L.A. Care Health Plan
Individual Conversion Plan

Membership Agreement and Disclosure Form and Evidence of Coverage

(MEMBER HANDBOOK)

www.lacare.org

Effective January 1, 2012
through
December 31, 2012

In Your Language

Dear *Member*,

We know that it is important to communicate clearly so you can get the *health care services* you need.

In the United States, there are laws, such as the Civil Rights Act of 1964, which protects you if you do not speak English. If you cannot hear or are hard of hearing (hearing impaired) or *disabled*, aged or blind, you are also protected by the Americans with Disabilities Act (ADA) of 1990. The ADA is a law that protects people with *disabilities* from discrimination. The ADA makes sure that there is equal opportunity for persons with *disabilities* in employment, state and local government services.

The doctor's office, clinic or *hospital* cannot deny services because you do not speak English or are hearing impaired. You have the right to free *interpreter* services when getting health care or any related service through your health plan. An interpreter is a person who translates orally what is said in one language to another language. This allows persons of different languages to speak with each other and understand each other.

The meanings of italicized words are found in the "Glossary Section" at the end of this Member Handbook.

L.A. Care Health Plan (L.A. Care) will cover you your legal spouse or registered domestic partner and your dependents that were covered under your group contract on the date of your termination from the group. Call **L.A. Care** Member Services at **1-888-839-9909** for more information.

About this Agreement

This **Individual Conversion Plan Membership Agreement** and **Disclosure Form** and **Evidence of Coverage (Agreement)** and any amendments describe the health coverage of **L.A. Care Individual Conversion Plan"** and constitute the legally binding contract between **L.A. Care** and you (member)**.**

The term of this Agreement begins when you, the member, first elect Conversion coverage.

The Evidence of Coverage is also called the Member Handbook. The Member Handbook tells you how to get health care. It also has the terms and conditions of your health *benefits* coverage. You should read the Member Handbook completely and carefully.

If you have special health needs, you should read the sections that apply to you.

This Member Handbook and the Summary of Benefits Section are only a summary of **L.A. Care** policies and rules. Call **L.A. Care** if you have questions about covered services or specific provisions.

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: Toll-Free 1-888-839-9909
TTY Service: 1-866-LACARE (1-866-522-2731)

www.lacare.org

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

WELCOME TO L.A. Care

Thank you for choosing health care coverage with **L.A. Care**. Please review the information in this guidebook carefully. The information will help you use the Plan's medical services effectively.

Your medical care will be provided by qualified, health care professionals in one of our doctor offices, clinics or hospitals. Your Primary Care Provider will work with other doctors in all major specialties, pharmacists, nurses and other health professionals to assure that you receive the best health care.

If you have any questions or comments about **L.A. Care** or would like additional information about **Conversion *Plan*** health care benefits, please contact a Plan Representative at the clinic/doctor office where you have chosen to receive your medical care (refer to the **L.A. Care** Provider Directory), or you may write or call us at:

L.A. Care Health Plan
Member Services
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
1-888-839-9909
TTY Service: 1-866-LACARE1 (1-866-522-2731)

Along with this Member Handbook you should have received a **L.A. Care** identification (ID) card. The *provider directory* may be obtained by mail by contacting **L.A. Care's** Member Services Department or printed online through the internet at www.lacare.org

We will be glad to answer your questions and listen to your comments.

YOUR RIGHTS AND RESPONSIBILITIES

Member Rights

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

Respectful and courteous treatment. You have the right to be treated with respect, dignity and courtesy from your health plan's providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about your care.

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

Choice and involvement in your care. You have the right to receive information about your health plan and its services. You have the right to choose your Primary Care Physician (doctor) from the doctors and clinics listed in your health plan's provider directory. You also have the right to get appointments within a reasonable amount of time. You have a right to talk with your doctor about any care your doctor provides or recommends. You have the right to a second opinion. You have a right to information about treatment regardless of the cost or what your benefits are. You have the right to say "no" to treatment. You have a right to decide in advance how you want to be cared for in case you have a life-threatening illness or injury.

Voice your concerns. You have the right to complain about **L.A. Care**, the health plans we work with, or our providers without fear of losing your benefits. **L.A. Care** will help you with the process. If you don't agree with a decision, you have a right to ask for a review. You have a right to disenroll from your health plan whenever you want.

Service outside of your health plan's provider network. You have a right to receive emergency services as well as family planning and sexually transmitted disease services outside of your health plan's network. You have the right to receive emergency treatment whenever and wherever you need it.

Service and information in your language. You have a right to request an interpreter at no charge and not use a family member or a friend to translate for you. You have the right to get the Member Handbook and other information in another language or format.

Know your rights. You have the right to receive information about your rights and responsibilities. You can make recommendations about these rights and responsibilities.

Member Responsibilities

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

Act courteously and respectfully. You are responsible for treating your doctor and all 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 check-ups and telling your doctor about health problems before they become serious.

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.

Report wrong doing. You are responsible for reporting health care fraud or wrong doing to **L.A. Care**. You can do this without giving your name by calling the **L.A. Care** Fraud and Abuse Hotline toll-free at **1-800-400-4889**.

Confidentiality

You have the right to keep your medical records confidential. **You can request a copy of our confidentiality policy.** Just call **L.A. Care**. Also, any results from genetic testing will not be disclosed. No one may tell others about the results of your genetic tests.

Health Information Privacy

At **L.A. Care**, we value the trust you have in us. We want to keep you as a **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 and your family private, **L.A. Care**:

- Uses secure computer systems
- Handles health information the same way, every time
- Reviews the way **L.A. Care** handles health information
- Follows all laws about the privacy of health information

All **L.A. Care** staff that have access to your health information are trained on privacy laws. They also follow **L.A. Care** guidelines. They even sign a note 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 give you appropriate health care services. This information includes:

- Name
- Gender
- Date of birth
- Language you speak
- Home address
- Home or work telephone number
- Occupation and employer
- Whether you are married or single
- Health history

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

- You
- A parent, guardian, or conservator
- Another health plan
- Your doctor
- Your application for the health care program
- Your health records

Before **L.A. Care** gives your health information to another person or group, we need your written approval. There are times when we may not get your written approval. 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 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

Sometimes, **L.A. Care** may also give out some information from your employer about job performance. This information will help determine your health coverage or manage our health plan.

If you have any questions or would like to know more about your health information, please call Member Services.

HOW TO USE L.A. CARE HEALTH PLAN

Conversion Plan

Conversion Plan coverage begins at the time your COBRA/Cal-COBRA coverage or group coverage ends, but only if you apply and pay the required premium no later than 63 days after termination of your COBRA/Cal-COBRA coverage or group coverage. If eligible, you must exhaust your COBRA/Cal-COBRA coverage before you become eligible for the Conversion Plan coverage.

Eligibility Requirements

You are eligible to enroll in the Conversion Plan when your coverage under a group plan has been terminated.

- You are not eligible to enroll in the Conversion Plan if:
- You are covered by or eligible for benefits under Title 28 of the United States Social Security Act.
- You are covered by or eligible for hospital, medical or surgical benefits under state or federal law.
- You are covered by or eligible for hospital, medical or surgical benefits under any arrangements of coverage for individuals in a group, whether insured or self-insured.
- You are covered for similar benefits by an individual policy or contract.
- You have not been continuously covered during the three-month period immediately preceding your termination of coverage.

Your Identification (ID) Card

Your **L.A. Care** ID card lets people know you are our *member*. Carry your **L.A. Care** ID card with you at all times. Show your **L.A. Care** ID card when you:

- Have a doctor's appointment,
- Go to the *hospital*,
- Pick up a *prescription*, or
- Get any other medical 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.

Primary Care Physician (PCP)

A *primary care physician (PCP)* is your personal doctor. A PCP will be assigned to you upon enrollment based on:

- The language you speak.
- How far you live from the PCP's office.
- Specialty care most appropriate for a *member's* age.

He/she will make sure that you get all the health care you need. He/she will refer you to a specialist when needed. As your *PCP* learns more about you and your health, he/she can provide you with better quality care.

How to Change Your Primary Care Physician (PCP)

Choose a *PCP*
To change PCP's call **L.A. Care**.
You may change your PCP for any reason if you are not happy with the assignment. It is important that you visit your PCP regularly.

You can choose any *PCP* from the **L.A. Care** *provider directory*.

Points to remember when choosing a *PCP*.

- When you choose a *PCP* you are also choosing the specialists*, hospitals* and other health care *providers* within their *network*.
- Your *PCP* chooses from the *providers* within their *network* when referring you to needed services.
- You will be informed within 30 days if your *PCP* stops working with **L.A. Care**.

Our doctor's professional qualifications

We're proud of our doctors and their professional training. If you have questions about the professional qualifications of network doctors and specialists, call **L.A. Care**. **L.A. Care** can tell you about the medical school they attended, their residency or board certification.

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

How to Get Health Care Services

How to Get Routine Care

Regular health check-ups help you stay healthy. Routine care is when you go to your *PCP* for a regular health check-up, even when you are not sick. To get a regular health check-up you need to call and make an appointment.

Scheduling a Doctor's Appointment

Call your PCP's office.

Your *PCP's* phone number can be found on your ID card or in the *provider directory*. To request a *provider directory*, please call **L.A. Care's** Member Services Department or you may print the *provider directory* online at www.lacare.org.

.

Canceling or Rescheduling a Doctor's Appointment

Please call and let your doctor know right away if you need to cancel an appointment. By canceling your appointment you allow someone else to be seen by the doctor. If you miss your appointment, call your doctor right away to reschedule.

How to See a Specialist

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

If your *PCP* thinks it is *medically necessary* for you to see a specialist, your *PCP* will refer you.

How To See a Mental Health Specialist

Specialized mental health services are provided through Los Angeles County Department of Mental Health (LACDMH). You may receive services from LACDMH with or without a referral from your PCP. LACDMH may be reached toll-free at 1-800-854-7771. Your PCP may treat some mental health conditions.

Prior Authorizations and Referrals

Your *PCP* must approve all *health care services* before you receive them. This is called *prior authorization*. A referral is when you request *health care services* that your *PCP* does not normally provide. Some services do not require a

referral. Emergency services do not require a prior authorization. Go to the "Summary of Benefits Section" for a list of services.

There are different types of referral requests:

- Routine or Regular
- Urgent
- Emergency

After you receive a referral request, it will be reviewed and responded to as follows:

- Routine - 5 business days
- Urgent - 24 to 48 hours
- Emergency - same day

Please call **L.A. Care** if you have not received a response within the above time frames.

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

How to Get a Second Opinion

A second opinion is a visit with another qualified health care professional when:

- You question the reasonableness or necessity of the recommended surgical procedures.
- You question a *diagnosis* or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indicators are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and you request an additional diagnosis.
- The treatment is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.
- If you have attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

The second opinion must be from an *appropriately qualified health care professional* in your *network*. If there is no qualified health care professional who meets the standards, your doctor may authorize the referral to an out-of-plan provider. You have the right to ask for and to get a second opinion.

If your second opinion is approved either inside or outside of your provider network your travel to the doctor will be taken into account. If your second opinion request is approved you may be charged a copayment for similar referrals.

What do you need to do?

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

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

Step 3: Call the second opinion qualified health care professional to make an appointment.

If you have a life threatening condition, or other condition with the potential for significant negative impact on your health if not addressed immediately, a second medical opinion will be granted to you within 72 hours after the Plan's receipt of the request, whenever possible.

You can request a copy of **L.A. Care's** written second opinion policy statement by calling the Member Services.

If you do not agree with the second opinion, you may file a *grievance* with **L.A. Care**. Go to the "Grievances/Complaints and Appeals Section" for more information.

How to Get a Standing Referral

You may receive a "standing referral" to a specialist if your PCP and the specialist decide that you have a condition or disease that requires specialized medical care over a prolonged period of time.

A standing referral needs *authorization*. Once you have a standing referral, you will not need *authorization* for each visit with the specialist or *appropriately qualified health care professional*. A standing referral is made to a specialist or *appropriately qualified health care professional* who is in your *network* or who is with a contracted specialty care center. For a list of *appropriately qualified health care professionals,* call **L.A. Care**.

Your specialist or *appropriately qualified health care professional* will develop a treatment plan for you. The treatment plan will show how often you need to go to the doctor. Once the treatment plan is approved, the specialist or *appropriately qualified health care professional* will be your coordinator of care, according to the treatment plan.

Continuity of Care or How to Keep Seeing Your Doctor if Your Doctor Has Left the Plan

You will be informed if your doctor stops working with **L.A. Care**. You can ask to keep seeing your doctor, if your doctor is no longer working with **L.A. Care** and has been treating you for any of the following conditions:

- *Acute condition*
- *Serious chronic condition*
- *Terminal Illness*
- Pregnancy, including the duration of the pregnancy and immediate postpartum care
- Children, which are eligible dependents, between birth and age 36 months. Not to exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee
- Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee

If you have any of the above conditions, you can continue to get services from your doctor for 90 days (or a longer period of time, if necessary) until a safe transfer can be made.

If you are pregnant, you can continue to get services from your doctor until post partum services (healthcare six (6) weeks after delivery) are completed or until a safe transfer can be made, whichever is longer. If you have any questions, please call **L.A. Care**.

L.A. Care requires a terminated provider to accept in writing his/her previous contract terms and contract rates as set forth in their individual contracts. If the terminated provider does not agree to the terms, conditions and rates, **L.A. Care** is not obligated to continue to provide services.

If you want to complete the necessary treatment with a non-affiliated doctor, you should submit a written request to your new **L.A. Care** Primary Care Provider. Contact **L.A. Care's** Member Services at 1-888-839-9909 to obtain a copy of **L.A. Care's** Continuity of Care Policy.

Terminated Medical Groups

Should **L.A. Care** terminate its contract with a medical group or general acute care hospital to which you are assigned, you will receive at least 60 days prior written notice of the contract termination.

How to Get Emergency Care

Emergency Care includes medical screening, examination, and evaluation by a physician, or, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by a physician that is necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Medical Condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, 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 is twenty-four hour medical care that includes medical screening, examination, and evaluation by a physician, or, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by a physician that is necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Services are provided for members who present with conditions that are manifested by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention may result in placing the health of the individual or unborn child in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

Emergency Services include active labor, or labor at a time that either of the following would occur:

- Inadequate time to effect a safe transfer to another hospital prior to delivery,
- Or a transfer poses a threat to the health and safety of the member or unborn child

Emergency services also include ambulance and *mental health* services for emergency cases. **L.A. Care** covers all emergencies (this includes out-of-area emergencies or *urgently needed services*).

Examples of emergencies include:

- Hard to breathe
- Seizures (convulsions)
- Lots of bleeding
- Unconsciousness/blackouts (will not wake up)
- Severe pain (including chest pain)
- Swallowing of poison or medicine overdose
- Broken bones

What to do in an emergency:
Call 911, or go to the nearest emergency room.

After you receive emergency care:
Step 1: Follow the instructions of the emergency room doctor.

Step 2: Call your *PCP* to make an appointment for follow-up care.

Unsure if you need emergency care?
Step 1: Call your *PCP* or **L.A. Care**.

Step 2: Tell them about your condition and follow their instructions.

Urgently Needed Services are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area.

Urgently needed services includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

Do Not Use The Emergency Room For Routine Health Care Services.

How to Get Urgent Care
Urgent care is what you need 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.

For urgent care, follow these steps:
Step 1: Call your *PCP*.

Another doctor may answer your call if your *PCP* is not available. A doctor is available by phone 24 hours a day, 7 days a week.

Step 2: Tell the person who answers the phone that you are a **L.A. Care** *member.*

Step 3: Ask to speak to your *PCP* or the doctor on-call. Tell the doctor what has happened and follow his/her instructions.

Call **L.A. Care** if you cannot contact your *PCP***.**

How to Get Emergency Transportation
Emergency transportation is available to you when you have an emergency medical condition. If you are not sure if you need emergency transportation, you may call your PCP and follow her/his advice or you may call the Plan's 24-hour Nurse Advice Line at 1-800-249-3619.

Ambulances for medical emergencies are paid for by **L.A. Care**. You should seek emergency services and/or "911" services (including ambulance transportation) if you believe that a medical condition is an emergency medical condition in accordance with **L.A. Care's** definition of emergency services.

How to Get Non-Emergency Transportation
Many **L.A. Care** doctors offer non-emergency transportation. This may include litter (stretcher) and wheelchair van services to and from appointments. Please call the doctor's office or **L.A. Care** if you want help with transportation for your medical visits.

How to Get Your Prescriptions Filled

L.A. Care covers drugs specified below when prescribed by a Plan Physician (except as otherwise described under "What drugs are covered") and in accordance with our drug formulary guidelines.

L.A. Care works with *pharmacies* in many neighborhoods. You must get your prescribed drugs (s) from a *pharmacy* in **L.A. Care's** *network*. A list of **L.A.**

Care's *pharmacies* can be found in your *provider directory,* which is included in your welcome packet.

To get prescriptions filled:

Step 1: Find a *pharmacy* that accepts **L.A. Care**.

Step 2: Bring and show your *prescription* and your **L.A. Care ID Card** to the pharmacist.

What drugs are covered

L.A. Care uses a list of approved drugs called a formulary. Your doctor normally prescribes drugs from the formulary. The formulary also identifies if a drug on the list is preferred over other listed drugs. Drugs in the formulary are reviewed by a committee made up of health plan physicians and pharmacists, which meets quarterly. Drugs are selected for this list based on how effective they are in treating a condition and how safe the medication is when compared to other available medications.

Authorization for an off-label use or a use other than approved by the FDA, when prescribed by a participating physician for a life-threatening or chronic and seriously debilitating condition, will be approved if your provider provides documentation supporting medical necessity, safety and efficacy for the intended use. Drugs listed on the Drug Formulary do not guarantee that they will be prescribed by your provider. However, authorization will be provided for a non-formulary medication if your doctor demonstrates that no formulary alternative exists and the medication is medically necessary. A Prior Authorization request (PA) for a drug not on the formulary can be submitted by a provider who has the clinical expertise to make the request.

L.A. Care allows you to get the following drugs or supplies when prescribed by your doctor and *medically necessary*:

- *Prescription drugs* or supplies listed in the formulary.
- *Maintenance Supply of Generic Drugs* for the treatment of chronic conditions may be supplied by our network of contracted pharmacies: 90 day supply. Brand name drugs are not a covered benefit for maintenance medications.
- Our network of contracted pharmacies may supply *Maintenance Supply Generic Drugs* for the treatment of chronic conditions: 90 day supply.
- Diabetic supplies:

1. Blood glucose monitors and blood glucose testing strips
2. Blood glucose monitors designed to assist the visually impaired
3. Insulin pumps and all related necessary supplies
4. Ketone urine testing strips
5. Lancets and lancet puncture devices

6. Pen delivery systems for the administration of insulin
7. Podiatric devices to prevent or treat diabetes-related complications
8. Insulin syringes
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
10. Food and Drug Administration (FDA) approved contraceptive devices (including oral contraceptives and diaphragms).
11. Drugs that have potential equivalency issues (narrow therapeutic index drugs). A list is available by calling **L.A. Care** Member Services at **1-888-839-9909**.

Drugs not on the formulary
Sometimes, your doctor may need to prescribe a drug that is not on the formulary. Your doctor and/or pharmacist may call to get *authorization* from **L.A. Care.**

To decide if the non-formulary drug will be covered, **L.A. Care** may ask your doctor and/or pharmacist for more information. **L.A. Care** will reply to your doctor and/or pharmacist within 24 hours after receiving all requested medical information.

Your 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 drug is not approved, you will receive notice in writing and you have the right to appeal the decision. Go to the "Grievances/Complaints and Appeals Section" for more information.

PAYMENT RESPONSIBILITIES

Prepayment Fees

Monthly Premium Fees

The rate you pay for your coverage depends on your age, and how many family members are enrolling. Use the younger age of subscriber or spouse to determine your rate.

RATE AREA 2

Los Angeles (RATE AREA 2)
[Zip Codes]

90004-39	90230-33	90895	91077	91201-10	91775
90041-51	90245	91001	91101-10	91214	91780
90053-57	90272	91003	91114-18	91221-22	91801-04
90060	90291-96	91006-12	91121	91224-26	91896
90062-76	90301-09	91016-17	91123-26	91501-08	
90078-84	90311-12	91020-21	91129	91510	
90086-90	90401-11	91023-25	91182	91521-23	
90093-96	90623	91030-31	91184-85	91709	
90189	90630-33	91046	91188-89	91754	
90209-13	90637-39	91066	91199	91756	

Monthly Rates

L.A. Care Individual Conversion Plan Rates
Rates Effective 1/2012
Los Angeles Area (Rate Area 2)

Monthly Rates by Subscription Categories

Subscriber only

Age	Copayment $25	Age	Copayment $25	Age	Copayment $25	Age	Copayment $25
<1	751	29	591	41	700	53	826
1–18	374	30	606	42	708	54	843
19	396	31	622	43	715	55	868
20	421	32	637	44	720	56	894
21	443	33	647	45	729	57	923
22	469	34	652	46	736	58	950
23	489	35	659	47	746	59	972
24	506	36	666	48	756	60	972
25	525	37	673	49	766	61	972
26	542	38	680	50	780	62	972
27	557	39	686	51	793	63	972
28	576	40	693	52	810	64	972
						65+	1943

Monthly Rates

All South Area (RATE AREA 3)
[Zip Codes]

90001-03	90254-55	90660-62	90831-35	91740-41	
90040	90260-62	90670-71	90840	91744-50	
90052	90266-67	90701-03	90842	91755	
90058-59	90270	90706-07	90844	91759	
90061	90274-75	90710-17	90846-48	91765-73	
90091	90277-78	90723	90853	91776	
90101	90280	90731-34	91702	91778	
90103	90310	90744-49	91706	91788-93	
90201-02	90501-10	90755	91711	91795	
90220-24	90601-10	90801-10	91714-16		
90239-42	90640	90813-15	91722-24		
90247-51	90650-52	90822	91731-35		

Monthly Rates

L.A. Care Individual Conversion Plan Rates
Rates Effective 1/2012
Los Angeles Area (Rate Area 3)

Subscriber only

Age	Copayment $25	Age	Copayment $25	Age	Copayment $25	Age	Copayment $25
<1	790	30	637	43	753	56	941
1–18	394	31	654	44	759	57	970
19	416	32	671	45	766	58	999
20	443	33	680	46	775	59	1023
21	469	34	688	47	785	60	1023
22	493	35	695	48	797	61	1023
23	515	36	700	49	807	62	1023
24	533	37	708	50	821	63	1023
25	554	38	715	51	836	64	1023
26	569	39	722	52	853	65+	2045
27	586	40	731	53	870		
28	605	41	737	54	887		
29	623	42	744	55	914		

RATE AREA 4
San Fernando Area (RATE AREA 4)
[Zip Codes]

90077	91324-31	91376	91426	93243	93563
90263-65	91333-35	91380-81	91436	93510	93584
90290	91337	91383-87	91470	93532	93586
91040-43	91340-46	91390	91482	93534-36	93590-91
91301-11	91350-62	91392-96	91495-96	93539	93599
91313	91364-65	91401-13	91499	93543-44	
91316	91367	91416	91601-12	93550-53	
91321-22	91371-72	91423	91614-18	93560	

Monthly Rates

L.A. Care Individual Conversion Plan Rates
Rates Effective 1/2012
Los Angeles Area (Rate Area 4)

Subscriber only

Age	Copayment $25	Age	Copayment $25	Age	Copayment $25	Age	Copayment $25
<1	829	29	654	41	775	53	914
1–18	414	30	669	42	782	54	931
19	436	31	688	43	788	55	960
20	467	32	703	44	799	56	991
21	493	33	714	45	805	57	1018
22	516	34	722	46	812	58	1048
23	540	35	731	47	824	59	1076
24	559	36	736	48	838	60	1076
25	581	37	742	49	848	61	1076
26	598	38	751	50	861	62	1076
27	615	39	759	51	877	63	1076
28	634	40	766	52	895	64	1076
						65+	2147

All Out of Area Enrollees (RATE AREA 7)

Rate Area 7 applies to members who live outside Rate Areas 2-4

[Zip Code]

90704

Monthly Rates

L.A. Care Individual Conversion Plan Rates
Rates Effective 1/2012
Los Angeles Area (Rate Area 7)

Monthly Rates by Subscription Categories

Subscriber only

Age	Copayment $25	Age	Copayment $25	Age	Copayment $25	Age	Copayment $25
<1	870	29	686	41	810	53	957
1–18	433	30	702	42	819	54	975
19	459	31	720	43	827	55	1006
20	489	32	737	44	836	56	1037
21	515	33	749	45	844	57	1067
22	542	34	756	46	851	58	1099
23	566	35	765	47	865	59	1127
24	586	36	771	48	875	60	1127
25	608	37	778	49	889	61	1127
26	627	38	787	50	904	62	1127
27	646	39	795	51	918	63	1127
28	666	40	804	52	938	64	1127
						65+	2249

Subscriber Liabilities

1. By statute and contract with providers, you will not be held liable for payment of Plan-referred services to any provider contracted with the Plan in the event that **L.A. Care** fails to pay the provider.

2. You are responsible for your share of monthly premiums and co-payments, if any.

3. Co-payments for Covered Services provided to you are to be paid at the time services are rendered or within 30 days after you receive notice from **L.A. Care**.

4. **L.A. Care** will reimburse non-Plan providers for authorized services and emergency care only. You may be financially responsible for payment for unauthorized, non-emergent services.

5. **L.A. Care** payments to network providers constitute payment in full for health care services rendered.

6. **L.A. Care** does not delegate its lien rights to contract providers.

HEALTH PLAN BENEFIT SUMMARY

Your *PCP* must arrange and *authorize* all your care before you receive services. All *health care services* are reviewed, approved or denied according to *medical necessity*.

There are some services your *PCP* does not need to arrange and *authorize*. These services include:

- Confidential HIV testing
- Emergency services
- *Family planning services*
- *Members* who receive certain Obstetrical/Gynecological (OB/GYN) services (includes pregnancy-related services). Just call an OB/GYN doctor who is in the same *network* as your *PCP* to make an appointment. Go to the "OB/GYN Section" for more information.
- Native American Indian *members* who receive health care from Indian Health Centers or a Native American Health Clinic
- Sexually Transmitted Disease (STD) services
- Women, Infant and Children (WIC) services

Services
The services listed below are subject to all terms, conditions, limits, and exclusions described in the Member Handbook. This is not a complete list.

Alcohol/Drug Abuse
Crisis services are covered. Call **L.A. Care** for more information or for a referral.

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 be for a *curative* reason, and approved by one of the following:

1. National Institute of Health (NIH)
2. Food and Drug Administration (FDA)
3. U.S. Department of Defense
4. U.S. Veteran's Administration

If you are part of an approved cancer *clinical trial*, most common services will be covered.

Cancer Screening
L.A. Care provides coverage for all generally medically accepted cancer-screening tests

Cervical Cancer Screening Test

If you are referred by your Primary Care Physician (PCP) or treating provider, you may get any other Cervical Cancer Screening test that is approved by the Food and Drug Administration (FDA), in addition to the usual annual Pap Smear Test.

Human Papillomavirus Screening Test and Vaccine
The Human Papillomavirus (HPV) Screening Test for cervical cancer is approved by the Food and Drug Administration. This 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 information on receiving this service, speak to your **L.A. Care** primary care provider.

Confidential HIV Testing
You do not need prior *authorization* from your *PCP* for confidential HIV testing. A list of sensitive services is available. Please call **L.A. Care** to request a copy. You can get confidential HIV testing from the following:

- Los Angeles County Department of Health Services
- *Family planning services providers*
- *PCP*
- Prenatal clinics

Diabetic Services
The following services are covered for diabetics when *medically necessary*:

- Blood glucose monitors and blood glucose testing strips
- *Blood glucose monitors designed to assist the visually impaired*
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Pen delivery systems for the administration of insulin
- Podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Insulin
- Prescriptive medications for treatment of diabetes
- Glucagon
- Training and education for self-management
- Family education for self-management

Doctor Office Visits
All visits, exams, treatments and shots are provided by your *PCP*.

Drugs /Medications
Prescription drugs on the **L.A. Care** formulary are covered. Go to the "How To Get Your Prescriptions Filled Section" for more information.

Durable Medical Equipment (DME)
DME is medical equipment that is used repeatedly by a person who is ill or injured. Examples include:

- Apnea monitors
- Blood glucose monitors
- Insulin pumps and related necessary supplies
- Nebulizer machines
- *Orthotics*
- Ostomy bags
- Oxygen and oxygen equipment
- *Prosthesis*
- Pulmo-Aides and related supplies
- Spacer devices for metered dose inhalers
- Tubing and related supplies
- Urinary catheters and related supplies
- Podiatric devices to prevent or treat diabetes-related complications
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

Medically necessary DME is provided when ordered by your *PCP*.

Emergency Services
Emergency Services is twenty-four hour medical care that includes medical screening, examination, and evaluation by a physician, or, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by a physician that is necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Services are provided for members who present with conditions that are manifested by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention may result in placing the health of the individual or unborn child in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

Family Planning

You may receive *family planning services* and FDA approved contraceptives from any health care *provider* licensed to provide these services. Family planning *providers* include, but are not limited to:

- Clinics
- Nurses/midwifes
- OB/GYN services
- *PCPs*
- Planned Parenthood locations

Family planning services also include counseling and surgical procedures for the termination of pregnancy (abortion). You may need *authorization* for these services. Please call **L.A. Care**.

You have the right to receive *family planning services* and choose a doctor or clinic not with **L.A. Care.** You do not need *authorization* from your *PCP*. A list of family planning clinics is available. Please call **L.A. Care** to ask for a copy.

Some *hospitals* and other *providers* may not provide one or more of the following services that may be covered under your plan contract and that you might need:

- *Family planning services*;
- Contraceptive services, including emergency contraceptives;
- Sterilization, including tubal ligation at the time of labor and delivery; or
- Abortion.

If you want more information, call your doctor, *medical group*, independent practice association (IPA), or clinic. You can also call **L.A. Care** to ensure that you can obtain the *health care services* that you need.

The *Department of Health Care Services (DHCS)* Office of Family Planning can also answer any questions or give you a referral for *family planning services*. You may reach them at 1-800-942-1054.

Health Education
Health education services:

- Promote healthy living
- Prevent diseases
- Help manage *chronic* diseases (such as asthma, diabetes and heart disease)

You can learn about health education services through:

- Classes

- Counseling
- Support groups

Diabetic self-management education programs are available. Go to Diabetic Services found in this "Summary of Benefits Section."

Ask your *PCP* for health education materials and classes. You can also call **L.A. Care**.

Home Health
Medically necessary home health services are provided when ordered by your *PCP*.

Hospice Care
Medically necessary *hospice* care is provided when ordered by your PCP. The *hospice* services prescribed by your PCP include: 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, and short-term inpatient care for pain control and symptom management. The benefit may include homemaker services, services of volunteers, and short-term inpatient respite care.

Limitations: The *hospice* benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of (1) year or less and who elect *hospice* care for such illness instead of the restorative services covered by the Plan. *Medically necessary hospice* care is provided when ordered by your *PCP*.

Hospital Care
Medically necessary hospital care is provided and includes, but is not limited to:

- *Inpatient* services
- Intensive care
- *Outpatient* services

Interpreter Services
An interpreter is a person who translates orally what is said in one language to another language. This allows persons of different languages to speak with each other and understand each other. **L.A. Care** provides free interpreter services for those members who speak a different language than their health care provider. You do not need to use your family members or friends to interpret for you. You have the right to file a grievance with **L.A. Care** if you do not receive your services in the language you request. We will work with you and your Primary Care Physician (PCP) to make sure that you can have services that you understand. Interpreter services in your language are available 24 hours a day, 7 days a week. If you have questions, please call **L.A. Care** or your *PCP***.**

Lab Services
These services (such as blood work, urine tests, and throat cultures) will be provided when ordered by your doctor, at a *network or out-of-network offices and facilities for emergency services and/or out-of-area urgent services:*

- Doctor's office
- *Hospital*
- Laboratory

Mastectomy
Mastectomy is a surgery to remove a breast, due to cancer. After a mastectomy **L.A. Care** covers *prostheses* and reconstructive surgery. Go to Reconstructive Surgery found in this "Summary of Benefits Section."

As *medically necessary* you and your doctor can decide how long you need to stay in the *hospital* after the surgery.

Maternity Care
Maternity care includes:

- Regular doctor visits during your pregnancy (prenatal)
- *Diagnostic* and genetic testing
- Nutrition counseling
- Labor and delivery
- Health care 6 weeks after delivery (postpartum)

Call your doctor right away if you think you are pregnant. It is important to receive care right away and during your pregnancy.

You can choose your maternity care doctor from a doctor in your *network*. Ask your *PCP* for more information. You can also call **L.A. Care**.
You have the right to stay in the *hospital* for at least 48 hours for a vaginal delivery. You have the right to stay in the *hospital* for at least 96 hours for a cesarean section.

After giving birth, you will receive breast-feeding education and special equipment, if needed. Ask your doctor, or call **L.A. Care** if you have any questions**.**

Go to the "Women, Infants, and Children (WIC) Program Section" for information about nutrition and food stamps.

Mental Health Services
Mental health benefits will be provided on the same basis as other illnesses. These benefits include:

- Outpatient services
- Inpatient hospital services
- Partial hospitalization services and prescription drugs

Outpatient and inpatient mental health services are covered benefits as follows:

- Inpatient and outpatient benefits for Serious Emotional Disturbances (SED) of children are unlimited.
- Inpatient and outpatient benefits for Severe Mental Illnesses are unlimited for members of all ages.
- Outpatient Mental Health Services (non – SED/SMI) visits are limited to 20 visits per year.
- Inpatient Mental Health Services (non – SED/SMI) are limited to 30 days per benefit year for treatment of acute phase of mental health conditions during a certified confinement in a Plan hospital.

SMI includes:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder shall include:
    - Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders –IV-Text revisions
- Anorexia nervosa
- Bulimia nervosa

SED is a mental condition in minors under the age of 18 years 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 which results in behavior inappropriate to the child's age according to expected developmental norms, and who meets the criteria in paragraph (2) of subdivisions (a) of Section 5600.3 of the Welfare and Institutions Code.

Military Disabilities

We will coordinate services with military connected disabilities for which facilities are reasonably available to members.

Newborn

L.A. Care will not cover your new baby after 31 days from birth unless your dependents were eligible for coverage under your prior group contract. If your newborn is not eligible for dependent coverage, contact the DPSS toll-free at 1-877-481-1044 to *enroll* your baby in *Medi-Cal and/or Healthy Families Program*.

An **L.A. Care** doctor in your *network* should see your baby within the first 2 weeks of birth.

Newborn screenings for certain treatable genetic disorders are covered. These genetic disorders include:

- Phenylketonuria (PKU)
- Galactosemia
- Hypothyroidism
- Sickle cell disease
- Related hemoglobinopathies.

Treatment of PKU includes medically prescribed formulas and special food products. PKU cases are followed by a health care professional who consults with a doctor specializing in PKU related diseases.

Non-Physician Health Care Practitioners
You are always assigned to a PCP; however, you may also receive services from a non-physician health care practitioner, if available, under the oversight of a supervising physician. A non-physician health care practitioner can be a nurse-midwife, a certified nurse practitioner or a physician's assistant that works in your *PCP's* clinic. You do not need prior *authorization*. For more information ask your *PCP* or call **L.A. Care.**

Obstetrics/Gynecologist (OB/GYN)
You do not need prior *authorization* from your *PCP* or **L.A. Care** to see an OB/GYN doctor that works in your *network*. Please call **L.A. Care** if you have any questions.

Nurse Advice Line
What is the Nurse Advice Line?
It is a telephone-based service available to all **L.A. Care** members. You can call them at any time when you have a health question. Caring registered nurses are on hand to answer your questions and help you make good health care choices.

Benefits of using the Nurse Advice Line:
- Get FREE professional help
- Phone line open 24 hours a day, 7 days a week
- No extra out-of-pocket fees
- Avoid needless time and travel

Do you have to call before going to the emergency room or doctor's office?
No. You don't need to call before getting care.

When you call the number, the nurse will ask you some questions. They can help decide if you need to see the doctor right away. Or, they can tell you what you can do at home to feel better. If you find that you don't need to get care right away, you will save

the cost of your co-payment, plus any other out-of-pocket fees. The nurse will make sure that you and your family get the best care you need.

Other features of the Nurse Advice Line:

- Audio Health Library
  This feature has more than 1100 pre-recorded health messages. You can call to get information on health topics and recipes that are good for your health.
- Informed Decision Support
  This feature will give in-depth counseling and decision support to members. This way, members can make good care choices.
- Navigation Service
  This service will give members referrals at the end of the advice line call if needed. Referrals can be made to other programs like disease management and behavioral health.

Nurse Advice Line:
1-800-249--3619

Prenatal Care
Go to Maternity Care found in this ″Summary of Benefits Section″.

Reconstructive Surgery
Reconstructive surgery repairs abnormal body parts, improves body function, or brings back a normal look. Reconstructive surgery is covered when *medically necessary.* Reconstructive surgery is provided, when requested by your treating *PCP* or surgeon and *authorized* by **L.A. Care**. **L.A. Care** will periodically review for continued medical necessity.

Sexually Transmitted Disease (STD) Services
STD services include:

- Preventive care
- Screening
- Testing
- *Diagnosis*
- Counseling
- Treatment
- Follow-up

You have the right to receive STD services from any doctor or clinic**.** You do not need prior *authorization* from your *PCP*.

Skilled Nursing Facility
Medically necessary care in a *skilled nursing facility* is provided when ordered by your *PCP*. **Therapy – Occupational, Physical and Speech**

Medically necessary occupational, physical, and speech therapy are provided, when ordered by your treating physician and *authorized* by **L.A. Care**. For treatment of acute conditions or the acute phase of chronic conditions if such conditions are medically necessary.

For information about vision care coverage call **L.A. Care.**

X-ray Services
These services will be provided when ordered by your doctor at a *network or an out-of-network facility for emergency or out-of-area urgent services*:

- Doctor's office
- *Hospital*
- Laboratory

2012 L.A. Care Health Plan Benefits Summary Matrix for Conversion Product

SUMMARY OF COVERED BENEFITS

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available on the plan's or insurer's site.

Plan Name	Plan Contact Name and Telephone Number
L.A. Care	Member Service Call Center 1-888-839-9909

Coverage Summary

Eligibility requirements	An employee or member whose coverage under a group contract has been terminated by an employer who is eligible for individual conversion coverage. Such coverage is not required to be offered under the circumstances (*1)
The premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of the subscriber.
When and under what circumstances benefits cease	Benefits cease due to: • Fraud • Loss of eligibility (*****5) • Failure to pay premiums or partial payment of premiums • Member may terminate by written notice to plan • Discontinuation of a product Benefits terminate as follows: • Fraud–upon receipt of notice • Loss of eligibility–the last day of the month in which you are no longer eligible • Failure to pay premium due–on the 30th day after the date of the Late Notice • Voluntary termination by member–the first of the month following adequate notice to plan
The terms under which coverage may be renewed	New sales are issued throughout the calendar year. All accounts renew annually.
Other coverage that may be available if benefits under the described benefit package cease	Not Applicable.
The circumstances under which choice in the selection of physicians	Members are encouraged to choose a primary care Plan physician from a list of available Plan physicians in the following specialties: internal medicine, obstetrics/gynecology, family medicine, and pediatrics. Members

and providers is permitted	may change their primary care Plan physician at any time.
Lifetime and annual maximums	Lifetime maximum: None Annual out-of pocket maximum: $2,500
Deductibles	None

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
Professional Services	Most primary and specialty care consultations, exams, and treatment	$25 per visit	
	Routine physical maintenance exams	No charge	
	Well-child preventive care exams (through age 23 months)	No charge	
	Family planning counseling	No charge	
	Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge	
	Eye exams for refraction	No charge	
	Hearing exams	No charge	
	Urgent care consultations, exams and treatment	$25 per visit	
	Physical, occupational, and speech therapy	$25 per visit	
Outpatient Services	Outpatient surgery and certain other outpatient procedures	$100 per procedure	
	Allergy injections (including allergy serum)	$5 per visit	
	Most immunizations (including vaccines)	No charge	
	Most X-rays and laboratory tests	$10 per encounter	
	Preventive X-rays, screenings, and laboratory tests as described in the “Health Plan Benefit Summary” section	No charge	

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
	MRI, most CT, and PET scans Health education Covered individual health education counseling and programs Covered group health education programs	$50 per encounter No charge No charge	
Hospitalization Services	Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$200 per day	
Emergency Health	Emergency Department visits	$100 per visit	This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered services.
Ambulance Services	Ambulance services	$100 per trip	

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
Prescription Drug Benefits	Covered outpatient items in accord with our drug formulary guidelines: Most generic items at a Plan Pharmacy Most generic refills through our mail-order service Most brand-name items at a Plan Pharmacy Most brand-name refills through our mail-order service	 $10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply $10 for up to a 30-day supply or $20 for a 31- to 100-day supply $35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply $35 for up to 30-day supply or $70 for a 31- to 100-day supply	
Durable Medical Equipment	The durable medical equipment for home use listed in the "Health Plan Benefit Summary" section is in accord with our durable medical equipment formulary guidelines (most durable medical equipment is not covered)	20% Coinsurance	

Mental Health Services	Inpatient psychiatric hospitalization (up to 30 day per calendar year) Outpatient mental health services evaluation and treatment: Up to a total of 20 individual and group visits per calendar year that include services for mental health evaluation treatment Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$200 per day $25 per individual visit $12 per group visit $12 per visit	Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses
Residential Treatment	Transitional residential recovery services	$100 per admission	Up to 60 days per calendar year, not to exceed 120 days in any five-year period
Chemical Dependency Services	Inpatient detoxification Individual outpatient chemical dependency evaluation and treatment Group outpatient chemical dependency treatment	$200 per day $25 per visit $5 per visit	
Home Health Services	Home health care	No charge	Part-time or intermittent home health covered up to: • Up to 2 hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist and up to 4 hours per visit for visits by a home health aide • Up to 3 visits per day • Up to 100 visits per calendar year

Custodial Care and Skilled Nursing Facilities	**Skilled Nursing Facility Care** Custodial care	No charge Not covered	Up to 100 days per benefit period
Other	The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the "Health Plan Benefit Summary" section (most external prosthetic and orthotic devices are not covered) Hospice care (****4)	No charge No charge	

(*1)
(a) the group contract terminated and is replaced with similar coverage under another contract within 15 days of the date of termination of group coverage or the subscriber's participation;
(b) coverage was terminated because the employee or member failed to pay amounts due the plan;
(c) the employee or member was terminated for cause as set forth in its evidence of coverage;
(d) the employee or member intentionally furnished incorrect information or otherwise improperly obtained benefits of the plan;
(e) the employer's insurance coverage is self-insured;
(f) the employee or member is covered by or eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
(g) the employee or member is covered for similar benefits under an individual contract or policy;
(h) the person has not been continuously covered during the 3 month period immediately preceding that person's termination of coverage.

(**2) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

(***3) Percentage co-payments present a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate. In a PPO, percentage co-payments for non-emergency services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges whichever is less, and enrollees are also responsible for any excess amount.

(****4) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.

(*****5) Once enrolled in Conversion Plan, an enrollee who subsequently becomes eligible for Medicare does not lose his/her eligibility to remain enrolled in Conversion Plan coverage.

Annual Out-of-Pocket Maximum
There are limits to the total amount of Copayments you must pay in a calendar year for certain Services covered under this *Agreement*. Those limits are:

- $2,500 for one Member
- $5,000 for an entire family unit

Copayments for only the following covered services apply toward these limits:

- Ambulance Services
- Amino acid-modified products used to treat congenital errors of amino acid metabolism
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care, except that for mental health hospital care, the only care that counts is care for these mental health conditions:
- Serious Emotional Disturbances (SED) of a child described under "Mental Health Services" in the "Benefits" section
- These severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa)
- Imaging, laboratory, and special procedures
- Office visits (including professional Services such as dialysis treatment and health education). However, chemical dependency and chiropractic office visits do not count toward the maximum, and for mental health visits, the only visits that count are visits for these mental health conditions:

    - Serious Emotional Disturbances (SED) of a child described under "Mental Health Services" in the "Benefits" section
    - These severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa

- Outpatient surgery
- Podiatric devices to prevent or treat diabetes-related complications
- Professional Services
- Prostheses and lymphedema wraps needed after a medically necessary mastectomy
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx

When you pay a Copayment for these services, ask for and keep the receipt. When the receipts add up to the annual Copayment limit, you can stop making Copayments. You should photocopy the receipts and send then original receipts to:

L.A. Care Health Plan
Member Services Department-Co-Pay Refund Request
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

The Plan will provide you with a "Copayment Certification" letter, which will verify that you are no longer required to make Copayments for the remainder of the benefit year. Keep the "Copayment Certification" letter with you whenever you obtain care and show it whenever you are asked about paying a Copayment. If you need assistance with a Copayment problem, contact your Primary Care Provider or the Member Services toll free at **1-888-839-9909** (***TTY 1-866-522-2731***).

SUMMARY OF COVERAGE EXCLUSIONS

- Acupuncture
- Biofeedback
- Chiropractic Services
- Conception by Artificial Means
- Contraceptive/Devices that do not require a prescription (unless deemed medically necessary by Plan physician)
- Convenience Items (ie, TVs, telephones, etc.)
- Cosmetic Services (i.e., surgery that is performed to alter or reshape normal structures of the body in order to improve appearance
- Custodial Care
- Routine Dental Services
- Experimental or Investigational Service/Supplies (Go to External Independent Review section for more information)
- Hearing Aids/Services
- Home/Vehicle Improvements
- Implants (except those deemed medically necessary)
- 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, gamete interfallopian transfer or other forms 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
- Obesity (treatment of except when deemed medically necessary by Plan physician)
- Orthopedic Devices/Other Supplies: except as provided under Orthotics and Prosthetics
- Over the Counter Drugs, Supplies, Devices
- Penile Implant Devices
- Physical Exams and Immunizations for Employment, Travel, etc. (unless the exam corresponds to the schedule of routine physical exams provided in preventive health services)
- Podiatry Services (other than diabetic foot care)
- Private Duty Nursing
- Sexual Reassignment Surgeries
- Sexual Dysfunction incident to non-physically related sexual dysfunction except as medically necessary
- Transportation (other than that provided under ambulance services)
- Vasectomy and Tubal Ligation Reversals
- Vision Care (not covered: eye glasses, contact lenses, routine eye exams except when provided as part of routine exam under preventive care)
- Workers' Compensation Benefits or other Liability

If you have questions about what is covered, please call **L.A. Care**.

SPECIAL SERVICES

Special Services for Children

California Children Services (CCS)

CCS is open to persons under the age of 21 with a *disability*. If your child has a *chronic* medical illness, he/she may be *eligible* for services under CCS. Talk to your child's *PCP* about CCS. Should your child be ineligible for CCS services or CCS fails to provide otherwise covered services, **L.A. Care** will provide coverage for covered services.

Child Health and Disability Prevention (CHDP)

Your child may receive CHDP through your child's local school. You may call CHDP at (323) 890-7941, if you have any questions.

Special Services for Native American Indians

Native American Indians have the right to receive health care services at Indian Health Centers and Native American Health Clinics. You do not need to disenroll from **L.A. Care** to get health care services from an Indian Health Center or Native American Health Clinic. You may also disenroll from **L.A. Care** any time and for any reason. Please call Indian Health Services at 1-916-930-3927 for more information. You may visit the Indian Health Services website at www.ihs.gov for more information. American Indians can access medical services from Indian Health Clinics without prior referral from Primary Care Providers

Women, Infants and Children (WIC) Program

The Women, Infants and Children (WIC) Supplemental Nutrition Program gives pregnant women, new mothers, and their babies nutrition information and food stamps. Ask your doctor or maternity nurse for more information about WIC. You may call WIC directly at 1-888-942-2229 or 1-888-WIC-Baby.

Federally Qualified Health Centers (FQHCs)

FQHCs are health centers that receive money from the federal government. FQHCs are located in areas that do not have a lot of *health care services*. As a *member* of **L.A. Care**, you have the right to receive your health care at a FQHC that is contracted with **L.A. Care**. Call **L.A. Care** for the names and addresses of the FQHCs that contract with **L.A. Care**.

GRIEVANCES/ COMPLAINTS AND APPEALS

Grievances/Appeals
L.A. Care is interested in resolving any problems you may have with the services you receive.

We encourage you to first speak with your doctor and to work with your PCP to solve your grievance. But, if you are unhappy you may always write, visit, or call **L.A. Care** at the address below. You may also file a grievance on-line through **L.A. Care's** Web Site at www.lacare.org.

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Toll free: 1-888-839-9909
TTY Service: 1-866-LACARE1 (1-866-522-2731)
www.lacare.org

Non-Urgent Grievance
L.A. Care will send you an acknowledgment letter within five (5) calendar days of getting your grievance. Your grievance will be resolved within 30 calendar days after it has been received by **L.A. Care**.

Urgent Grievance
An urgent grievance is when you are not happy with a health care service you received and feel that any delay with a decision can lead to a life-threatening or debilitating condition. An urgent grievance will be resolved within three (3) calendar days after it has been received by **L.A. Care**. **L.A. Care** will send you an acknowledgment letter within 24 hours of receiving your grievance.

If you are not happy with the outcome of your grievance, you can appeal that decision to the Department of Managed Health Care (DMHC).

Appeals to the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against your Health Plan, you should first telephone your Health Plan at (**1-888-839-9909**) and use your Health Plan's grievance process before contacting the Department.

Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 calendar days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet Web Site http://www.hmohelp.ca.gov has complaint forms IMR application forms and instructions online."

Independent Medical Review

Independent Medical Review (IMR)

The Independent Medical Review (IMR) is another appeal process that you may use if you believe a health care service should not have been denied, changed, or delayed by **L.A. Care**. You have up to six (6) months from the date of denial to file an IMR. You must first go through the **L.A. Care** grievance process, before applying for an IMR. In an urgent situation, you may file for an IMR with DMHC within a shorter time period.

There are no fees for an IMR. You have the right to give information in support of 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 any statutory right to pursue legal action against **L.A. Care.**

The IMR is filed with the Department of Managed Health Care (DMHC). You will receive information on how to file an IMR with your denial letter. You may reach the DMHC at toll-free **1-888-HMO-2219** or **1-888-466-2219.**

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

1. a) Your doctor has recommended a health care service as *medically necessary* and it was denied; or
   b) You have received *urgent* care or *emergency* services that a *PCP* determined was necessary and payment was denied; or
   c) You have been seen by a *network* doctor or a PCP for the *diagnosis* or treatment of the medical condition for which you seek independent review (even if the health care service was not recommended by a network *provider*).

2. The *disputed health care service* has been denied, changed, or delayed by **L.A. Care.** Care based in whole or in part on a decision that the health care service is not *medically necessary*.

3. You have filed a *grievance* with **L.A. Care** and the service is still denied, modified, delayed, or the *grievance* remains unresolved after 30 calendar days.

The dispute will be submitted to a DMHC medical specialist if it is *eligible* for an IMR. The specialist will make a decision as to whether the requested treatment is or is not likely to be more beneficial than any available standard therapy. You will receive a copy of the IMR decision from the DMHC. If it is decided that the service is *medically necessary*, **L.A. Care** will provide the health care service.

If your grievance requires an expedited review, you do not have to participate in **L.A. Care's** grievance process for more than three (3) calendar days.

If there is an imminent and serious threat to your health as your information is reviewed by an independent medical review organization (within 24 hours of approval of request review) the DMHC may waive the requirement that you follow **L.A. Care's** grievance process.

NON-URGENT CASES
The IMR decision will be made within 30 calendar days. The 30 calendar days is counted from the time your application and documents are received by the DMHC.

URGENT CASES
If your *grievance* is *urgent* and requires fast (expedited) review you may contact the DMHC right away. You will not be required to remain in **L.A. Care's** *grievance* process for more than three (3) calendar days.

The urgent IMR decision will be made within three (3) calendar days from the time your information was received. Urgent cases include, but are not limited to:

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

If a medical service, treatment, drug, or device is denied because it is experimental or investigational, you will be informed of:

- the decision in writing within 5 business days from the decision to deny coverage; AND
- your right to file an Independent Medical Review for Experimental or Investigational Therapies (IMR-EIT)

IMRs for Experimental or Investigational Therapies (IMR-EIT)
You are not required to submit a grievance with **L.A. Care** before requesting an IMR-EIT through the Department of Managed Health Care (DMHC).
You can request an IMR-EIT through the DMHC when a medical service, drug or equipment is denied because it is *experimental or investigational* in nature. You have up to 6 months from the date of denial to file an IMR-EIT. You may provide information to the IMR-EIT panel. If your Primary Care Provider determines that the requested therapy is greatly less effective if not promptly initiated, you will receive a decision within seven (7) calendar days of the request for an expedited review. In urgent cases the

IMR-EIT panel will give you a decision within three (3) business days from the time your information is received.

The IMR-EIT is filed with the Department of Managed Health Care (DMHC). You will receive information on how to file an IMR-EIT with your denial letter. You may reach the DMHC at toll-free **1-888-HMO-2219** or **1-888-466-2219.**

When to file an IMR-EIT:

You may file an IMR-EIT, if you meet all of the following requirements:
1. Have a very serious condition (*life-threatening* or seriously *debilitating*)
2. Your doctor must certify that:
   - The standard treatments were not effective; or
   - The standard treatments were not medically appropriate; or
   - The proposed treatment will be the most effective.
3. Your doctor certifies in writing that:
   - A drug, device, procedure, or other therapy is likely to work better than the standard treatment; or
   - You or your doctor may request a therapy which, based on two medical and scientific documents, is likely to work better than the standard treatment.
4. You have been denied a drug, device, procedure, or other therapy requested by your doctor.
5. The drug, device, procedure or other therapy normally would be covered as a benefit, but **L.A. Care** has determined that it is experimental or investigational in nature.

The dispute will be submitted to a DMHC medical specialist if it is *eligible* for an IMR-EIT. The specialist will make a decision as to whether the requested treatment is or is not likely to be more beneficial than any available standard therapy. You will receive a copy of the IMR-EIT decision from the DMHC. If it is decided that the service is *medically necessary*, **L.A. Care** will provide the health care service.

For more information or help with the IMR-EIT process, or to request an application form, please call **L.A. Care**.

Arbitration

1. By enrolling in **L.A. Care**, all Members agree to submit any and all disputes and claims (including malpractice claims) between the Member (or any person submitting a dispute or claim on behalf of the Member) and **L.A. Care** and **L.A. Care's** medical providers to binding neutral arbitration, rather than being heard before a court or jury. This means that both **L.A. Care** and the Member agree to forego rights to jury or court trial.

2. The arbitration costs will be shared equally by the Member and the parties (**L.A. Care**, **L.A. Care's** medical providers) involved with the Member's claim or dispute, unless the Member is unable to pay his/her share of the costs of the neutral arbitrator's fees.

3. Any arbitration proceeding will be held under the Commercial Rules of the American Arbitration Association. Copies of the current rules and details of the format and information required for an arbitration demand may be obtained by writing to **L.A. Care** Member Services Department at 1055 West 7th Street, 10th Floor, Los Angeles, CA 90017, or call **L.A. Care** Member Services at **1-888-839-9909**.

DISENROLLMENTS

Enrollees will receive prompt, prior written notification of cancellation of enrollment at least 15 days prior to the effective date of the cancellation of coverage.

L.A. Care managed care coverage for *members* will end if any of the following has occurred:

- Fraud
- Loss of eligibility
- Failure to pay premiums
- Failure to make only partial of premiums due
- Nonpayment of any amounts due the Plan, Plan hospitals, a medical group or copayment due to a plan provider
- Plan hospitals, a medical group or copayment due a plan provider

You will receive at least 15 days prior written notice that you must either pay and/or make arrangements for payment within such time or your coverage will be cancelled.

If you are cancelled for non-payment of premium, your coverage will be renewed as if it had never been cancelled if payment is receive on or before the due date of your next monthly premium payment.

Mandatory *members* will be *involuntarily disenrolled* from **L.A. Care** if any of the following has occurred:

- You allow someone else to use your **L.A. Care** ID card
- Your behavior is abusive or disruptive to the extent that it threatens the safety of employees, providers, members and/or patients
- Your repeated behavior substantially impairs the plan's ability to furnish or arrange services for you or other members or a provider's ability to provide services to other patients.

If you are *disenrolled* from **L.A. Care** we will send you a letter that says when your coverage will end and why. You may file an appeal with **L.A. Care.** Go to the "Grievances/Complaints and Appeals Section" for more information. You may also ask for a review from DMHC. Call **L.A. Care** for more information.

TERMINATION OF BENEFITS

Termination for Cause
If your membership terminates, all rights to benefits end at 12:00 a.m. on the termination date (for example, if your termination date is January 1, 2004, your last moment of coverage was at 11:59 p.m. on December 31, 2003). You will be billed as a non-Member for any Services you receive after your membership terminates. When your membership terminates under this section, Health Plan and Plan Providers have no further liability or responsibility under this *Agreement,* except as provided under "Payments after Termination" in this "Termination of Membership" section.

How you May Terminate your Membership
You may terminate your Individual Conversion Plan membership by sending written notice to the address below (the notice must be signed by the Subscriber). If we receive your notice on or before the last day of the month, your termination date will be the first of the following month. For example, if we received your notice on December 31, 2003, your last moment of coverage was at 11:59 p.m. on December 31, 2003 and your termination date was January 1, 2004. Also, you must include with your notice all amounts payable related to this *Agreement*, including Dues, for the period prior to the termination effective date.

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

L.A. Care managed care coverage will terminate if any of the following has occurred:

- The Member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan.
- Loss of eligibility the last day of the month in which you are no longer eligible.
- Failure to pay the entire premium (individual premium and/or family premium) due 15 days after the date of mailing of the prior written notification of cancellation of enrollment notice.
- Non-payment of other charges at least 15 days after receipt of written notice
- Voluntary termination by member the first of the month following adequate notice to plan.
- The member was terminated by **L.A. Care** from the Individual Conversion Plan for good cause.
- The employer's hospital, medical or surgical expense benefit program is self-insured.

Your Primary Care Provider will assist you in obtaining alternative coverage to ensure continuity of care if you become disenrolled due to non-payment of premiums or periodic charges while hospitalized or while receiving treatment for an ongoing medical condition. You will be notified in writing of the effective date of disenrollment. Benefits shall cease as of 12:00 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 by the Director of the Department of Managed Health Care of such cancellation.

MORE INFORMATION: WHAT ELSE DO I NEED TO KNOW?

If You Move
When you move it is important to call the following people:

- Call **L.A. Care.** You will need to update your information (address and phone number). This allows **L.A. Care** to send you your ID Card and important information about your health care *benefits*.

If You Get a Bill
L.A. Care pays for all covered medical costs approved by your *PCP* or for an emergency. You should not receive a bill for any services covered by **L.A. Care.** Please call **L.A. Care** if you receive a bill for medical services.

If You Have Other Insurance
If you have any health insurance other than **L.A. Care**, it is important to let us know. If you are covered by more than one group health plan or group insurance coverage, **L.A. Care** will coordinate benefits with the other carrier. Please call **L.A. Care** if you have any questions. We will send all bills to the correct place for payment.

How a Provider Gets Paid
Health care *providers* are paid in the following one way:

- Capitation - a flat rate paid each month per *member*

Please call **L.A. Care** if you would like to know more about how your doctor is paid, or about financial incentives or bonuses.

Affirmative Statement About Incentives
To ensure that all **L.A. Care** members receive the most appropriate medical care available, we have a team of people who review certain treatments, tests or hospital stays in a process called Utilization Management (UM). We require that all UM employees contracted physicians and management staff who deal with utilization management activities to sign an affirmative statement acknowledging the following:

- Utilization Management decision making is based only on appropriateness of care and service and existence of coverage.
- **L.A. Care** does not directly or indirectly reward practitioners or other individuals for issuing denials of coverage, service or care.
- **L.A. Care** does not provide financial incentives or compensation to Utilization Management decision makers to encourage underutilization of services.

If you have any questions regarding the Affirmative Statement About Incentives, please call **L.A. Care** Member Services at **1-888-839-9909.**

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. If you are unhappy with the Plan's decision on new technology, you can file a complaint (also known as a grievance). Please refer to the section "**Grievances/Complaints and Appeals**" on page 46. The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department of Managed Health Care 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 web site, http://www.hmohelp.ca.gov, has complaint forms, IMR application forms, and instructions online.

Organ Donation

There is a need for organ donors in the United States. You can agree to donate your organs in the event of your death. The California Department of Motor Vehicles (DMV) will give you a donor card if you wish to become an organ or tissue donor. The DMV will also give you a donor sticker to place on your driver's license or I.D. card.

What is an Advance Directive?

An advance directive allows you to select a person to make your health care choices for you when you cannot make them yourself. For example, when you are in a coma. An advance directive must be signed when you are able to make your own decisions. Ask your *PCP* or call **L.A. Care** for more information about advance directives.

Workers' Compensation

L.A. Care will not pay for work related injuries covered by Workers' Compensation. **L.A. Care** will provide health care services you need while there are questions about an injury being work related. Before **L.A. Care** will do this, you must agree to give **L.A. Care** all information and documents needed to recover costs for any services provided.

Governing Law

L.A. Care coverage is subject to the requirements of the California Knox-Keene Act, Chapter 2.2 of Division 2 of the California Health and Safety Code, and the regulations set forth at Subchapters 5.5 and 5.8 of Chapter 3 of Title 28 of the California Administrative Code. Any provision required to be in this benefit program by either the Knox-Keene Act or the regulations shall be binding on **L.A. Care** even if it is not included in this Evidence of Coverage or the Group Service Agreement.

THIRD PARTY LIABILITY& COORDINATION OF BENEFITS

Third Party Liability
If you are injured through the act or omission of another person (a "third party"), **L.A. Care** shall, with respect to services required as a result of that injury, provide the Benefits under **L.A. Care** only on the condition that the Member agrees in writing:

- to immediately upon collection of damages, whether by action at law, settlement, or otherwise, reimburse **L.A. Care** the sum of the costs actually paid by **L.A. Care**, medical group, or independent practice association for health care services not provided on a capitated basis or

- for health care services provided on a capitated basis, to reimburse **L.A. Care** 80% of the usual and customary charges for the same services by medical providers that provide health care services on a noncapitated basis.

Coordination of Benefits
If you are covered by more than one group health plan or group insurance coverage, **L.A. Care** will coordinate benefits with the other carrier. If another carrier covering you under a group health plan is primary, then **L.A. Care** or its **L.A. Care** Providers will seek compensation from that carrier for benefits provided under **L.A. Care** coverage. You will receive all of the Benefits to which you are entitled under this Plan, but no more than these benefits. This coordination of benefits will be done by **L.A. Care** in accordance with the rules of the California Department of Managed Health Care.

When coordinating benefits, **L.A. Care** determines the primary carrier as follow:

- If you are the Subscriber, then the coverage that you obtain through employment is primary.

Note: Even if you have other coverage, benefits will only be covered under **L.A. Care** if provided by **L.A. Care** providers and authorized in accordance with **L.A. Care** rules.

PARTICIPATING IN PUBLIC POLICY MEETINGS

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

RCAC's 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.

OTHER SERVICES

Questions about your health can come up at any time and the L.A. Care Nurse Advice Line gives you information, 24 hours a day, 7 days a week, at no cost to you. Call 1-800-249-3619. Hearing- or speech- impaired members can contact L.A. Care Nurse Advice Line through the California Telecommunications Relay Service at 1-866-735-2929 (TTY) or 1-800-854-7784 (speech-to-speech). Staff will inform you on what type of care you may need, based on your health condition/symptoms.

MISCELLANEOUS PROVISIONS

Administration of Agreement
L.A. Care may adopt reasonable policies, procedures and interpretations to promote orderly and efficient administration of this Agreement.

Agreement Binding on Members
By electing coverage or accepting benefits under the Agreement, all members legally capable of contracting and the legal representatives of all members incapable of contracting, agree to all provisions of this Agreement.

Amendment of Agreement
Upon 30 days written notice to the member, **L.A. Care** may amend this Agreement. All such amendments are deemed accepted by the member unless the member gives **L.A. Care** written notice of nonacceptance within 30 days of the notice in which case this Agreement terminates the day before the effective date of the amendment.

If **L.A. Care** notified the member that **L.A. Care** had not received all necessary governmental approvals related to this Agreement, **L.A. Care** may amend this Agreement by giving written notice to the member after receiving all necessary governmental approval. Such government approved provisions go into effect on September 1, 2003 (unless the government requires a later effective date).

In addition, **L.A. Care** may amend this Agreement at any time by giving written notice to the member, in order to address any law or regulatory requirement, which may include amending the **L.A. Care** monthly premium fees to reflect an increase in costs to **L.A. Care** or its Providers (or any of their activities).

Applications and Statements
You must complete any applications, forms or statements that **L.A. Care** requests in our normal course of business or as specified in this Agreement.

Assignment
You may not assign this Agreement or any of the rights, interests, claims for money due, benefits or obligations hereunder without our prior written consent.

No Waiver
L.A. Care's failure to enforce any provision of this Agreement will not constitute a waiver of that or any other provision, or impair **L.A. Care's** right thereafter to require your strict performance of any provision.

Non discrimination
We do not discriminate in our employment practices or in the delivery of services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation or physical or mental disability.

Notices
Notices will be sent to the most recent address we have for the member. The member is responsible for notifying **L.A. Care** of any changes in address. Members who move should call the Member Service toll free at 1-888-839-9909 (*TTY 1-866-522-2731*), as soon as possible.

Term of Agreement
This Agreement is effective when you, the member, first elects Conversion coverage, unless terminated as set forth in the "Termination of Benefits" Section.

GLOSSARY

This glossary may be used to help you understand words and terms used in this Member Handbook. Please call **L.A. Care** if you have any questions about the words listed here or a word you cannot find.

Acute/Acute Condition is a term used for a serious and sudden condition that lasts a short time. Not *chronic*. Examples include a heart attack, pneumonia, or appendicitis.

Appropriately qualified health care professional(s) is a professional who is licensed to practice medicine. The doctor also has the training and expertise to treat the person's specific medical condition. When requesting a second opinion or standing referral the *member* will be referred to this doctor (*PCP* or specialist).

Authorize/Authorization is when a health plan approves treatment for covered *health care services*. *Members* must pay for all non-approved treatment.

Benefits are the *health care services*, supplies, drugs, and equipment that are *medically necessary*.

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.

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

Curative is having the ability to cure or heal.

Diagnostic/Diagnosis is when a doctor identifies a condition, illness or disease.

Disability/Disabled/Disabling is a physical or mental problem that totally or seriously limits one or more major life activity.

Disenroll(ment)/Enroll(ment) is when a *member* leaves/joins a health plan.

Eligible/Eligibility means a member whose coverage under a group contract has been terminated is eligible for individual conversion coverage.

Experimental or investigational in nature is 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.

Grievance/Complaint is the process used when a *member* is not happy with his/her health care. *Grievances* are about services of care received or not received.

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

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

Hospital provides *inpatient* and *outpatient* care from doctors or nurses.

Incarceration is when a person is placed in jail, prison or a mental institution for a long time.

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**.**

Inpatient is when a person is admitted to (stays overnight in) a *hospital* or other health care facility.

Involuntary/Involuntarily is when something is done without choice.

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

Medi-Cal is a state and federal health coverage program for low-income families.

Medical group is a group of *PCPs*, specialists, and other health care *providers* that work together.

Medically necessary/Medical necessity are those services provided to treat an illness or injury according to established and accepted medical practice standards.

Subscriber/Member is a person who has joined a health plan.

Member Services 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*.

Occupational therapy is used to improve and maintain a patient's daily living skills, because of a disability.

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

Outpatient is the medical treatment in a *hospital* or clinic without an overnight stay.

Pharmacy is a place to get prescribed drugs.

Physical therapy uses exercise to improve and maintain a patient's ability to function after an illness or injury.

Physician is a doctor.

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

Primary care physician (PCP) is a personal doctor. The *PCP* takes care of health care needs and works with *members* to keep them healthy. The *PCP* will also make specialty referrals when *medically necessary*.

Prosthesis is an artificial device 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 directory is a list of *providers* contracted with a health plan for covered *health care services*. The list includes *PCPs*, h*ospitals, skilled nursing facilities,* urgent care, *pharmacies*, and vision care *providers.*

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

Skilled nursing facility is a facility licensed to provide medical services for non-*acute* conditions.

Speech therapy is used to treat speech problems.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.

Urgently Needed Services are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area.

IMPORTANT PHONE NUMBERS

California State Services	
Department of Health Care Services (DHCS)	**1-916-445-4171**
DHCS Ombudsman Office	1-888-452-8609
Department of Social Services	1-800-952-5253
Department of Managed Health Care (DMHC)	1-888-466-2219 1-888-HMO-2219
Supplemental Social Income (SSI)	**1-800-772-1213**
Children Services and Programs	
California Children 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
Healthy Families Program	1-800-880-5305
Disability Services	
Americans Disabilities Act Coordinator	1-916-324-4695
Hearing Impaired/California Relay Service (TTY)	1-800-735-2929

L.A. Care Health Plan Services

L.A. Care Member Services	1-888-839-9909
Authorizations	1-877-431-2273
Pharmacy (MedImpact)	1-800-788-2949
L.A. Care Nurse Advice Line	1-800-249-3619
L.A. Care Compliance Line	1-800-400-4889

Los Angeles County Services

Department of Public and Social Services (DPSS)	1-888-678-4477
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	1-888-942-2229 1-888-WIC-Baby

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
1-888-839-9909
TTY Service: 1-866-LACARE1 (1-866-522-2731)
www.lacare.org