health Hotline at 1.877.344.2858. We will help you find the kind of help that is right for you.</p>	\$5 per visit
<i>Transplants</i>	Medically necessary organ and bone marrow transplant; medical and hospital expenses of a donor or prospective donor; testing expenses and charges associated with procurement of donor organ	No co-payment



The PASC-SEIU health benefit plan in Los Angeles County is considered a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your PASC-SEIU health benefit plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the **L.A. Care Member Services at 1-888-839-9909.**

Plan Benefits



Asthma Care

Benefit includes nebulizers (including face mask and tubing), inhaler spacers and peak flow meters and education on the proper use of these items when medically necessary for management and treatment of asthma. Members identified with asthma are enrolled in the L.A. Care's About Asthma® disease management program that includes educational mailings and phone condition monitoring by a nurse for high severity members. For inquiries on the program, or to opt out of the program, members can contact: 1.888.200.3094 (TTY/TDD 711) Monday through Friday 8 a.m. to 4 p.m. or email: asthmadm@lacare.org

Blood and Blood Products

Processing, storage, and administration of blood and blood products in inpatient and outpatient settings includes the collection and storage of autologous blood when medically indicated.

Behavioral Health Services

Behavioral health services include mental health and substance use disorder services. Behavioral health services benefits will be provided on the same basis as other physical illnesses. All medically necessary behavioral health (1) outpatient services, (2) inpatient hospital services, (3) partial hospitalization services, and (4) prescription drugs are covered benefits including but not limited to coverage for services described below. Please note, all inpatient behavioral health services require prior authorization and some other behavioral health services also require prior authorization as indicated in the Summary of Benefits section of this Member Handbook.

A list of all services that do not require prior authorization is listed in "How to Get Care- Behavioral Health Services."

There are no day or visit limits for any mental health or substance use disorder services.

Severe Mental Illnesses ("SMI") includes the conditions listed below and may be treated as medically necessary for a person of any age by outpatient services, inpatient services, partial hospitalization services, or prescription drugs.

- Anorexia Nervosa
- Autism or Pervasive Developmental Disorder
- Bipolar Disorder (manic-depressive illness)
- Bulimia Nervosa
- Major Depressive Disorders
- Obsessive Compulsive Disorder
- Panic Disorder
- Schizophrenia
- Schizoaffective Disorder

In addition to the SMI conditions above, L.A. Care covers mental disorders set forth in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Severe Emotional Disturbances ("SED") of a child is a child under the age of 18 years who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder that results in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Behavioral Health Treatment ("BHT") for Members with Autism Spectrum Disorder (includes Asperger's Syndrome, Autism and Pervasive Developmental Disorder) requires prior authorization and is covered when prescribed by a physician or licensed psychologist who is a Plan Provider. A BHT treatment plan must be prescribed by a Participating Provider and BHT

services must be provided by Participating Providers. BHT used for the purposes of providing respite, day care, or educational services or to reimburse a parent for participation in the treatment is not covered.

Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder (includes Asperger's Syndrome, Autism and Pervasive Developmental Disorder).

For additional information, please call the Behavioral Health Hotline at **1.877.344.2858/TTY 1.800.735.2929**.

Cancer Clinical Trials

If you have cancer, you may be able to be part of a cancer clinical trial that meets certain requirements, when referred by your L.A. Care PCP or treating provider. The cancer clinical trial must have a meaningful potential to benefit you, and be approved by one of the following: the National Institute of Health (NIH), the Food and Drug Administration (FDA), the U.S. Department of Defense or the U.S. Veteran's Administration. Coverage for treatment in a clinical trial is limited to participating hospitals and participating providers in California, unless the protocol for the clinical trial is not provided for by a California hospital or a California physician. If you are part of an approved cancer clinical trial, L.A. Care will provide coverage for all routine patient care costs related to the clinical trial.

If you have a life-threatening or debilitating condition, or were eligible, but denied coverage for a cancer clinical trial, you have the right to request an Independent Medical Review or denial. Go to the, "When to file an Independent Medical Review" section.

Cataract Spectacles and Lenses

Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of eyeglasses or contact lenses is covered if necessary after cataract surgery with insertion of an intraocular lens.

Confidential HIV and STD Testing

You do not need prior authorization from your doctor for confidential HIV and STD testing. A list of services is available. Please call Member Services at **1.888.839.9909** to request a copy. You can get confidential HIV and STD testing from the following:

- Los Angeles County Department of Health Services
- Family planning service providers
- Your PCP (doctor)
- Prenatal clinics

Dental Services

When medically necessary, there is no coverage for routine dental services (e.g., cleaning, cosmetic). Routine dental coverage is offered separately and paid through a monthly payroll deduction to SEIU. For information, contact SEIU at 1.877.698.5829.

Diabetic Care

Supplies, equipment, and services for treatment and/or control of diabetes when medically necessary are covered. This benefit also covers outpatient diabetes education programs for self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications. Members identified with diabetes are enrolled in the *L.A. Cares About Diabetes*® disease management program that includes educational mailings and phone condition monitoring by a nurse for high severity members. For inquiries on the program or to opt out of the program, members can contact: 1.877.796.5878 (TTY/TDD **711**) Monday through Friday, 8 a.m. to 4 p.m. or email diabetesdm@lacare.org

Diagnostic X-Ray and Laboratory Services

- Laboratory tests for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).
- Diagnostic laboratory services, diagnostic and therapeutic radiological (x-ray) services necessary to evaluate, diagnose, treat, and follow-up on the care of members.

- Other diagnostic services, which shall include, but not be limited to, electrocardiography (EKG) and electro-encephalography (EEG).

Durable Medical Equipment (DME)

Durable medical equipment (DME) is medically necessary equipment appropriate that is ordered by your physician and for use in the home, which is:

- Intended for repeated use
- Generally not useful to a person without illness or injury
- Primarily serves a medical purpose

L.A. Care will decide whether to rent or purchase DME for members. Repair or replacement of DME is covered unless the DME has been misused or lost. All equipment purchased or rented must be authorized by L.A. Care

Examples include:

- Apnea monitors
- Blood glucose monitors, including monitors for the visually impaired for insulin dependent, non-insulin dependent, and gestational diabetics
- Insulin pumps and all related supplies
- Wheelchairs
- Hospital beds
- Nebulizer machines
- Ostomy bags
- Oxygen and oxygen equipment
- Podiatric devices to prevent or treat diabetes complications
- Pulmo-aides and related supplies
- Spacer devices for metered dose inhalers
- Tubing and related supplies
- Urinary catheters and supplies
- Visual aids, excluding eyewear to assist the visually impaired with proper dosing of insulin

Exclusions:

- Coverage for comfort or convenience items
- Disposable supplies except ostomy bags and urinary catheters and supplies consistent with L.A. Care's coverage guidelines
- Exercise and hygiene equipment

- Experimental or research equipment
- Devices not medical in nature such as sauna baths and elevators
- Modifications to the home or car
- Deluxe equipment
- More than one piece of equipment that serves the same function.

Emergency Care Services

L.A. Care covers emergency care services 24 hours a day, seven days a week. Emergency care services are medically necessary covered services, including ambulance and behavioral health services, which a reasonable person, in good faith, would have considered necessary to stop or relieve:

- a serious illness or symptom,
- an injury or severe pain, or
- a condition that needs immediate diagnosis and treatment

Emergency services include a medical screening, exam and evaluation by a doctor or other appropriate personnel. Emergency services also include both physical and mental emergency conditions, and active labor.

Examples of some emergencies include, but are not limited to:

- Breathing problems
- Seizures (convulsions)
- Extreme bleeding
- Unconsciousness/blackouts (will not wake up)
- Severe pain (including chest pain)
- Swallowing of poison or medicine overdose
- Head Injury
- Eye Injury
- Thoughts or actions about hurting yourself or someone else

Non-emergency services given after the medical screening exam and the services needed to stabilize the condition, require that the provider get an authorization from L.A. Care

If you are admitted to a non-participating hospital or to a hospital that your PCP or other participating provider cannot work at, L.A. Care has the right to transfer you to a participating hospital as soon as it is medically safe.

If an emergency occurs while out of the service area, you may receive emergency services at the nearest emergency facility (doctor, clinic or hospital). You must report such services to L.A. Care within 48 hours, if possible. Your PCP must provide the follow-up care after receipt of emergency services. You will be reimbursed for all charges paid by you for covered emergency services, including medical transportation services, provided by non-participating providers.

Post-Stabilization and Follow-up Care After an Emergency

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

If the hospital where you received emergency services is not part of L.A. Care Health Plan’s contracted network (“non-contracted hospital”), the non-contracted hospital will contact L.A. Care to get approval for you to stay in the non-contracted hospital.

If L.A. Care approves your continued stay in the non-contracted hospital, you will not have to pay for services.

If L.A. Care has notified the non-contracting hospital that you can safely be moved to one of L.A. Care’s contracted hospitals, L.A. Care will arrange and pay for you to be moved from the non-contracted hospital to a contracted hospital.

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

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get L.A. Care’s contact information to ask for approval to provide services once you are stable.

If you feel that you were improperly billed for post-stabilization services that you received from a non-contracted hospital, please contact L.A. Care Member Services at 1.888.839.9909.

Eye Exam/Vision Services

No coverage for routine services (eyeglasses and contact lenses).

Family Planning Services

You may receive family planning services and Food and Drug Administration (FDA) approved contraceptives from any health care provider licensed to provide these services. Voluntary family planning services include:

- Counseling
- Surgical procedures for sterilization as permitted by state and federal law
- Diaphragms
- Coverage for other FDA approved devices
- Contraceptive drugs according to prescription drug benefit, including emergency contraceptives

Some hospitals and other providers do not provide one or more of the following services that may be covered under your L.A. Care contract, and that you or your family member might need:

- Family planning
- Contraceptive services, including emergency contraceptives
- Sterilization
- Tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortions or
- Vasectomy

You should get more information before you enroll. Call your potential doctor, medical group, PPG, or clinic, or call L.A. Care to make sure you can get the health care services that you need.

Health Education Services

L.A. Care’s health education services program is called *Health in Motion™*. *Health in Motion™* services include an array of fun wellness workshops and group appointments to help you stay healthy and manage your chronic conditions. Come learn the skills you need to meet your health goals in an interactive and exciting way! Wellness workshops and group appointments are offered in English and Spanish at places and times convenient for you. Free interpreters

can be there for other languages. If you cannot make it to a workshop, an L.A. Care Certified Health Coach and/or Registered Dietician will call you and talk to you over the phone. Health topics include asthma, diabetes, heart health, chronic condition support, nutrition and exercise, among others.

Health education resources include written materials, community referrals, online information, CDs/DVDs or videos, and L.A. Care's Nurse Advice Line. Resources are available in multiple languages for many health topics.

All health education services and resources are free. Call L.A. Care for more information at **1.888.839.9909/711** (TTY/TDD) or go to **lacare.org**.

You can also access health information and resources through L.A. Care's website. Visit lacare.org/healthy-living/health-resources/health-library to view information on many health topics. To find out about upcoming health workshops in your area, visit lacare.org/healthy-living/health-resources/health-education.

L.A. Care partners with healthycity.org to connect you with free or low-cost community resources. To view an online searchable database of community resources near you, visit lacare.org/providers/provider-resources/social-services-directory.

If you are ready to quit smoking or need help staying smoke free, you can call the California Smokers' Helpline toll free at 1.800.NO.BUTTS (1.800.662.8887).

Hearing tests, hearing aids and services: Hearing evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid. Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords, and other ancillary equipment. There is no charge for visits for fittings, counseling, adjustments, repairs, etc., for a one year period following the provision of a covered hearing aid.

Exclusions:

- The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, charges for a hearing aid which exceed specification prescribed for correction of a hearing aid purchase, and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss.

- Replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of 36 months, and surgically implanted hearing devices.

Home Health Services

Home health services are provided in the home by health care personnel when prescribed by a licensed practitioner acting within the scope of his or her licensure. This includes visits by:

- Registered Nurses,
- Licensed Vocational Nurses and home health aides,
- Physical, occupational and speech therapy, if medically necessary, and
- Respiratory therapy

Services are limited to those authorized by L.A. Care. If a service can be provided in more than one location, L.A. Care will work with the provider to choose the location.

Exclusions: Custodial care

Hospice

The hospice benefit includes nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit also includes physical therapy; occupational therapy, speech therapy, short-term inpatient care, pain control, and symptom management.

The hospice benefit may include, at the option of L.A. Care, homemaker services, services of volunteers, and short-term inpatient respite care.

The hospice benefit is limited to individuals who are diagnosed with a terminal illness with a life expectancy of 12 months or less, and who elect hospice care for such illness instead of the traditional services covered by L.A. Care.

The hospice benefit includes medical treatment to relieve pain and other symptoms related to the terminal illness, but does not include efforts to cure the illness. The hospice election may be stopped at any time.

Hospital Services – Inpatient

The following inpatient hospital services are covered when authorized by L.A. Care and provided at a participating hospital. Any hospital may be used in case of an emergency.

- A hospital room of two or more beds with standard furnishings and equipment, meals, including special diets as medically necessary, and general nursing care.
- Intensive care, coronary care, and definitive observation unit services as medically necessary.
- Operating room and related facilities.
- Surgical, anesthesia, and oxygen supplies.
- Special duty nursing, as medically necessary.
- Discharge planning and planning of continuing care.
- Devices implanted surgically.
- Hospital ancillary services in connection with hospital inpatient services, including:
 - Laboratory
 - Laboratory,
 - Inhalation and respiratory therapy,
 - Pathology,
 - Imaging and radiation therapy,
 - Radiology and cardiology, and
 - Other diagnostic, therapeutic and rehabilitative services as appropriate.
- Drugs, medications, and biologicals, which are approved by the FDA and are supplied by and used in the hospital.
- Administration of blood and blood products.
- Rehabilitative therapy services. This includes physical, occupational, speech, and other therapy services as appropriate.
- Maternity care that includes regular doctor visits during your pregnancy (prenatal), diagnostic and genetic testing, nutrition counseling, labor and delivery, and health care 6 weeks after delivery (postpartum).
- Hemodialysis

Exclusions: Personal or comfort items, including a private room in a hospital are excluded, unless medically necessary as determined by L.A. Care.

Hospital Services – Outpatient

The following outpatient services are covered when authorized by L.A. Care and provided at a participating hospital or outpatient facility: Diagnostic, therapeutic, and surgical services done at a hospital or outpatient facility. This includes physical, occupational, and speech therapy as appropriate, and hospital services, which can reasonably be provided on an ambulatory basis. Related services and supplies which include:

- Operating room,
- General anesthesia,
- Treatment room,
- Ancillary services, and
- Medications which are given by the hospital or facility for use during the member's treatment at the facility.

Human Papillomavirus Screening Test and Vaccine

The Human Papillomavirus (HPV) screening test for cervical cancer is approved by the FDA. The test is available to all L.A. Care female members. In addition, L.A. Care female members ages 9 through 26 are eligible to receive the HPV Vaccine as recommended by the Advisory Committee on Immunization Practices. The HPV Vaccine helps prevent cervical cancer and other diseases in females caused by HPV. For more information on receiving this service, speak to your L.A. Care primary care provider.

Medical Nutrition Therapy (MNT)

MNT is intense nutrition counseling with a registered dietitian over the phone. MNT is used to treat serious health problems such as diabetes, pre-end-stage renal disease, and obesity. **Physician referral required.** Some members may not qualify.

Medical Transportation

Emergency

Emergency transportation to the first hospital which accepts the member for emergency care is covered. This includes ambulance and ambulance transportation services provided through the 911 emergency response system.

Non-Emergency

The benefits below are covered when:

- Medically necessary, and
- Requested by an L.A. Care provider, and
- Authorized in advance by L.A. Care.

Non-emergency medical transportation includes the transfer of a member in the following cases:

- From a hospital to home
- From a facility to home
- From a hospital to another hospital
- From a hospital to a facility, or
- Psychiatric transport van

Non-emergency medical transportation can be provided via the following vehicle types:

- Wheelchair van
- Gurney/litter/stretchers van
- Non-emergency Ambulance:
 - Basic Life Support
 - Advanced Life Support
 - Critical Care Transport: includes a nurse, respiratory therapist, etc.

Mental Health Services

See Behavioral Health Services

Transportation Exclusions

Coverage for transportation by airplane, passenger car, taxi or other form of public transportation is excluded, even if it is the only way to travel to a participating provider. This provision does not exclude medically necessary air ambulance services or transportation by a licensed ambulance or psychiatric transport van that is owned and operated by a public agency.

Physical, Occupational, and Speech Therapy

This benefit covers short-term neuromuscular rehabilitative services, including physical, occupational, speech, and inhalation therapies for the treatment of acute conditions or the acute phase of chronic conditions as medically necessary. Therapy may be provided in a

medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. L.A. Care may require periodic evaluations as long as medically necessary therapy is provided.

Pregnancy and Maternity Care

Coverage for prenatal and postnatal PCP office visits and delivery which are medically necessary, professional and hospital services including prenatal and postnatal care, and care for complications of pregnancy. Alpha Feto Protein program (AFP) is routinely offered and covered for pregnant women between 15 and 20 weeks gestation. The test is voluntary and it is a woman's own choice whether or not to have the test. The Plan also offers coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy, newborn examinations and nursery care while the mother is hospitalized. The PASC-SEIU Homecare Workers Plan does not provide coverage to spouses or dependents. Services are provided under L.A. Care to newborns only within the first 31 days after birth. After 31 days of birth, your new baby will not be covered by L.A. Care. To find out if your baby is eligible for Medi-Cal, contact the Department of Public Social Services (DPSS) toll-free at 1.877.481.1044.

Inpatient Hospital Services are provided for vaginal and cesarean section delivery and for complications or medical conditions arising from pregnancy or resulting childbirth. The length of inpatient hospital stay is based upon the mother's condition.

L.A. Care 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. However, coverage of inpatient hospital care may be less than a 48-96 hour time period if the following two conditions are met:

- the discharge decision is made by the treating provider, in consultation with the mother; and
- the treating doctor schedules a follow-up visit for the mother and newborn within 48 hours of discharge. Nurse-midwife services are available to Members seeking obstetrical care. The chosen nurse-midwife must be associated with the Member's Primary Care Provider and contracted with L.A. Care.

Prescription Drug Program

Coverage is provided for medically necessary drugs when prescribed by a licensed participating provider acting within the scope of his or her licensure and included on the L.A. Care drug formulary. L.A. Care will provide non-formulary medications based on medical necessity. In cases where the formulary drug has a medical contraindication, a non-formulary drug will be provided. Non-formulary drugs need to be requested through a prior authorization approval process. If denied after the review, the request can be appealed through the L.A. Care Grievance and Appeals process and will be responded to within 30 days, or three days, if necessary because of your medical condition.

Brand name drugs will not be provided as a plan benefit if FDA approved generic equivalents are available (unless such generic equivalents are medically contraindicated).

All of the following will be provided, as medically necessary:

- Injectable medication (including insulin)
- Needles and syringes
- Diabetic supplies: insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices, pen delivery systems, blood glucose monitors including monitors for the visually impaired, and ketone urine testing strips
- FDA-approved birth control pills/drugs and birth control devices on the L.A. Care formulary
- Emergency contraception
- Glucagon
- EpiPens
- Lancets and lancet puncture devices

With the exception of self-administered injectable drugs listed in the L.A. Care Formulary (in the “How to Get Your Prescriptions Filled” section), injectable medication must be administered in a physician facility to be covered.

Exclusions: Experimental or investigational drugs, unless accepted for use by professionally recognized standards of practice; drugs or medications for cosmetic purposes; most over-the-counter medicines including non-prescription ointments, foams, etc.; medications not requiring a written prescription order (except insulin); and dietary supplements (except for medically prescribed formulas or special food products to treat Phenylketonuria [PKU], appetite suppressants or any

other diet drugs or medications as medically necessary for morbid obesity).

How to Get Your Prescription Drugs

Your doctor may give you a prescription when you are sick or have a health condition like high blood pressure or diabetes. The prescription is based on your health status.

For New Prescriptions

If you are filling a prescription for the first time, you must go to a pharmacy that works with L.A. Care. L.A. Care partners with pharmacies throughout Los Angeles County (including Albertson’s /Sav-On, CVS, Rite Aid, Target, Vons, Wal-Mart, and Walgreens). A list of pharmacies that work with your health plan is in L.A. Care’s Provider Directory, or you may call **Member Services toll-free at 1.888.839.9909** during regular business hours, Monday thru Friday 7 a.m. to 7 p.m. for a pharmacy close to you.

For Prescription Refills

If you are refilling a prescription that you already have, you must go to a pharmacy that works with L.A. Care. If your medication is listed on the maintenance medication list, you may be able to receive a 90-day supply of generic maintenance medications at select local pharmacies. Maintenance medications are drugs that you need to take for a long time, such as pills for high blood pressure or diabetes.

How to Get a Prescription Filled at the Pharmacy

1. Choose a pharmacy near you
2. Bring your prescription to the pharmacy
3. Give the prescription to the pharmacy with your L.A. Care **member ID** card. This will help the pharmacy fill your prescription.
4. Make sure you give the pharmacy your correct address and phone number.
5. Make sure the pharmacy knows about all medications you are taking and/or any allergies you have to any medicine.
6. If you have any questions about your prescriptions(s), make sure you ask the pharmacist.
7. PASC-SEIU members pay \$5 for each prescription. For more information on your co-payment, please check your Evidence of Coverage.

Preventive Care Services

Periodic health exams include all routine diagnostic testing and laboratory services.

- A variety of voluntary family planning services
- Prenatal care
- Sexually transmitted disease (STD) tests, including Human Immunodeficiency Virus (HIV) tests
- Hearing tests, hearing aids and services: Hearing evaluation to measure the extent of hearing loss and a hearing and evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid: monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords, and other ancillary equipment. Visits for fittings, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid
- Cytology exam, on a reasonable and periodic basis
- Health education
- Cancer screening: All generally medically accepted cancer screening tests

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, charges for a hearing aid which exceed specification prescribed for correction of a hearing aid purchase, and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Replacement parts for hearings aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of 36 months, and surgically implanted hearing devices.

Professional Services

Primary care provider office visits for examination, diagnosis and treatment of a medical condition, disease or injury, including referred specialist office visits, consultations or second opinions; urgent care visits; office surgery with applicable co-payment; outpatient chemotherapy and radiation therapy. In addition, Professional services include:

- Office visits for the purpose of allergy testing and treatment, including allergy injections and serum.

- Office visits for administration of injectable medications approved by the Food and Drug Administration (FDA) are covered for medically necessary treatment of medical conditions when prescribed by a Primary Care Provider and authorized in accordance with L.A. Care rules
- Home visit (for medically necessary treatment)
- Screening, diagnosis and treatment of breast cancer.
- Phenylketonuria (PKU) Screening and testing for PKU.
- Doctor services in a hospital or skilled nursing facility for examination diagnosis, treatment, and consultation including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist. Inpatient professional services are covered only when authorized and the Primary Care Provider has referred the services of the hospital or skilled nursing facility.
- Hospital and professional services provided for conditions of the teeth, gums, or jaw joints and jawbones, including adjacent tissues are a covered benefit only to the extent that these services are:
 - Provided for the treatment of tumors of the gums
 - Provided for the treatment of damage to the natural teeth caused solely by an accidental injury. This benefit does not include damage to the natural teeth that is not accidental
 - Medical treatment of temporomandibular joint syndrome, which is non-surgical and is medically necessary (TMJ)
 - Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed
 - Surgery to reposition the upper and/or lower jaw that is medically necessary to correct skeletal deformity.

This benefit does not include:

- Services customarily provided by dentists and oral surgeons, including hospitalization;
- Orthodontia (dental services to correct irregularities or mal-occlusion of the teeth) for any reason;
- Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- Dental implants (endosteal, subperiosteal or transosteal).

Prosthetics and Orthotics

Orthotics and prosthetics, when prescribed and authorized by an L.A. Care licensed provider acting within the scope of his or her licensure. This includes medically necessary replacement orthotics and prosthetic devices. Coverage includes the initial and subsequent prosthetic devices, installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee support and elastic stockings; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

Reconstructive Surgery

Reconstructive surgery repairs abnormal body parts, improves body function, or creates a normal appearance. This benefit includes reconstructive surgery to restore and achieve symmetry due to mastectomy. This includes medically necessary surgery to repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to the extent possible.

Transgender Services

These services are provided when medically necessary and may include:

- Psychotherapy
- Continuous hormonal therapy
- Laboratory testing to monitor hormone therapy
- Sex reassignment surgery that is reconstructive and not cosmetic in nature (i.e. surgery that is performed to alter or reshape normal structures of the body in order to improve appearance)

Exclusions: Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Skilled Nursing Care

Services prescribed by an L.A. Care physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing

on a 24 hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

Exclusion: Custodial care

Substance Use Disorder Treatment *See Behavioral Health Services*

Transplants

Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a member.

Coverage includes charges for testing of relatives for matching bone marrow transplants, charges associated with the search and testing of unrelated bone marrow donors through a recognized donor registry, and charges associated with the procurement of donor organs through a recognized donor transplant bank, if the expenses directly related to the anticipated transplant of a member.

Exclusions and Limitations

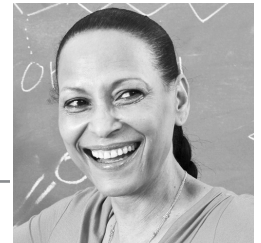
Certain services listed below are limited in time, as described in “Plan Benefits.” Other services listed below in this section are excluded and are not covered benefits.

- Acupuncture services;
- Alternative Therapies, unless the treatment is newly approved as evidence-based practice and prescribed by a licensed physician and surgeon or by a licensed psychologist as Behavioral Health Treatment for pervasive developmental disorder or autism, and such treatment is provided pursuant to a treatment plan administered by qualified autism providers
- Biofeedback, unless the treatment is medically necessary and prescribed by a licensed physician, surgeon or licensed psychologist
- Chiropractic Services;

- Conception by artificial means including gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), invitro fertilization (IVF), or any other process that involves the harvesting or manipulation (physical, chemical, or by any other means) of the human ovum to treat infertility. Any service, procedure, or process that prepares the member to receive conception by artificial means is not covered
- Contraceptives and contraceptive devices that do not require a prescription (unless deemed medically necessary by Plan physician);
- Convenience items such as telephones, TVs, guest trays, private room in a hospital and personal items;
- Cosmetic Services (i.e., surgery that is preformed to alter or reshape normal structures of the body in order to improve appearance);
- Custodial care incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, or to control or change a person's environment;
- Routine dental care services or appliances (e.g. teeth cleaning, cosmetic);
- Emergency facility services for non-emergency conditions;
- Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standard or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the time or service in question is recommended or prescribed. If L.A. Care denies your request for services based on the determination that the services are experimental or investigational, you may request an Independent Medical Review. For information about the Independent Medical Review (IMR) process, please refer to the "Grievance and Appeals" section of this Member Handbook.
- Hearing aids/services; are subject to the limitations set forth in the "Preventive Care Services" section of this member handbook.
- Home/vehicle improvements including any modifications or attachments made to dwellings, property, or motor vehicles including ramps, elevators, stair lifts, swimming pools, air filtering systems, environmental control equipment, spas, hot tubs, or automobile hand controls;
- Implants, except those that are medically necessary and are not cosmetic, experimental or investigational in nature; however, prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy are not excluded;
- Infertility treatments (except treatments for medical conditions of the reproductive system if deemed medically necessary by a Plan physician); treatments such as in-vitro fertilization, GIFT (Gamete Interfallopian Transfer) or any other form of induced fertilization, artificial insemination or services incident to or resulting from procedures for or the services of a surrogate mother are not covered services;
- Long Term Care;
- Medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices that are either:
 - Experimental or investigational in nature or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question; or
 - If services are denied due to the experimental or investigational nature of the treatment, you may immediately have this decision reviewed by the Department of Managed Health Care (DMHC) through the IMR process. You do not need to participate in the Plan's Grievance Process before having your case heard through DMHC's IMR process. You may apply directly to DMHC for participation in the IMR process;
- Non-skilled care that can be performed safely and effectively by family members (whether or not such family members are available to provide such services) or persons without licensure certification or the presence of a supervising licensed nurse, except for authorized homemaker services for hospice care, and except for Behavioral Health Treatment that is provided by a qualified Autism service professional or qualified Autism service paraprofessional for the

- treatment of Autism Spectrum Disorder (includes Asperger's Syndrome, Autism and Pervasive Development Disorder);
- Obesity (treatment of except when deemed medically necessary by Plan physician), including treatment of obesity by medical and surgical means, except for treatment of morbid obesity. In no instance shall treatment for morbid obesity be provided primarily for cosmetic reasons;
 - Orthopedic devices/other supplies including orthopedic shoes (except for diabetics) and elastic supports. Disposable medical supplies home testing devices, comfort items, environmental control equipment, exercise equipment, self-help/educational devices, home monitoring equipment, any type of communicator, voice enhancer, voice prosthesis or any other language assistance devices, except as provided under Orthotics and Prosthetics;
 - Over-the-counter drugs, supplies, and devices including air filters or medications not requiring a prescription, vitamins, minerals, food supplements, or food items for special diets or nutritional supplements, except those required for the treatment of Phenylketonuria (PKU);
 - Penile implant devices and surgery, and related services or any resulting complications, except as penile devices and surgery are medically necessary;
 - Physical exams and immunizations required for licensure, employment, insurance, participation in school or participation in recreational sports, ordered by a court, or for travel, unless the examination corresponds to the schedule of routine physical examinations and immunizations provided in "Preventive Health Services;"
 - Private duty nursing of any sort. Special duty nursing, if authorized as medically necessary, may be covered as part of an authorized Hospital or skilled nursing facility admission;
 - Services received prior to the member's effective date of coverage or after the date the member ceases to be a member, except as provided with respect to an extension of benefits;
 - Sexual dysfunction incident to non-physically related sexual dysfunction, sexual inadequacies, except as medically necessary;
 - Skin aging relating to the diagnosis and treatment to retard or reverse the effects of aging of the skin;
 - Substance (drug) abuse includes substance abuse admissions (whether or not court-ordered), unless medically necessary for Inpatient medical detoxification.
 - Transportation other than provided under "Ambulance Services" including coverage for transportation by commercial airplane, passenger car, taxi, or other form of public transportation is excluded;
 - Vasectomy and tubal ligation reversal or incident to the reversal of a vasectomy or tubal ligation, repeat vasectomy or tubal ligation (unless due to non-successful initial vasectomy or tubal ligation), or the infertility resulting thereof. The Plan covers medically necessary services necessary to treat complications arising out of any reversal or sterilization procedure;
 - Workers' compensation benefits or other liability including any injury arising out of, or in the course of, any employment for salary, wage or profit, or any disease covered, with respect to such employment, by any workers' compensation law, occupational disease law or similar legislation. If L.A. Care pays for such services, it shall be entitled to establish a lien upon such other benefits up to the reasonable cash value of benefits provided by L.A. Care for the treatment of the injury or disease as reflected by the providers' usual billed charges. Also, L.A. Care may recover the cash value of its benefits from the member, up to an amount equal to what was actually paid by the Plan, to the extent that such benefits would have been covered or paid for as Workers' Compensation Benefits if the member had diligently tried to establish his or her rights thereto.

General Information



Benefit Program Participation

L.A. Care will apply the health plan contract and this Member Handbook to decide your benefits. L.A. Care will serve the best interests of all persons eligible to receive benefits.

Notifying You of Changes in Benefits

L.A. Care will let you know when there are changes to your benefits. L.A. Care will send you a letter 30 days before any changes in benefits, exclusions or limitations take place. Services provided after the date of change in benefits will be based on the new benefits.

Termination of Benefits

You (as Subscriber) may be disenrolled from the PASC-SEIU Homecare Workers Healthcare Plan and your benefits may be terminated if:

1. You fail to meet any of the eligibility requirements, such as, but not limited to:
 - a. You are no longer authorized by the Department of Public Social Services (DPSS) to work 77 or more hours per month for two consecutive months.
 - b. You no longer work within L.A. Care's Service area (Los Angeles County is L.A. Care's Service Area).
 - c. You no longer reside within a 15-mile radius of Los Angeles County.
2. PASC fails to pay the monthly premium to L.A. Care on your behalf.
3. L.A. Care may disenroll you for good cause if any of the following conditions are met:
 - a. You knowingly omit or misrepresent a material fact on the application for membership; or in the course of receiving care or services from an L.A. Care physician, nurse, or other L.A. Care provider;
 - b. You fail to pay on demand any charges owed to L.A. Care within 30 days after notice to you;

- c. You use or permit the fraudulent use of health care coverage under L.A. Care, which includes allowing others to use your L.A. Care member ID card to receive services from L.A. Care providers.

In the event that you are disenrolled from the PASC-SEIU Homecare Workers Health Care Plan, you will be notified in writing of the effective date of disenrollment at least 15 days before the end of coverage. Benefits shall cease as of 12 a.m. midnight on such effective date.

If you believe that your membership was terminated or not renewed because of your health status or requirements for health care services, you may request a review of such cancellation by the Department of Managed Health Care. A member may ask for a review by the DMHC if L.A. Care cancels or refuses to renew a member's enrollment, and the member feels that it was due to reasons of health or use of benefits. The member can call the DMHC toll-free at 1.888.HMO.2219 (1.888.466.2219).

Continuation Coverage and New Options

If you are not eligible for primary group plan coverage, you may be eligible for:

- COBRA/Cal-COBRA Continuation Coverage
- Covered California

COBRA Continuation Coverage

L.A. Care is the COBRA administrator for PASC under the terms of the group benefit agreement between PASC and L.A. Care (i.e., for the PASC-SEIU Homecare Workers Health Care Plan). Under this agreement, you may be entitled to COBRA continuation coverage in the event that your group health coverage terminates due to a "qualifying event." While this agreement covers newborn infants up to 31 days old, it does not cover spouses or other dependents.

"Qualifying events" are events that cause an individual to lose his or her group health coverage.

The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage.

The following are qualifying events for a covered PASC-SEIU worker if they cause the covered employee to lose coverage:

- Termination of the PASC-SEIU worker employment for any reason other than “gross misconduct”; or
- Reduction in the PASC-SEIU workers hours of employment.

If you qualify for, and timely elect COBRA continuation coverage, you will be entitled to receive that coverage beginning on the date of the loss of group health plan coverage.

Duration of continuation coverage

Maximum periods

COBRA requires that continuation coverage be made available for a limited period of time of 18 or 36 months. The length of time for which continuation coverage must be made available (the “maximum period” of continuation coverage) depends on the type of qualifying event that gave rise to the COBRA rights.

When the qualifying event is the covered PASC-SEIU worker’s termination of employment or reduction in hours of employment, qualified beneficiaries are entitled to a maximum of 18 months of continuation coverage.

Early termination

COBRA continuation coverage may be terminated earlier than the end of the maximum period for several reasons—as allowed by federal regulations—including:

- You fail to pay the required premium on a timely basis;
- PASC ceases to maintain any group health plan to any PASC-SEIU worker;
- You begin coverage under another group health plan after electing continuation coverage, as long as that plan doesn’t impose an exclusion or limitation affecting a preexisting condition that applies to you;
- You become entitled to Medicare benefits after electing continuation coverage;

- You engage in conduct that would justify L.A. Care in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

Further, you (or your dependents) may not be eligible for COBRA continuation coverage if you (or they) have other coverage at the time of the qualifying event and for certain other reasons as allowed by federal regulations. You may obtain more information on COBRA continuation coverage qualifying and termination events, and eligibility requirements from the L.A. Care Member Services Department.

How to obtain COBRA continuation coverage

PASC is responsible for providing you with an election notice, which describes your right (and the right of your dependents) to continuation coverage, and how to make an election. To qualify for COBRA continuation coverage, you must notify L.A. Care in writing (using a reliable delivery method). Send correspondence to:

L.A. Care Health Plan
PASC-SEIU Plan,
P.O. Box 512540,
Los Angeles, CA 90051-0540.

You have 60 days from the date you receive the COBRA election notice, or the date your health care coverage terminates, whichever is later, to decide whether to elect COBRA continuation coverage. You may submit the initial payment with the COBRA Election Form.

Member cost for COBRA continuation coverage

For COBRA continuation coverage, you may be charged the full cost of the group health plan coverage, plus a two percent (2%) administrative fee. PASC will provide you with the exact premium amount. In the Notice of Eligibility for Continuation of Coverage provided by PASC, you will find the exact premium amount.

Payment of COBRA Premiums

To pay your premium:

1. Make payments for COBRA continuation coverage on a monthly basis.
 - There must be no lapse in your coverage
 - The first premium payment will cover the period of coverage from the date of the COBRA Election Form to the date coverage ended under the group health plan.

- The initial premium payment must be made within 45 days after the date you sign the COBRA Election Form. Failure to submit the correct premium amount will disqualify you from COBRA continuation coverage.
- Consider including your initial premium payment with the COBRA Election Form. This will allow you to obtain health benefits with no interruption.
- After the first or initial premium payment, all premium payments are due on the first of the month.
- If payment is not received by the first of the month, you have a 30-day grace period to submit payment. However, you are not eligible for coverage until payment is received.

If payment is received within the grace period, coverage is reinstated retroactively to the beginning of the coverage period.

- Cash is not accepted.

2. L.A. Care offers several payment options.

Cash is not accepted. You may pay by:

- Personal checks
- Money orders
- Cashier's checks
- Business checks
- e-Check (ACH)
 - electronic fund transfer system
- Visa, Mastercard, and Discover debit/credit cards

To pay by mail:

Make your payment payable to:
L.A. Care Health Plan,
P.O. Box 512540,
Los Angeles, CA 90051-9822

To pay online:

Go to the L.A. Care Website:
lacare.org
PASC-SEIU Plan, Payment Options

To pay by phone:

Call L.A. Care's Member Services
Department toll free at **1.888.839.9909**

Please call Member Service at **1.888.839.9909** if you have questions or need assistance.

Cal-COBRA Continuation Coverage

Extension of an 18-month period of continuation coverage (Cal-COBRA)

If you have exhausted coverage under federal COBRA and were not entitled to the maximum period of 36 months, you will have the opportunity to apply to continue group health coverage—as allowed under the California Continuation Benefits Replacement Act (Cal-COBRA)—for up to a total of 36 months from the date your COBRA continuation coverage began. You may be able to continue uninterrupted group health coverage for a limited time in compliance with Cal-COBRA if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA continuation coverage and that time limit was 18 or 29 months
- You are not entitled to Medicare
- You pay the monthly premiums by the billing due date set by L.A. Care.
- You have a total disability. (Coverage may be extended for up to 12 months.)

The premium rate for your Cal-COBRA continuation coverage may be as high as one hundred ten percent (110%) of your applicable group health plan coverage rate. L.A. Care will notify you of the terms and conditions of Cal-COBRA continuation coverage, and of the exact premium for such coverage, in its notice to you of the pending termination of your COBRA continuation coverage.

To extend federal COBRA and continue coverage under Cal-COBRA for up to a total of 36 months, you must notify L.A. Care within 30 calendar days prior to the date the initial COBRA continuation coverage is scheduled to end.

The premiums for extension of COBRA Coverage/Cal-COBRA Coverage during total disability or after age sixty (60) will be higher than premiums payable during the initial COBRA/Cal-COBRA continuation coverage period. L.A. Care will provide you with detailed information on premium amounts after receiving all the information required for extension of COBRA/Cal-COBRA continuation coverage.

Termination of Cal-COBRA continuation coverage

As for COBRA continuation coverage, Cal-COBRA continuation coverage may be terminated earlier than the end of the maximum period for several reasons—as allowed by state regulations—including:

- You fail to pay the required premium on a timely basis;
- PASC ceases to maintain any group health plan to any employee;
- You begin coverage under another group health plan after electing continuation coverage, as long as that plan doesn't impose an exclusion or limitation affecting a preexisting condition that applies to you;
- You become entitled to Medicare benefits after electing continuation coverage;
- You engage in conduct that would justify L.A. Care in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

Covered California

When your group health plan coverage ends, you may also be eligible to buy health insurance through Covered California. This new option is available due to federal and state laws. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, Medi-Cal or Medicare.

You must apply during an open or special enrollment period. Open Enrollment is scheduled annually by Covered California. A special enrollment period is triggered by a life change such as marriage, divorce, a new child, or loss of a job.

Through Covered California, you may also get help paying for your health insurance:

- Receive tax credits. You can use your tax credit to help pay your monthly premium.
- Reduce your out-of-pocket costs. Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.

To qualify for help paying for insurance, you must:

- Meet certain household income limits
- Be a U.S. citizen, U.S. national or be lawfully present in the U.S.
- Other rules and requirements apply.

For More Information or to learn more about Covered California or Medi-Cal, visit **CoveredCA.com** or call toll free **1.800.300.1506** (TTY/TDD 711). You can also call or visit your county social services office.

How a Provider Gets Paid

L.A. Care pays your doctor, hospital, or other provider in different ways:

- A fee for each service, or
- Capitation, which is a set amount, regardless of services provided.

Providers are sometimes rewarded for providing quality care to L.A. Care members. If you have any questions, please call L.A. Care.

L.A. Care works with a large number of providers to provide health care services to its members. Most of the doctors are organized into groups (also known as a Participating Provider Groups (PPG) or medical group). PPGs cannot, except for collection of co-payments, seek payment from members for covered benefits.

Reimbursement Provisions – If You Receive a Bill

Members can submit provider bills or statements directly to our claims department to the following address:

L.A. Care Health Plan
Claims Department
P.O. Box 712129
Los Angeles, CA 90071

You can call L.A. Care Member Services at **1.888.839.9909** (TTY users should call 711). This call is free.

Independent Contractors

L.A. Care physicians, PPGs, hospitals, and other health care providers are not agents or employees of L.A. Care. Instead, they are independent contractors. Although L.A. Care regularly credentials the doctors who provide services to members, L.A. Care does not, itself, provide these services. As such, L.A. Care is not responsible for the actions or omissions of any person who does provide these services to members. This includes any doctor, hospital or other provider or their employees.

Review by the Department of Managed Health Care (DMHC)

A member may ask for a review by the DMHC if L.A. Care cancels or refuses to renew a member's enrollment, and the member feels that it was due to reasons of health or use of benefits.

The member can call the DMHC toll-free at 1.888.HMO.2219 (1.888.466.2219).

Duplicate Coverage

If an L.A. Care member is also entitled to benefits under any of the conditions listed below, L.A. Care's liability for benefits shall be reduced by the amount of benefits paid, or the reasonable value of the services provided without any cost to the member, because he or she is entitled to these other benefits. This exclusion is applicable to benefits received from any of the following sources:

- Benefits provided under the Medicare program. If a member receives services he or she is entitled to under Medicare and those services are also covered under L.A. Care, the L.A. Care provider may seek compensation for the services provided under Medicare if the cost of such services is in excess of the PASC-SEIU benefits provided or if the service is not covered under the PASC-SEIU Plan.
- Benefits provided by any other federal or state government agency, or by any county or other political subdivision. Also excluded are the reasonable costs of services provided at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the person is not on active duty.
- Benefits provided free of charge or without expectation of payment.
- Benefits provided under workers' compensation coverage.

Coordination of Benefits

When a member has other health care coverage, L.A. Care will coordinate benefits for members, in cases when members are eligible for:

- Other health benefits, such as California Children's Services (CCS),

- Health benefits under another contract, or
- Another government program.

L.A. Care will coordinate payments for covered services based on California state law and regulations, and L.A. Care policies.

In the event that L.A. Care covers benefits greater than required by law, L.A. Care or the PPG has the right to recover the excess payment from any person or entity which may have benefited from the excess payment. As an L.A. Care member, you agree to help L.A. Care in recovering any over payment.

You must complete and return any Coordination of Benefits questionnaires you receive from L.A. Care, PASC, or the medical group within 30 days of receipt. Also, if information about your other coverage changes or your contact information changes, you must complete a new form and/or notify L.A. Care (or PASC) in writing with 30 days of such change.

Third Party Liability

L.A. Care will provide covered services where an injury or illness is caused by a third party. The term "third party" includes insurance companies, individuals, or government agencies. Under California state law, L.A. Care or the PPG may assert a lien on any payment or right to payment, which you have or may have received as a result of a third party injury or illness. The amount of this lien claim may include:

- Reasonable and true costs paid for health care services given to you, and
- An additional amount under California state law.

As a member, you also agree to assist L.A. Care in recovering payments for services provided. This may require you to sign or provide documents needed to protect the rights of L.A. Care.

Public Policy Participation

L.A. Care is an independent public managed care health plan run by a Board of Governors. The L.A. Care Board of Governors meets monthly. L.A. Care encourages you to:

- Attend Board of Governors meetings
- Offer public comment at the Board of Governors meeting
- Take part in establishing policies that assure the comfort, dignity and convenience of members, their

families, and the public when seeking health care services. (Health and Safety Code 1369)

Regional Community Advisory Committees (RCACs)

There are 11 L.A. Care Regional Community Advisory Committees (RCACs) in Los Angeles County. “RCAC” is pronounced “Rack.” The purpose of the RCAC is to:

- Talk about member issues and concerns, and resolve them through L.A. Care Member Services
- Advise the L.A. Care Board of Governors
- Educate and empower the community on health care issues

RCACs meet once a month. RCAC members include L.A. Care members, member advocates (supporters), and health care providers. For more information about RCACs, call L.A. Care Community Outreach and Education at 1.888.522.2732. This call is free.

Notice of Information Practices

The Insurance Information and Privacy Protection Act states that “L.A. Care may collect personal information from person(s) other than the person(s) applying for insurance coverage.” L.A. Care will not disclose any personal information without written consent. If you have applied for insurance coverage through L.A. Care, you can have access to your personal information collected through the application process.

Governing Law

L.A. Care must abide by any provision required to be in this benefit program by any of the laws listed below, even if they are not found in this Member Handbook or the health plan contract. [California Knox-Keene Act (Chapter 2.2 of Division 2 of the California Health and Safety Code), and Title 28 regulations].

New Technology

L.A. Care follows changes and advances in health care. We study new treatments, medicines, procedures, and devices. We call all of this “new technology.” We review

scientific reports and information from the government and medical specialists. Then we decide whether to cover the new technology. Members and providers may ask L.A. Care to review new technology.

Natural Disasters, Interruptions, Limitations

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Participating Medical Groups and hospitals will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for emergency services. L.A. Care will later provide appropriate reimbursement.

Definitions



This section will help you understand words used in this Member Handbook.

Active Labor is labor where there is inadequate time to safely transfer you to another hospital prior to delivery or when transferring you may pose a threat to your health and safety of the unborn child.

Acute Condition means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Anesthesia is the loss of sensation due to a pharmacological depression of nerve function.

Appropriately Qualified Health Professional is a Primary Care Provider, Specialist, or other Health Professional who is acting within his or her scope of license and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a Second Opinion.

Arbitration is a way to solve problems using a neutral third party. For problems that are settled through Arbitration, the third party hears both sides of the issue and makes a decision that both sides must accept. Both sides give up the right to a jury or court trial. To learn more, read the "Arbitration" section of the PASC-SEIU Homecare Workers Health Care Plan Enrollment Form.

Authorization (Authorized) is the requirement that certain services be approved by L.A. Care before they are rendered.

Behavioral Health Services are psychoanalysis, psychotherapy, counseling, medical management, or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage, family and child counselor or other mental health professional or paraprofessional, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or other condition; or diagnosis/treatment of substance use disorders. **Mental Health**, or emotional disorders include, but are not limited to: Anorexia Nervosa, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Autism or Pervasive

Developmental Disorder, Bipolar Disorder, Bulimia Nervosa, Major Depressive Disorders, Obsessive Compulsive Disorder, Panic Disorder, Psychosis, Schizophrenia, Schizoaffective Disorder.

Behavioral Health Treatment is professional services and treatment programs that are prescribed by a physician, surgeon or is developed by a licensed psychologist and provided under a treatment plan prescribed by a qualified autism service provider, and administered by a qualified autism service provider, professional or paraprofessional, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder (includes Aspergers, Autism and Pervasive Development). The treatment plan shall have measurable goals developed and approved by the QAS (Qualified Autism Service) provider that is reviewed every six months and modified whenever appropriate. The treatment plan is not use to provide respite, day care, or educational services or to reimburse a parent for participation in the treatment.

Benefits (Covered Services) are those medically necessary services, supplies, and drugs that are benefits of the Group Agreement in which member is enrolled and for which medical group is a contracted provider.

Behavioral Health Treatment is professional services and treatment programs that are prescribed by a physician, surgeon or is developed by a licensed psychologist and provided under a treatment plan prescribed by a qualified autism service provider, and administered by a qualified autism service provider, professional or paraprofessional, including applied behavior analysis and evidence based, behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Capitation is a set flat rate paid each month to providers for covered services provided to L.A. Care members.

Cardiology is the medical specialty of the diagnosis and treatment of heart disease.

Chemotherapy is the treatment of a disease using chemical substances or drugs.

Chiropractic is the practice of locating, detecting and assisting in correcting vertebral subluxation. This is done by hand only with adjustment.

Chronic is a term used for a condition that is long-term and on-going. Not acute. Examples include diabetes, asthma, allergies, and hypertension.

Clinical Trial is a research study with cancer patients, to find out if a new cancer treatment or drug is safe and works with the type of cancer that you have.

Continuation Coverage is continued group coverage by L.A. Care for Members or Member's Dependents beyond the point at which group coverage might otherwise be terminated.

Continuity of Care is your right to continue seeing your doctor or using a hospital.

Contract is the agreement with L.A. Care and PASC-SEIU (the Employer of record), on behalf of the County of Los Angeles, to administer or otherwise pay or arrange for the payment of benefits under the In-Home Supportive Services program.

Contraindicated is the showing that a method of treatment that would normally be used is not advisable due to the special circumstances of an individual case.

Conversion Coverage occurs when Plan coverage, including any COBRA Coverage and Cal-COBRA continuation coverage (if applicable) ends. The enrollee may be eligible for individual coverage without necessity of providing the Plan with evidence of insurability.

Co-payment is the amount a member is required to pay for certain benefits.

Covered Services (Benefits) see Benefits.

Credential is a certificate showing that a person is entitled to treat a member.

Custodial Care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living including, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

Curative is having the ability to cure or heal.

Diagnostic/Diagnosis is when a doctor identifies a condition, illness or disease, in certain cases, even if your doctor or hospital leaves your health plan or medical group.

Diagnostic testing is the use of tests to reach a diagnosis.

Dialysis is a form of filtration to separate smaller molecules from larger ones in a solution. This is achieved by placing a semi permeable membrane between the solution and water.

Disability is an injury, an illness, or a condition. All injuries sustained in any one accident will be considered one Disability; all illnesses existing simultaneously which are due to the same or related causes will be considered one Disability; if any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous Disability and not a separate Disability.

Disenroll(ment) is when a member leaves a health plan.

Disputed Health Care Service means any requested health care service eligible for coverage and payment under the Group Agreement and this Evidence of Coverage that has been denied, modified, or delayed by a decision of the Health Plan, or by one of its Participating Providers, in whole or in part due to a finding that the service is not Medically Necessary.

Durable Medical Equipment (DME) is medical equipment meant for repeated use over a prolonged period of time; not considered disposable, with the exception of ostomy bags; ordered by a licensed Health Professional acting within the scope of his or her license; intended for the exclusive use of the enrollee; does not duplicate the function of another piece of equipment or device covered by the carrier for the Member; generally not useful to a person in the absence of illness or injury; primarily serves a medical purpose; and appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain or a psychiatric disturbance) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1) placing the patient's health in serious jeopardy; 2) serious impairment to bodily functions; 3) serious dysfunction of any bodily organ or part.

Emergency Services are covered anywhere in the United States – 24 hours a day, seven (7) days a week. Emergency care is a service a member reasonably believes is necessary to stop or relieve serious illness or symptoms, injury, or conditions requiring immediate diagnosis and treatment, including physical and psychiatric emergency conditions and active labor.

Employee is an individual who is employed by the Employer and meets all of the eligibility requirements as described in the PASC Contract.

Enroll(ment) is when a member joins a health plan. Enrollment may also mean the act of starting a program like the PASC-SEIU Plan. Combined Evidence of Coverage and Disclosure Form (EOC/DF) is the L.A. Care Member Handbook which has information about benefits, services and terms for members.

Exclusion is any medical, surgical, hospital or other treatment for which the program offers no coverage.

Experimental or Investigational in Nature refers to new medical treatment that is still being tested but has not been proven to treat a condition.

Family Planning Services help people learn about and plan the number and spacing of children they want, through the use of birth control.

Formulary is a list of brand-name and generic prescription drugs approved for coverage and available without prior authorization from L.A. Care. The presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Generally Medically Accepted is a term used for tests or treatments that are commonly used by doctors for the treatment of a specific disease or diagnosis

Grievance/Complaint is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by you or your representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Health Plan refers to L.A. Care.

Health Care Services include some of the following:

- Doctor services (includes one-on-one visits with a doctor and referrals)
- Emergency services (includes ambulance and out-of-area coverage)
- Home health services
- Hospital inpatient and *outpatient services*
- Laboratory services
- *Pharmacy* services
- Preventive health services
- *Radiology* services

Health Professional is a person holding a license or certificate, appropriate to provide health care services in the State of California. Health Professionals include, but are not limited to: psychologists, podiatrists, nurses, physical therapists, speech therapists, occupational therapists, optometrists, dentists, and laboratory technicians.

Hemodialysis is the dialysis of soluble substances and water from the blood by diffusion through a semi-permeable membrane.

Hospice Care is care and services provided to people who have received a diagnosis for a terminal illness. The services are given in a home or facility to relieve pain and provide support.

Hospital provides inpatient and outpatient care from doctors or nurses.

Immunizations help your immune system attack organisms that can cause disease. Some immunizations are given in a single shot or oral dose. Others require several shots over a length of time.

Independent Medical Review (IMR) is a review of your health plan's denial of your request for a certain service or treatment. (The review is provided by the Department of Managed Health Care and conducted by independent medical experts, and your health plan must pay for the service if an IMR decides you need the service).

Infertility is when a person is not able to conceive and produce children after having unprotected sex on a regular basis for more than 12 months.

In-patient is when a person receives medical treatment in a hospital or other health care facility with an overnight stay.

Interpreter is a person who speaks the languages of two people who would like to speak with each other, but cannot because of language differences. The interpreter transfers from one language to the other, the meaning of what is heard without changing what is being said.

Intraocular Lens is the lens within your eyeball.

Involuntary/Involuntarily is when something is done without choice.

Laboratory is the place equipped for the running of tests, experiments, and investigative procedures.

L.A. Care Health Plan is a non-profit managed health care organization.

Liable/Liability is the responsibility of a party or person according to law.

Lien is a claim or charge on property, which a creditor (one who is owed the money) has as security for a debt or charge that is owed to him/her.

Life-threatening is a disease, illness or condition that may put a person's life in danger if it is not treated.

Maintenance drug is any drug taken continuously for a chronic medical problem.

Medical Group means the L.A. Care Network, which is the Medical Group with which the Member's Primary Care Provider is associated for the provision of Benefits to L.A. Care Members and with whom L.A. Care is contracted.

Medically Necessary/Medical Necessity refers to all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to ease severe pain through the diagnosis or treatment of disease, illness or injury.

Member is an individual entitled to receive benefits under the PASC-SEIU agreement.

Member Representative is a person or persons appointed by the member, via written statement, to represent them in the State of California as a healthcare proxy, trustee named in a durable power of attorney or court appointed guardian. Also known as Personal Representative(s), a Member Representative may be a spouse, relative, friend, advocate, your doctor, a practitioner or someone designated as a representative by the member under Durable Power of Attorney, or as an Executor/Administrator of Estate or as a legal/court appointed guardian.

Member Services Department is the health plan's department that helps members with questions and concerns.

Mental Health is the diagnosis or treatment of a mental or emotional illness.

Network is a team of health care providers contracted with a health plan to provide services. The health care providers may be contracted directly with the health plan or through a medical group.

Non-formulary Drug is a drug that is not listed on L.A. Care's Formulary and requires an authorization from L.A. Care in order to be covered.

Non-participating Provider is a provider who has not contracted with L.A. Care to provide services to members.

Occupational Therapy is used to improve and maintain a patient's daily living skills when the patient has a disability or injury.

Orthotic is used to support, align, correct, or improve the function of movable body parts.

Outpatient is when a person receives medical treatment in a hospital or other health care facility without an overnight stay.

Participating Hospital is a hospital approved by L.A. Care to provide covered services to its members.

Participating Provider is a doctor, hospital, pharmacy, or other health care professional approved by L.A. Care to provide covered services to its members.

Participating Provider Group is a physician group your doctor or PCP is a part of. Also see "medical group."

Participating Specialist is a doctor with specialized training, who has been approved by L.A. Care to provide covered services to its members.

PASC-SEIU Homecare Worker Health Care Plan refers to the agreement between the Personal Assistance Services Council (PASC) and Service Employees International Union (SEIU) to provide eligible and enrolled Homecare Workers with health care benefits described in this handbook.

Pharmacy is a place to get prescribed drugs.

Physical Therapy is treatment under the direction of a Primary Care Provider and provided by a licensed physical therapist, certified occupational therapist or licensed doctor of podiatric medicine, which may utilize physical agents to improve a patient’s musculoskeletal, neuromuscular, and respiratory systems.

Plan means L.A. Care.

Physician is a doctor.

Premium means the contribution required of PASC on behalf of the PASC-SEIU Member under the terms of the Group Agreement.

Prescription is a written order given by a licensed provider for drugs and equipment.

Primary Care Provider (PCP) is a doctor that takes care of a member’s health care needs and works with the member to keep them healthy. The PCP will also make specialty referrals when medically necessary.

Prosthesis is used to replace a missing part of the body.

Providers are contracted with a health plan to provide covered health care services. Examples include:

- Doctors
- Hospitals
- Skilled nursing facilities
- Home health agencies
- Pharmacies
- Laboratories
- X-ray facilities
- Durable medical equipment suppliers

Provider/Pharmacy directory is a list of providers contracted with a health plan for covered health care services. The list includes PCPs, hospitals, skilled nursing facilities, urgent care, and pharmacies.

Prudent Layperson is an individual who does not belong to a particular profession or specialty, but has awareness of information to make a good decision.

Qualified health care professional is a PCP, specialist, or other licensed health care provider who is acting within his/her scope of practice. A qualified health care professional also has a clinical background in the illness, disease, or condition(s). Clinical background includes training, and expertise or a high degree of skill and knowledge.

Radiology is the use of radiation to diagnose and treat a disease.

Reconstructive Surgery repairs abnormal body parts, improves body functions, or brings back a normal look.

Referral is when a doctor sends a member to another doctor, such as a specialist or providers of services including lab, X-ray, *physical therapy* and others.

Rehabilitative Services are the services used to restore the ability to function in a normal or near normal way, after a disease, illness, or injury.

Respiratory Therapy is treatment under the direction of a doctor and provided by a trained and certified respiratory therapist, to preserve or improve a patient’s pulmonary function.

Routine Patient Care Costs are ordinary or normal costs for patient care services.

Screenings protects your health by detecting disease early and when it may be easier to treat.

Second Opinion is an additional consultation with another primary care physician other than the member’s selected primary care physician or a referred Specialist before scheduling certain services.

Serious Chronic Condition means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

- Persists without full cure or worsens over an extended period of time.
- Requires ongoing treatment to maintain remission or prevent deterioration.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Serious Emotional Disturbances (SED) shall be defined as a person who 1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, and 2) who meets the criteria in paragraph 2) of subdivision a) of Section 5600.3 of the Welfare and Institutions Code.

Service Area means the zip codes in Los Angeles County that the health plan, to which a member is assigned, serves.

Severe Mental Illness (SMI) includes the following mental disorders of a person of any age; schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorder, panic disorder, obsessive-compulsive disorder, Pervasive Development Disorder or Autism, anorexia nervosa, and bulimia nervosa.

Skilled Nursing Facility is a facility licensed to provide medical services for non-acute conditions.

Specialist is a physician or other health professional who has advanced education and training in a clinical area of practice and is accredited, certified, or recognized by a board of physicians or peer group, or an organization offering qualifying examinations.

Speech Therapy is treatment under the direction of a Primary Care Provider and provided by a licensed speech pathologist or speech therapist.

Standing referral is a referral by a doctor for more than one visit by a specialist.

Third Party includes insurance companies, individuals, or government agencies.

Triage and screening is the evaluation of a member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the member's need for care.

Total Disability means that you are unable to obtain and hold meaningful employment due to a physical or mental disability and a physician concludes your condition is long-term or terminal.

TTY/TDD is a communication device for the deaf, using a telephone system..

Urgent Care is any service required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Urgent Grievance is when you are not happy with the health care service and feel that any delay with decision could lead to a life-threatening or debilitating condition. Urgent grievances include, but are limited to:

- Severe pain
- Potential loss of life, limb, or major bodily function

Important Phone Numbers



California State Services

California State Department of Health Services	1-916-445-4171
Department of Managed Health Care (DMHC)	1-888-HMO-2219 (1-888-466-2219)
Department of Public and Social Services (DPSS)	1-877-481-1044
Supplemental Social Income (SSI)	1-800-772-1213

Children’s Services and Programs

Access for Infants and Mothers (AIM)	1-800-433-2611
California Children’s Services (CCS).....	1-800-288-4584
Child Health and Disability Prevention (CHDP)	1-800-993-CHDP (1-800-993-2437)
Medi-Cal	1-877-481-1044

Disability Services

American Disabilities Act Information.....	1-800-514-0301
Hearing Impaired/California Relay Service	1-800-735-2929
California Relay Services (CRS) –TTY/TDD	711

L.A. Care Health Plan Services

L.A. Care Member Services.....	1-888-839-9909
Authorizations	1-877-431-2273
Pharmacy	1-844-268-9787
L.A. Care Behavioral Health Hotline	1-877-344-2858
L.A. Care Nurse Advice Line	1-800-249-3619
L.A. Care Compliance Helpline.....	1-800-400-4889

Los Angeles County Services

Los Angeles County Department of Health Services	1-213-250-8055
Los Angeles County Department of Mental Health	1-800-854-7771
Women, Infant and Children (WIC) Program.....	1-888-942-9675

PASC	1-877-565-4477
SEIU - Dental Services	1-877-698-5829

How to Get Your Prescription Drugs



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Your doctor may give you a prescription when you are sick or have a health condition like high blood pressure or diabetes. The prescription is based on your health status.

For New Prescriptions:

If you are filling a prescription for the first time, you must go to a pharmacy that works with L.A. Care. L.A. Care partners with pharmacies throughout Los Angeles County (including Albertson's / Sav-On, CVS, Rite Aid, Target, Vons, Wal-Mart, and Walgreens). A list of pharmacies that work with your health plan is in L.A. Care's provider directory, or you may call **Member Services toll-free at 1.888.839.9909** during regular business hours, Monday thru Friday, 7:00 am to 7:00 pm, for a pharmacy near you.

For Prescription Refills:

If you are refilling a prescription that you already have, you must go to a pharmacy that works with L.A. Care. If your medication is listed on the maintenance list you might be able to receive a 90-day supply of generic maintenance medications at select local pharmacies. Maintenance medications are drugs that you need to take for a long time, such as pills for high blood pressure or diabetes.

How to Get a Prescription Filled at the Pharmacy:

1. Choose a pharmacy near you.
2. Bring your prescription to the pharmacy.
3. Give the prescription to the pharmacy with your L.A. Care **member ID** card. This will help the pharmacy fill your prescription.
4. Make sure you give the pharmacy your correct address and phone number.
5. Make sure the pharmacy knows about all medications you are taking and/or any allergies you have to any medicine.
6. If you have any questions about your prescription(s), make sure you ask the pharmacist.
7. PASC-SEIU members pay \$5 for each prescription. For more information on your co-payment, please check this Evidence of Coverage.





L.A. Care
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Stay Healthy

Preventive Health Guidelines for Adults 2015

For the latest update on immunizations and health screenings, visit the L.A. Care website lacare.org

- Click on **I Am A Member**
- On the left, click the name of your program, then
- On the left, click on **Health Topics**, scroll down to **Staying Healthy**,
- Select **"How to Stay Healthy"** (PDF)

Stay Healthy

Go to your doctor for regular wellness visits to help you stay healthy.

Use this guide to:

- Know when to go to the doctor
 - Know what needs to be done at each visit
- *Ask your doctor which tests/exams are right for you.

Remember:

- If you are a new member, see your doctor right away
- Get a wellness visit every year
 - Regular wellness visits help you stay healthy

Well Care Guidelines for Adults*

Tests/Exams/Visits	19 to 39 Years	40 to 64 Years	65+ Years
<input type="checkbox"/> Checkup: Medical and family history, physical exam, height, weight, and Body Mass Index (BMI, a measure for a healthy weight)		Every year	
<input type="checkbox"/> Blood Pressure		Every year	
<input type="checkbox"/> Cholesterol Screening		Age 20 and older if at risk for heart disease	
<input type="checkbox"/> Colon and Rectal Cancer Screening		Age 50 to 75 Your doctor will talk with you about having one of these tests: <ul style="list-style-type: none"> • Fecal Occult blood test Every year Test to see if there is blood in your stool (bowel movement) • Flexible sigmoidoscopy Every 5 years Test to check the lower part of your colon for cancer • Colonoscopy Every 10 years Test to check the larger part of your colon for cancer 	
<input type="checkbox"/> Diabetes Screening Check for diabetes and pre-diabetes	Adults whose blood pressure is greater than 135/80 and as recommended by your doctor		
<input type="checkbox"/> Hearing and Vision	As recommended by your doctor		
<input type="checkbox"/> Hepatitis C	Adults born between 1945-1965, one-time testing. Testing for at risk as recommended by your doctor		
<input type="checkbox"/> Human Immunodeficiency (HIV) Screening Check for the virus that causes HIV infection	Screening at least once for adults ages 19-65. Screening for pregnant women and all age groups at risk as recommended by your doctor		
<input type="checkbox"/> Tuberculosis (TB) Risk Screening and Test	Risk screening recommended for all adults as part of their first checkup. Doctors will also test those at a higher risk for TB		

Immunizations/Shots for Adults*

Immunizations (Shots)	19 to 39 Years	40 to 64 Years	65+ Years
<input type="checkbox"/> Hepatitis B A disease of the liver	Shot may be recommended by your doctor if you are at risk		
<input type="checkbox"/> Human Papilloma Virus (HPV) Virus can cause cervical cancer and genital warts	For women up to age 26 and men up to age 21 (3 doses), if not immunized before	No recommendation	
<input type="checkbox"/> Influenza (Flu) Influenza or flu virus	Every year! During flu season in fall or winter		
<input type="checkbox"/> Measles, Mumps, and Rubella (MMR)	If born after 1957 (1 or 2 doses)	As recommended by your doctor	
<input type="checkbox"/> Pneumococcal Bacteria can cause lung or blood infection	As recommended by your doctor	One dose	
<input type="checkbox"/> Tetanus-Diphtheria, Pertussis (Td/Tdap) Lockjaw tightening of the jaw muscle	One dose then a Td booster every 10 years		
<input type="checkbox"/> Zoster (Shingles) Virus - can cause painful skin rash with blisters	No recommendation	One dose, starting at age 60 if recommended by your doctor	

Stay Healthy

Well Care Guidelines for Women

Tests/Exams/Visits	16 to 49 Years	50 to 64 Years	65+ Years
<input type="checkbox"/> Breast Cancer Screening Mammogram X-ray of the breasts	No recommendation	Every 2 years for women 50 to 74 years. Ask your doctor if you need a mammogram before age 50	
<input type="checkbox"/> Cervical Cancer Screening Pap smear to check for cancer	Every three years ages 21 to 65		No recommendation
<input type="checkbox"/> Chlamydia Screening Test for a sexually transmitted disease (STD)	To be done regularly for women 16 to 24 years if sexually active and only for women over age 25 who are at high risk		
<input type="checkbox"/> Osteoporosis Thinning of the bone	Screening for 65 years and older or as recommended by your doctor		

Stay Healthy When You are Pregnant*

Before Pregnancy Care:

- Talk with your doctor about the vitamin (folic acid) that helps prevent birth defects.
- See your doctor RIGHT AWAY! As soon as you think or know you are pregnant.
- Know your HIV status RIGHT AWAY as soon as you think or know you are pregnant.

During Pregnancy (Prenatal) Care:

Checkups:	How Often?
First 28 weeks	Every 4 weeks
29 - 36 weeks	Every 2 - 3 weeks
36 weeks and beyond	Weekly

After Pregnancy (Postpartum) Care:

- ▶ Get your postpartum checkup between 21 and 56 days after you have your baby, whether you had a C-section (surgical delivery) or not.
 - You will be screened for healing and postpartum depression.
 - Your doctor will also talk with you about birth control/family planning.
- ▶ Get your C-section (surgical delivery) checkup about 1-2 weeks after giving birth.

Each checkup is important to help keep you and your baby healthy

- ▶ Needed tests are done at each visit.
- ▶ Your doctor may want to see you more often.

Stay Healthy

Well Care Guidelines for Men

Tests/Exams/Visits	19 to 39 Years	40 to 64 Years	65+ Years
<input type="checkbox"/> Abdominal Aortic Aneurysm Screening Ultrasound		No recommendation	One-time screening if you have ever smoked



You may also talk to your doctor about:

(check the ones you want to talk with your doctor about)

- Abuse and Violence
- Aspirin
- Asthma
- Dental Health
- Depression
- Diabetes
- Drug and Alcohol Problems
- Exercise
- Family Planning/Birth Control/Breast Feeding
- High Blood Pressure
- How to Quit Smoking
- Medications
- Mental Health Concerns
- Nutrition
- Pain Management
- Parenting
- Prenatal Health (for pregnant women)
- Safety
- STDs and HIV
- Weight Concerns
- Any other concerns you may have

Nurse Advice Line
24/7 for health questions

Call 1.800.249.3619
TTY/TDD 711

Member Services

Call 1.888.839.9909
TTY /TDD 711

Notice of Privacy Practices

L.A. Care Health Plan

Please read carefully.



L.A. Care
HEALTH PLAN®

lacare.org

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

You get your health care through L.A. Care Health Plan (L.A. Care). By law L.A. Care must safeguard your Protected Health Information (PHI). We must also give you this notice. This notice tells you how we may use and share your PHI. It tells you what your rights are.

I. What is “Protected Health Information?”

Protected Health Information (“PHI”) is health information that has your name, Social Security number, race/ethnicity, language, or other information that can let others know who you are. For example, your health record is PHI because it has your name on it.

II. How We Protect Your PHI

PHI can be spoken, written, or electronic (on a computer). By law L.A. Care must protect your PHI and tell you about our legal duties and privacy practices. We must tell you if there is a breach of your unsecured PHI.

L.A. Care staff is trained on how to use or share PHI at L.A. Care. Staff has access only to the information they need to do their job. Staff protects what they say about your PHI. For example, staff may not speak about you in common areas such as hallways. Staff also protects written or electronic documents that have your PHI.

L.A. Care computer systems protect your PHI at all times. Passwords are one way we do this.

Fax machines, printers, copiers, computer screens, work stations, and portable media disks with your

PHI are not shared with others who do not have access. Staff must pick up PHI from fax machines, printers, and copiers. They must make sure it is received by only those who need it. Portable media devices with PHI are password protected. Computer screens and work stations are locked when not in use. Drawers and cabinets are also locked.

III. Your Information is Personal and Private

L.A. Care gets information about you when you join our health plan. We use this information to give you the care you need. We also get PHI from your doctors, labs, and hospitals. We use this PHI to approve and pay for your health care.

IV. Changes to Notice of Privacy Practices

L.A. Care must adhere to the notice we are now using. We have the right to change these privacy practices. Any changes will apply to all your PHI, including information we had before the changes. We will let you know when we make changes to this notice.

V. How We May Use and Share Information About You

L.A. Care may use or share your information only for health care reasons. Some of the information we use and share is:

- Your name
- Address
- Health care given to you
- The cost of your care
- Your health history

Here are some of the things we do with your PHI:

- Check if you are covered
- Approve, give, and pay for care
- Check the quality of your care
- Make sure you get all the care you need.

Here are some ways we may use and share PHI:

- **Treatment:** Some care must be approved before you get it. We will share PHI with doctors, hospitals and others to get you the care you need.
- **Payment:** We may send bills to other health plans or doctors for payment.
- **Health Care Operations:** We may use PHI to check the quality of your health care. We may also use PHI for audits, programs to stop fraud, planning, and day-to-day functions.

VI. Other Uses for Your PHI

By law L.A. Care may use or share some PHI.

L.A. Care may use your PHI to review payment decisions or to check how well L.A. Care is giving care. We may also share your PHI with people giving you health care, or with your designee.

L.A. Care must share your PHI with the U.S. government when it is checking on how well L.A. Care meets privacy rules.

We may share your information with other groups that help us with our work. But we won't do this unless those groups agree in writing to keep your information private.

We may give out your PHI for public health reasons to:

- Prevent or control disease, injury or disability
- Report births and deaths
- Report child abuse or neglect
- Report problems with medications and other health products
- Tell people of product recalls
- Tell a person they may be at risk for getting or spreading a disease.

We may also tell the authorities if we think you have been the victim of abuse, neglect, or family violence. We will do this only if you agree or if required by law.

By law L.A. Care can give out PHI to an oversight agency for audits, inspections, or disciplinary actions. The government uses these to monitor the health care system, government programs, and to check compliance with civil rights laws.

If you are part of a lawsuit or dispute, we may give out your PHI in response to a court order. We may also give out your PHI in response to a subpoena, discovery request, or other lawful process by someone else in the dispute. We will do this only if the person asking for it has tried to tell you about the request or if the person asking for your PHI has made reasonable efforts to get an order protecting the information.

We may give out PHI if asked by a law enforcement official:

- In response to a court order, subpoena, warrant, or summons
- To find a suspect, fugitive, material witness or missing person
- About the victim of a crime when we are not able to get the person's okay
- About a death we think may be caused by criminal conduct
- About criminal conduct at our health plan.

We may give out PHI to a coroner or medical examiner to identify a deceased person or find out the cause of death. We may give PHI to funeral directors so they can do their job.

If you are an organ donor, we may give your PHI to groups that work with organ and tissue donations.

In some cases, we may use and give out your PHI for health research. All research projects undergo a special approval process.

We may use and give out PHI to stop a serious threat to the health and safety of a person or the public. We would only give it to someone who could help stop the threat. We may also use or give out information needed for law enforcement to catch a criminal.

If you are a member of the armed forces, we may release your PHI to military authorities. We may also release information about foreign military personnel to foreign military authorities.

We may give out PHI to federal officials for national security purposes. These officials would use it to protect the President, other persons or heads of state, or to conduct investigations.

We may give out PHI to comply with workers' compensation or other laws.

VII. When Written Permission is Needed

If we want to use your PHI in a way not listed here, we must get your written okay. For example, using or sharing PHI for marketing or sale needs your written okay. If we use or share psychotherapy notes, we may also need your okay. If you give us your okay, you may take it back in writing at any time.

VIII. What Are Your Privacy Rights?

You have the right to ask us not to use or share your PHI. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. We may not be able to grant your request. If we cannot grant your request, we will let you know.

You have the right to ask us to contact you only in writing or at a different address, post office box, or by phone. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. We will grant requests within reason.

You have the right to look at and get a copy of your PHI. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. You may have to pay the costs for copying and mailing. By law we have the right to keep you from seeing some parts of your records.

You have the right to ask that your records be changed if they are not correct. We will send you a form to fill out to tell us what you want changed. Or, we can fill out the form for you. We will let you know if we can make the changes. If we can't make the changes, we will send you a letter telling you why. You may ask that we review our decision if you disagree with it. You may also send a statement telling us why you disagree. We will keep your statement with your records.

You have the right to get a list of when we shared your PHI including:

- With whom we shared the information
- When we shared it
- For what reasons
- What information was shared

The list will cover the last six years unless you want a shorter timeframe. The list will not have information shared before April 14, 2003. The list will not include when we share information with you, with your okay, or for treatment, payment, or health plan operations.

You have the right to ask for a paper copy of this notice. You can find this notice on the L.A. Care website at www.lacare.org. Or, you can call our Member Services Department at (888) 839-9909.

IX. How Do You Contact Us to Use Your Rights?

If you want to use the rights in this notice, please call or write us at:

L.A. Care Privacy Officer
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: 1-888-839-9909
TTY/TDD: 711
Email: PrivacyOfficer@lacare.org

X. Complaints

If you think L.A. Care has not protected your PHI, you have the right to complain. You may file a complaint (or grievance) by contacting us at:

L.A. Care Member Services
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: 1-888-839-9909
TTY/TDD: 711
Email: PrivacyOfficer@lacare.org

You may also contact:

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TTY/TDD: 1-800-537-7697

Medi-Cal Members Only:

California Department of Health Care Services
Office of HIPAA Compliance
Privacy Officer
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Phone: 1-916-445-4646
Fax: 1-916-440-7680
E-mail address: privacyofficer@dhcs.ca.gov

XI. Use Your Rights Without Fear

L.A. Care cannot take away your health care or hurt you in any way if you file a complaint or use the privacy rights in this notice.

XII. Effective Date

L.A. Care's privacy policies are effective April 14, 2003. This notice was revised and is effective on September 1, 2013.

XIII. Questions

If you have questions about this notice and want to learn more, please call or write us at:

L.A. Care Privacy Officer
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Toll-free: 1-888-839-9909
TTY/TDD: 711
Email: PrivacyOfficer@lacare.org

XIV. Do You Need this Notice in Another Language or Format?

To get this notice in other languages (Armenian, Chinese, Farsi, Khmer, Korean, Russian, Spanish, Tagalog, or Vietnamese), alternative format (upon request), call L.A. Care's Member Services Department at 1-866-839-9909, 24 hours a day, 7 days a week, including holidays. TTY/TDD users should call 711.

You can also write to:

L.A. Care Privacy Officer
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Email: PrivacyOfficer@lacare.org

Nurse Advice Line

List of Audio Health Topics

1.800.249.3619



L.A. Care
HEALTH PLAN®

lacare.org

For life-threatening or limb-threatening emergencies, call 911 or the appropriate local emergency services.

How do you use the AudioHealth Library®?

The AudioHealth Library® is easy to use. Simply call the same toll-free number you call to speak with a nurse. You can call anytime for information on a variety of health care topics. If you are calling from a touchtone phone, just follow the directions below. If you are calling from a dial phone (rotary phone), please stay on the line and a nurse can direct you to a topic.

Call instructions:

- Look up the 4-digit number for the topic you want to hear.
- Call the toll-free number.
- Select the option for the AudioHealth Library®. You will hear the AudioHealth Library® menu. Follow the instructions to select a topic.
- Listen to the recording. Topics are usually 2 to 5 minutes in length.

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You can call L.A. Care's 24-hour nurse advice line at 1.800.249.3619.

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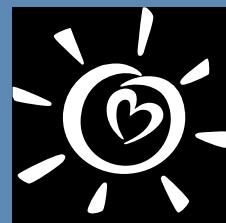
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