PASC-SEIU Homecare Workers Health Plan For In-Home Supportive Services Workers

Coverage Period: 2020 - 2021

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: Individual | Plan Type: HMO

This SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **1-844-854-7272** or visit us at **lacare.org**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.**healthcare.gov/sbc-glossary** com or call **1-844-854-7272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**No**	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$1,000**	The out-of-pocket limit is the most you could pay in a year for covered services
What is not included in the out-of-pocket limit?	Premiums, balance billing, and health care services this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes**. For a list of contracted providers, please see lacare.org or call 1-844.854.7272	This plan uses a provider network. You will pay less if you use a participating provider in the plan's network. You will pay the most if you use an non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**Yes.**	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.
Are there services this plan doesn't cover?	**Yes**	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) In some cases, a non-plan provider may provide covered services at an in-network facility where you have been authorized to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-network facilities where we have authorized you to receive care.
- This plan requires you to use in-network providers unless authorized by the plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 co-pay/visit	Not covered	None
	Specialist visit	$2 co-pay/visit	Not covered	Referral from primary care physician required. Member will pay for services if not referred.*
	Other practitioner office visit	Not covered	Not covered	None
	Preventive care/screening/ immunization	$5 co-pay/visit	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$0 per test	Not covered	None
	Imaging (CT/PET scans, MRIs)	$0 per test	Not covered	None
If you need drugs to treat your illness or condition More information about	Generic drugs on Formulary	$5 per prescription	Not covered	Covers up to 30-day supply. 90-day supply for maintenance drugs. Exclusions apply, see your policy or plan document for additional information about excluded services.*

* For more information about limitations and exceptions, see the plan or policy document at **lacare.org.**

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
prescription drug coverage is available at https://www.lacare.org/members/getting-care/pharmacy-services	Brand named drugs on Formulary	$5 per prescription	Not covered	Covers up to 30-day supply. Exclusions apply, see your policy or plan document for additional information about excluded services.*
	Non-Formulary drugs	$5 per prescription	Not covered	Covered if authorized. Exclusions apply, see your policy or plan document for additional information about excluded services.*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 co-pay	Not covered	Exclusions apply, see your policy or plan document for additional information about excluded services.*
	Physician/surgeon fees	$0 co-pay	Not covered	Exclusions apply, see your policy or plan document for additional information about excluded services.*
If you need immediate medical attention	Emergency room services	$35 co-pay	$35 co-pay	Waived if admitted to hospital.
	Emergency medical transportation	$0 co-pay	$0 co-pay	Excludes coverage for transportation by airplane, passenger car, taxi or other form of public transportation.
	Urgent care	$5 co-pay	$5 co-pay	Out-of-network only covered outside of L.A. County.
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 co-pay	Not covered	
	Physician/surgeon fees	$0 co-pay	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 co-pay	Not covered	Prior authorization is required for Psychological Testing
	Facility based Outpatient services	$0 co-pay	Not covered	Prior authorization is required for some services.*

* For more information about limitations and exceptions, see the plan or policy document at **lacare.org.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	$0 co-pay	Not covered	Prior authorization is required.*
If you are pregnant	Office visits	$5 co-pay	Not covered	
	Childbirth/delivery professional services	$0 co-pay	Not covered	
	Childbirth/delivery facility services	$0 co-pay	Not covered	
If you need help recovering or have other special health needs	Home health care	$0 co-pay	Not covered	Medically necessary skilled care. Custodial care not covered.*
	Rehabilitation services	$5 co-pay	Not covered	Includes outpatient physical, occupational, speech, and respiratory therapy.*
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	$0 co-pay	Not covered	Benefit is limited to a maximum of 100 days per benefit year.*
	Durable medical equipment	$0 co-pay	Not covered	Equipment for home used as medically necessary.*
	Hospice services	$0 co-pay	Not covered	Limited to individuals who are diagnosed with a terminal illness with a life expectancy of 12 months or less.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic Care
- Cosmetic surgery
- Habilitation services
- Hearing Aids
- Infertility treatment (unless medically necessary for medical conditions)
- Long term care
- Private-duty nursing
- Routine dental care (unless medically necessary)
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-844-854-7272.**

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-844-854-7272.**

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **1-844-854-7272.**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-844-854-7272.**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$110**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$290
Coinsurance	$0
What isn't covered	
Limits or exclusions	$815
The total Joe would pay is	**$1,105**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $
- **Specialist *[cost sharing]*** $
- **Hospital (facility) *[cost sharing]*** %
- **Other *[cost sharing]*** %

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$70**

The plan would be responsible for the other costs of these EXAMPLE covered services.