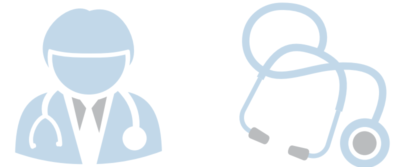
L.A. Care
HEALTH PLAN®

PASC-SEIU *Homecare Workers*

Health Care Plan for In-Home Supportive Services Workers

2024



A Helpful Guide to Your Health Care Benefits

Guía útil para sus beneficios de atención médica

您醫療保健福利的實用指南

유용한 의료 혜택 가이드

Ձեր առողջական խնամքի նպաստների օգտակար ուղեցույց

Полезное руководство по льготам на медицинское страхование

Thank you for your membership with L.A. Care Health Plan.
When you join, you will get this package of important information in the mail. It is about your health coverage. We need you to read and understand it.

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

- **Combined Evidence of Coverage and Disclosure Form.. 3**
- **How to Get Your Prescription Drugs...45**
- **Notice of Privacy Practices 65**
- **Non-discrimination Notice..72**
- **Getting Help in Other Languages...75**

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

Basic Information

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

L.A. Care has the following Special Programs:

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

How Decisions Are Made About Your Care

- How our doctors and staff make decisions about your care based only on need and benefits. We do not encourage doctors to provide less care than you need and doctors are not paid to deny care.
- How to reach us if you want to know more about how decisions are made about your care
- How to appeal a decision about your care
- L.A. Care has a list of covered drugs called a Formulary
- The formulary is updated and posted monthly, and you can find the formulary and updates on our website at **lacare.org**.
- Certain covered drugs have restrictions such as Step Therapy (ST), Quantity Limits (QL), and or require a Prior Authorization (PA).

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- FDA approved generic drugs will be used in most situations, even when a brand-name drug is available.
- If your drug is non-Formulary, or has a restriction, your doctor will need to submit a request to L.A. Care. The request can be approved if there is a documented medical need.
- To see a full list and explanation of the pharmaceutical management procedures and restrictions, visit L.A. Care's website at **lacare.org**.

Member Issues

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

You may view this Member Handbook before enrollment in a program. Be sure to see our website **lacare.org**, or call us at **1.844.854.7272** if you would like paper copies.

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

Combined Evidence of Coverage and Disclosure Form (Member Handbook)

2024

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Customer Service

Welcome!

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

Health Information Privacy

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

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

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

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

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

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

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

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

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

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

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

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

Sometimes, we may also give your health information to:

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

Confidentiality of Medical Information

In accordance with California law, L.A. Care protects the confidentiality of individual enrollees' medical information.

Medical information includes reproductive or sexual health application information pursuant to Civil Code §§ 56.05 and 56.06.

The steps we take for this include:

- We do not require a protected individual* to obtain the primary subscriber or other enrollee's authorization to receive sensitive services.**
- We will direct communications*** regarding a protected individual's receipt of sensitive services:
  - o Directly to the protected individual's designated alternate mailing address, email address, or telephone number, or,
  - o In the absence of a designated alternate address or phone number, we will direct the communications to the telephone number on file in the name of the protected individual.
- We will not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any other plan enrollee without expressed authorization of the protected individual.

**A protected individual is any adult covered by the ubscriber's health plan or a minor who can consent to health care service without the consent of a parent or legal guardian.*

***Sensitive services means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care and intimate partnerviolence.*

****Communications include:*

- *Bills and attempts to collect payment*
- *Notices of adverse benefits determinations*
- *Explanation of benefits notices*
- *Requests for additional information regarding a claim*
- *Notices of a contested claim*
- *The name and address of a provider, description of services provided, and other information related to a visit*
- *Any written, oral or electronic communication from a plan that contains protected health information.*

Individuals may request accommodation for confidential communications by contacting L.A. Care Member Services at **1.855.270.2327** (TTY **711**) or by sending a written request by first class mail at the following address:

L.A. Care Health Plan
Attention: Director of Customer Solution Center
1200 W. 7th Street
Los Angeles, CA 90017

The request must include the member's information and the alternate contact information. Any request will be implemented within 7 days of receipt of a telephone request or 14 days of receipt of a first class mail request. The accommodation will remain in effect until the individual revokes the request or submits a new confidential communication request.

If you have any questions or want to know more about how L.A. Care protects your health information or would like a copy of L.A. Care's Notice of Privacy Practices, please call L.A. Care Member Services at **1.844.854.7272.** (TTY **711**).

A STATEMENT DESCRIBING L.A.CARE HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Identification Card (ID Card)

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

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

The Provider Directory

The Provider Directory is a list of all doctors, hospitals, pharmacies, and behavioral health services in L.A. Care's network. The Provider Directory lists the languages spoken at each provider's office. New members should have received the Provider Directory in their welcome packet with this Member Handbook. You can also request the Provider Directory by calling L.A. Care Member Services at **1.844.854.7272** (TTY **711**) or you can visit L.A. Care's website, lacare.org, to find a provider.

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

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

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

Call your prospective doctor, medical group, independent practice association, or clinic, or call L.A. Care Member Services at association, or **1.844.854.7272** to ensure that you can obtain the health care services that you need.

Language and Interpreting Services

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

L..A. Care provides free interpreting services for those members who speak a different language than their health care provider. Interpreting services are available 24 hours a day, 7 days a week, including weekends and holidays. You may call L.A. Care at **1.844.854.7272** (TTY **711**) to request an interpreter for your doctor's visit. You should not use your family members or friends to interpret for you. Minors should not be used to interpret. You have the right to file a grievance with L.A. Care if your language needs are not met. You can also file a grievance if you believe your cultural needs were not met. If you have any questions, please call L.A. Care.

Services for the Deaf and Hard-of-Hearing

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

Vision Impaired Services

You may ask for this document and other materials in audio and large print formats. Please call L.A. Care if you have any questions, at **1.877.421.0177**.

Health Care Access for Patients with Disabilities

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

Service Area

You must live or work in Los Angeles County (including Catalina Island) in order to receive services through L.A. Care. You must choose a Primary Care

Physician (PCP) in Los Angeles County. The only benefits available to you without returning to our service area (Los Angeles County) are emergency care and out of area urgent care. Please see the "Emergency Services" section under "Emergency and Urgent Care Services" for more details.

Timely Access of Care

California law requires health plans to provide timely access to care. This means that there are limits on how long you have to wait to get health care appointments and telephone advice.

Appointment Wait Times

Health plan members have the right to appointments for medical care and mental health or substance use disorder care within the following time frames:

Urgent Appointments	Wait Time
For services that do not require prior approval	48 hours
For services that does require prior approval	96 hours
Routine Appointments	**Wait Time**
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health or substance use care provider (who is not a physician)	10 business days*
Appointment for other services to diagnose or treat a health condition	15 business days

* This is not intended to limit follow-up appointments to once every 10 business days.

Please contact L.A. Care's Nurse Advice Line at **1.800.249.3619** 24 hours a day, 7 days a week, including holidays to access triage or screening services, at no cost to you. Hearing- or speech- impaired members can contact L.A. Care's Nurse Advice Line through the California Telecommunications Relay Service at **711** (TTY) or **1.800.854.7784** (speech-to-speech).

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

Helpful information at lacare.org on the Internet

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

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

You can check your eligibility for medical coverage. You can even request to change your doctor or medical group. Since this information is private, you will need to log in. Go to **lacare.org** and then click **"I Am A Member"** to find out what to do. (Be sure to have your ID card ready as we ask for your member ID number.)

Member Bill of Rights

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

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

Privacy and confidentiality. You have 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 consent.

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

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

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

Service outside of L.A. Care's provider network. You have a right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside L.A. Care's provider network. You have the right to receive emergency treatment whenever and wherever you need it. You will pay no more than the same cost sharing that you would pay for the same covered services received within L.A. Care's provider network.

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

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

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

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

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

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

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

How to Get Care

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

Primary Care Physician (PCP)

Please read the following information so you will know from whom or what group of providers health care may be obtained.

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

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

Scheduling Appointments

Step 1: Call your PCP

Step 2: Explain why you called

Step 3: Ask for an appointment

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

Clinic/doctor appointments are generally available Monday through Friday between 8:00 a.m. and 4:30 p.m. Evening and Saturday clinic/doctor office appointments may be available at some L.A. Care sites. Please see the provider directory for more information about each clinic/doctor.

If you need medical advice during clinic/doctor office hours, you may call your PCP and speak to her/him. You can also call the nurse advice line number that is on your ID card. This number is available to you 24 hours a day, seven (7) days a week, to help answer your health care questions and have your health concerns and symptoms reviewed by a registered nurse.

This service is free of charge and available to you in your language. The PCP or L.A. Care Health Plan nurse will answer your questions and help you decide if you need to come into the clinic/doctor's office.

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

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

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

A PCP will be assigned to you

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

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

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

How to change your PCP

If you would like to change your PCP or clinic, call L.A. Care at **1.888.854.7272**. Review the PASC-SEIU Homecare Workers Health Care Plan Provider/Pharmacy

Directory to choose a PCP from the list of providers. You will find the names of PCPs along with their address, telephone number, specialty, and the languages they speak.

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

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

Some things to think about when choosing a PCP:

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

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

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

Referrals and Prior Authorizations

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

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

- Routine or regular referral – 5 business days
- Urgent referral – 24 to 72 hours
- Emergency referral – same day

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

The following services do not require a prior authorization.

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

All health care services are reviewed, approved, or denied according to medical necessity. Call L.A. Care if you would like a copy of the policies and procedures used to decide if a service is medically necessary. The phone number is **1.844.854.7272** (TTY **711**).

Referrals to Specialty Physicians

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

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

Services from non-physician providers

You may get services from non-physician providers who work in your PCP's office. Non-physician providers may include, but are not limited to, clinical social workers, family therapists, nurse practitioners, and physician assistants.

Standing Referrals

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

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

The specialist or qualified health care professional will develop a treatment plan for you. The treatment plan will indicate how often you need to be seen.

Once the treatment plan is approved, the specialist or qualified health care professional will be authorized to provide health care services. The specialist will provide health care services in his or her area of expertise and training based on the treatment plan.

Second Opinions

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

What is a second opinion?

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

- Question a diagnosis, or
- Do not agree with the PCP's treatment plan, or
- Would like to confirm the treatment plan.

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

What do you need to do?

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

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

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

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

Behavioral Health Services

Behavioral health services include treatment for mental health and substance use disorders. This may include treatment for behavioral health problems such as anxiety, depression, substance use disorders, etc. Your PCP, will provide you with some outpatient behavioral health services and screening within the scope of their training and practice. When you need behavioral health services beyond your PCP's training and practice you will be directed to behavioral health specialists. Behavioral health services include treatment for pre and post-partum maternal mental health. Your PCP or you can call the Behavioral Health Hotline at **1.877.344.2858/1.800.735.2929** TTY, to get an appointment. No prior authorization is requirement for most outpatient behavioral health services.

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

- Emergency Care Services
- Individual and Group Therapy
- Medication Management
- Opioid Replacement Therapy
- Diagnostic Evaluation
- Crisis Intervention
- Medically necessary treatment of Mental Health or Substance Use Disorder provided by a 988 center, mobile crisis team or other provider of behavioral health crisis services

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

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

How to Find a Pharmacy

L.A. Care works with many pharmacies. The drugs prescribed by your PCP or specialist must be filled at one of these pharmacies. You can receive a 90-day supply

of maintenance medications at certain local pharmacies. Ask your doctor to write a 90-day prescription.

To find a pharmacy near you:

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

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

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

What drugs are covered?

L.A. Care uses a formulary of approved drugs. The Formulary is a list of drugs that are generally accepted in the medical community as safe and effective for your diagnosis. The Formulary is reviewed and approved by a committee of L.A. Care's participating physicians and pharmacists on a quarterly basis. You may call L.A. Care to ask for a copy of the Formulary or to ask if a specific drug or drugs are included. You can also view the Formulary on L.A. Care's website, **lacare.org**.

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

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

If a previously approved drug is removed from the Formulary, but your doctor is currently prescribing it to you, L.A. Care will continue to cover the medication as long as the drug is appropriately prescribed and is considered safe and effective for treating your medical condition. To obtain authorization for continuing coverage, please refer to the process described in the "Non-formulary Drugs" section in this handbook.

Restrictions or Special Rules

Some drugs have coverage rules or have limits on the amount you can get. In some cases your doctor or other prescriber must do something before you can fill the prescription. For example:

Prior approval (or prior authorization):

For some drugs, your doctor or other prescriber must get approval from L.A. Care before you fill your prescription. If you do not get approval, L.A. Care may not cover the drug.

Quantity limits:

For your safety, L.A. Care may limit the amount of some drugs you can get per prescription, or limit the number of times you can refill some drugs. If your doctor or other prescriber thinks that the limited amount is not enough for your medical condition, then an exception to the quantity limits rule can be requested.

Step Therapy:

Some drugs have a special rule called step therapy. This means that you must first try another drug on the formulary before the prescribed drug is covered. If your doctor or other prescriber thinks that the first drug does not work for you, or is inconsistent with good professional practice for the provision of medically necessary covered services then an exception to the step therapy rule can be requested.

Exceptions to Coverage:

Requests to make an exception to a quantity limits or step therapy rule or for coverage of a non-formulary drug, can be submitted to L.A. Care Health Plan by your doctor or other prescriber in the form of a prior authorization with justification and clinical documentation supporting the provider's determination. A decision for approval or denial of the exception request can be made within 24 hours if the request is urgent or within 72 hours if the request is not urgent. If you are not satisfied with the exception-to-coverage decision, you have the right to appeal the decision with L.A. Care Health Plan or

file a grievance with 3 different reviewers: 1) L.A. Care Health Plan, 2) an external reviewer and 3) an independent medical reviewer at the Department of Managed Care. Please refer to the "Grievance and Appeals" section for more information.

The L.A. Care formulary includes:

- Approved prescription drugs
- Diabetic supplies: Insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices
- Pen delivery systems such as EpiPens
- Inhaler extender devices
- Emergency Contraceptive Drugs: You may get emergency contraceptive drugs from your doctor or pharmacy with a prescription from your doctor.

You may also get emergency contraceptive drugs from a certified pharmacist without a prescription.

For information on pharmacies offering emergency contraceptive drugs from registered pharmacists without a prescription, please call L.A. Care Member Services at **1.888.854.7272 (**TTY **711**).

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

Non-formulary drugs

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

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

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

Pharmacy Home

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

You may be chosen to enroll in this program if:

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

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

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

- You are in hospice care or have cancer;
- Being in the Pharmacy Home Program causes you trouble in finding care or causes an unnecessary health risk;
- Other reasons will be considered on a case by case basis.

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

Emergency and Urgent Care Services

Urgent care services

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

How to get urgent care

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

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

Telehealth Services

L.A. Care has partnered with Teladoc™ Health, Inc. to provide telehealth services for our members as an alternative for urgent care. Teladoc™ delivers care wherever you are by phone or video conferencing.

To access care through Teladoc™:

- Visit www.teladoc.com – click "Log in/Register"
- Call Teladoc at **1.800.835.2362**
- Contact L.A. Care at **1.888.854.7272** (TTY **771**)

Your cost for accessing telehealth services will not exceed what your cost would be if you received the same services through Teladoc™ or through independent or private telehealth services offered through your participating provider group or primary care provider.

If you use Teladoc™ services, you have the right to access your resulting medical records, and those records will be shared with your primary care provider, unless you object.

Emergency services

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

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

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

Examples of emergencies include but are not limited to:

- Having trouble breathing
- Seizures (convulsions)
- Lots of bleeding
- Unconsciousness/blackouts (will not wake up)
- In a lot of pain (including chest pain)
- Swallowing of poison or medicine overdose
- Broken bones
- Head injury
- Eye injury
- Thoughts or actions about hurting yourself or someone else

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

What to do in an emergency:

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

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

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

Post stabilization and follow-up care after an emergency

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

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

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

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

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

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

If you feel that you were improperly billed for post-stabilization services that you received from a non-contracted hospital, please contact the L.A. Care Member Services at **1.888.854.7272 (**TTY **711**).

Non-Qualified Services

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

Continuity of Care

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

- Acute condition – For the duration of the condition.
- Serious chronic (long-term) condition – For a period of time necessary to complete a course of treatment and arrange for a safe transfer to another provider.
- Pregnancy – Includes care for the term of the pregnancy and immediate postpartum care thereafter.
- Terminal illnesses/conditions – For the length of the illness.
- Care of a newborn child from birth to age 36 months – For up to 12 months.
- You have a surgery or other procedure that has been authorized by the plan as part of a documented course of treatment.

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

If you have one of the conditions listed above, ask your doctor if you can keep seeing him/her. You can also call L.A. Care Member Services at **1.888.854.7272** (TTY **711**) and ask how to request continuity of care.

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

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

OR

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

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

Continuity of Care when being treated for Maternal Mental Health Conditions

If an individual is receiving treatment for a maternal mental health condition with a provider who is not part of the L.A. Care PASC provider network because:

- The individual has changed health insurance plans to L.A. Care PASC and the existing provider is not part of the L.A. Care PASC provider network, or
- The L.A. Care PASC provider withdraws from the L.A. Care provider network after the individual begins treatment, L.A. Care PASC will, on request, arrange for the individual to continue services with the existing provider for up to 12 months from the date of diagnosis, or from the end of the pregnancy, whichever is later.

Grievance & Appeals

L.A. Care Grievance Process

Complaints: What should I do if I am unhappy?

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

What is a grievance?

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

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

How to File a Grievance

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

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

L.A. Care Health Plan
Member Services Department
1200 West 7th Street
Los Angeles, CA 90017
1.844.854.7272
TTY Service: **711**
lacare.org

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

L.A. Care can help you fill out the grievance form. Or, we can send you a form for you to fill out and send back to us. Within five calendar days of receiving your grievance, you will get a letter from L.A. Care saying we have your grievance and are working on it.

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

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

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

For members with hearing or speech loss, you can call L.A. Care's Member Services TTY/TDD line **711**. Members and providers can also dial **711** on their phones to call the California Relay Service directly.

If you do not agree with the outcome of your grievance

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

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

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

Within five calendar days of receiving your grievance, you will get a letter from L.A. Care saying we have received your grievance and that we are working on it. The letter will also let you know the name of the person working on your grievance. Then, within 30 calendar days, you will receive a letter explaining how the grievance was resolved.

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

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

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

How to File a Grievance for Urgent Cases

Examples of urgent cases include:

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

In urgent cases, you can request an "expedited review" of your grievance. You will receive a call and/or a letter about your grievance within 24 hours. A decision will be made by L.A. Care within three (3) calendar days (or 72 hours) from the day your grievance was received.

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

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

If you do not hear from L.A. Care within three (3) calendar days (or 72 hours), or you do not agree with the decision about your grievance, you may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to *"Review by the Department of Managed Health Care (DMHC)"* section.

Independent Medical Review

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

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

When to file an Independent Medical Review (IMR)

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

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

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

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

Urgent cases

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

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

Examples of urgent cases include:

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

Independent Medical Review (IMR) for Denials of Experimental/ Investigational Therapies

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

Review by the Department of Managed Health Care

The Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against the health plan, you should first call L.A. Care at 1.844.854.7272 (TTY711 for the hearing impaired). Use L.A. Cares' grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number (1.888.466.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired. The department's Internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

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

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

Eligibility and Enrollment

Requirements for member eligibility

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

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

Starting date of coverage

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

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

Notification of eligibility changes

You must meet and continue to meet all of the employer's eligibility requirements throughout the period of coverage. You should contact PASC-SEIU for questions regarding the eligibility requirements.

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

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

Payment Responsibilities

Monthly Premium

The monthly premium is as follows:

Enrollees	Gross Monthly Premium
PASC-SEIU Worker Only	$1.00

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

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

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

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

Co-payments

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

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

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

Step 1: Save your receipts.

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

Payments that count toward the maximum

Any cost sharing payments you make for in-network services accumulate toward the maximum out-of-pocket expense.

Tracking Your Out of Pocket Maximum (OOPM)

L.A. Care will keep track of charges that are counted toward your out of pocket maximum (OOPM). We will provide you with the balance for every month in which you have used benefits until the annual balance equals the full OOPM. You may also request your accrual balances for the OOPM from L.A. Care at any time. .L.A. Care will mail you these updates unless you have opted out of mailed notices.

To request information or opt out of the mailed updates, please contact L.A. Care Member Services at **1.855.270.2327**.

L.A. Care will make every effort to ensure accurate and timely information, but there may be delays in reporting of visits and payments from your provider which may impact the net accrual information. Please request and save all receipts for payments you make to your health care providers for covered services for your records.

Member Maximum Lifetime Benefits

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

There is no maximum limit on the total payments by the plan for covered services provided under L.A. Care.

Member Liability

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

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

Members are only eligible to get health care services that are covered services in the PASC-SEIU Plan. Even if your doctor recommends that you get health care services that are not covered services, members are only able to get covered services as described in this Member Handbook. If you have any questions about what are covered services, please call L.A. Care Member Services at **1.888.854.7272** (TTY **711**).

Annual Co-payment Maximum

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

Summary of Benefits

Services are covered only if they are medically necessary.

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

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

All health care services are reviewed, approved or denied according to medical necessity. It is important that you learn about your benefits before you need them. Please call L.A. Care Member Services at **1.844.8547272** (TTY **711)** if you have any questions.

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

Benefits	Covered Services	Member Pays
Asthma Care	Coverage for medically necessary supplies and equipment relating to the management and treatment of asthma, including inhaler spacers, nebulizers (including face masks and tubing), peak flow meters and education on the proper use of these items.	No co-payment
Blood and Blood Products	Inpatient and outpatient processing, storage, and administration and collection, and storage of autologous blood, when medically necessary.	No co-payment
Clinical Trials	Coverage for a member's participation in a clinical trial, when the member's physician has recommended participation in the trial and member meets certain requirements	$5 per visit Co-payment for prescriptions as described in the *"Prescription Drug Program"*
Cataract Spectacles and Lenses	Cataract spectacles and lenses, cataract contact lenses or intraocular lenses that replace the natural lens of the eye after cataract surgery	No co-payment
Confidential HIV and STD Testing	Testing available from L.A. County Department of Health Services, family planning services providers, your doctor, or prenatal clinics; no prior authorization required.	No co-payment

Benefits	Covered Services	Member Pays
Dental Services	Only when medically necessary; no coverage for routine dental services (e.g., cleaning, cosmetic) Routine dental coverage is offered separately and paid through a monthly payroll deduction to SEIU. For information, contact SEIU at **1.877.421.0177**.	No co-payment
Diabetic Care	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary, even if the items are available without prescription. Training and health education for diabetes self-management. Family education for self-management.	*No co-payment*
Diagnostic, X-Ray and Laboratory Services	Therapeutic radiological services, ECG, EEG, mammography, other outpatient diagnostic laboratory and radiology tests	No co-payment
Durable Medical Equipment	Equipment for home used as medically necessary	No co-payment
Emergency Care Services	Health care services which a reasonable person would consider necessary to relieve a serious illness or symptom, injury, severe pain, thoughts or actions about hurting yourself or someone else or condition requiring immediate diagnosis. Offered 24 hours a day, 7 days a week.	$35 per visit (waived if admitted to hospital)
Emergency Contraception	FDA-approved contraceptive drugs and devices	No co-payment
Eye Exam/Vision Services	No coverage for routine vision services (eyeglasses and contact lenses)	
Family Planning Services	Voluntary family planning services	No co-payment
Health Education Services	Effective health education services and materials. This includes education on personal health behavior and health care, and recommendations regarding the optimal use of health care.	No co-payment
Home Health Care Services	Services provided at the home by health care personnel Medically necessary skilled care; does not cover custodial care	No co-payment

Benefits	Covered Services	Member Pays
Hospice	Medically necessary skilled care; counseling; medical supplies; short term inpatient care; pain control and symptom management; bereavement services; physical, speech and occupational therapies; medical social services; and respite care.	No co-payment
Hospital Services – Inpatient	Room and board, nursing care and all medically necessary ancillary services • anesthesia • dialysis • obstetrical care and delivery (including Caesarean section)	
Hospital Services – Outpatient	Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility • ambulatory surgery • specialty care consultations/visits • therapeutic radiology, chemotherapy, renal dialysis • physical, occupational and speech therapy performed on an outpatient basis • emergency health care services (waived if the member is hospitalized)	No co-payment No co-payment No co-payment No co-payment $5 per visit $35 per visit
Human Papillomavirus Screening & Vaccine (HPV)	Screening test for cervical cancer available to all female members ages 9 through 26	No co-payment
Medical Nutrition Therapy	Treatment of diagnosed medical conditions (uncontrolled diabetes, obesity, underweight or pre-end-stage renal disease) through dietary interventions. Requires physician order.	No co-payment
Medical Transportation	Ambulance, or air ambulance, transportation in an emergency or when medically necessary	No co-payment
Mental Health - Inpatient Care	Prior authorization is required for the following inpatient, in-network services: • Adult Residential Treatment Services • Psychiatric Inpatient Hospital Services • 23-hour Observation • Crisis Residential Treatment Services Call L.A. Care's toll free Behavioral Health Hotline at **1.877.344.2858**. We will help you find the kind of help that is right for you.	No co-payment

Benefits	Covered Services	Member Pays
Mental Health - Outpatient Visits	Services obtained during a provider office visit, outpatient hospital visit, or urgent care visit. This includes: • Individual and Group Therapy • Medication Management • Diagnostic Evaluation • Crisis Intervention Prior authorization is required for psychological testing. Call L.A. Care's toll free behavioral health hotline at **1.877.344.2858**. We will help you find the kind of help that is right for you.	$5 per visit
Mental Health - *Outpatient Facility-Based Services*	Services outside of an office setting, such as a treatment center or home, that involve daily or weekly treatment delivered over several hours. Prior authorization is required for the following outpatient, in-network services: • Acute Partial Hospitalization • Intensive Outpatient • Behavioral Health Treatment for Autism Spectrum Disorders (includes Asperger's Syndrome, Autism and Pervasive Developmental Disorder) • Transcranial Magnetic Stimulation (TMS) • Outpatient Electroconvulsive Therapy (ECT) • Intensive Day Treatment Call L.A. Care's toll free Behavioral Health Hotline at **1.877.344.2858**. We will help you find the kind of help that is right for you.	No co-payment
Physical, Occupational and Speech Therapy	Outpatient Inpatient Therapy may be provided in a medical office or other appropriate outpatient setting	$5 per visit No co-payment
Pregnancy and Maternity Care	Prenatal and postpartum care	No co-payment

Benefits	Covered Services	Member Pays
Prescription Drug Program	Drugs prescribed by a licensed practitioner	
	• 30-day supply for generic drugs. See limitations for brand name drugs under "Plan Benefits."	$5 per prescription
	• 90-day supply of maintenance drugs – generic only	$5 per prescription
	• Prescription drugs provided in an inpatient setting	No co-payment
	• Drugs administered in the doctor's office or in an outpatient facility	No co-payment
	• FDA-approved contraceptive drugs and devices	No co-payment
	• Respiratory devices for the management and treatment of asthma	No co-payment
	Call L.A. Member Services for mail order form or for a list of participating pharmacies at **1.844.854.7272** (TTY **711**).	
	If the retail price for a covered prescription drug, supply, or supplement is less than the co-payment, you will pay the lesser amount.	
Preventive Care Services	• Periodic health exams	$5 per visit
	• Immunizations, STD tests, and cytology exams on a reasonable periodic basis	No co-payment
	• Vision/Hearing Screening	No co-payment
	• Cancer Screening	No co-payment
	• Health Education	No co-payment
	• Well-Child Care – limited to first 31 days of life	No co-payment
Professional Services	• Outpatient Visit Urgent care; office visit, or home visit	$5 per visit
	• Specialty care consultations/visits	$2 per visit
	• Chemotherapy, dialysis, surgery, anesthesiology, or radiation	No co-payment
	• Inpatient Visit Licensed hospital, skilled nursing facility, hospice, mental health facility	No co-payment
Prosthetics and Orthotics	Prosthetics and orthotics as prescribed by L.A. Care providers	No co-payment
Reconstructive Surgery	Reconstructive surgery repairs abnormal body parts, improves body function, or brings back a normal look.	No co-payment

Benefits	Covered Services	Member Pays
Skilled Nursing Care	Services provided in a licensed skilled nursing facility. Benefit is limited to a maximum of 100 days per benefit year.	No co-payment
Substance Use Disorder Treatment Outpatient–Facility-Based Services	Prior authorization is required for the following in-network services: • Acute Partial Hospitalization • Intensive Outpatient Call L.A. Care's toll free Behavioral Health Hotline at **1.877.344.2858**. We will help you find the kind of help that is right for you.	No co-payment
Substance Use Disorder Treatment – Inpatient Care	Prior authorization is required for the following inpatient, in-network services: • Inpatient Acute Detoxification • Inpatient Rehabilitation • Residential Detoxification • 23-Hour Observation Call L.A. Care's toll free Behavioral Health Hotline at **1.877.344.2858**. We will help you find the kind of help that is right for you.	No co-payment
Substance Use Disorder Treatment – Outpatient Visits	Services obtained during a provider office visit, outpatient hospital visit, or urgent care visit. This includes: • Opioid Replacement Therapy • Diagnostic Evaluation • Crisis Intervention • Individual and Group Therapy Call L.A. Care's toll-free Behavioral Health Hotline at **1.877.344.2858**. We will help you find the kind of help that is right for you.	$5 per visit
Transplants	Medically necessary organ and bone marrow transplant; medical and hospital expenses of a donor or prospective donor; testing expenses and charges associated with procurement of donor organ.	No co-payment

The PASC-SEIU health benefit plan in Los Angeles County is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your PASC-SEIU health benefit plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the L.A. Care Member Services at **1.844.854.7272** (TTY **711**).

Plan Benefits

Asthma Care

Benefit includes nebulizers (including face mask and tubing), inhaler spacers and peak flow meters and education on the proper use of these items when medically necessary for management and treatment of asthma.

Blood and Blood Products

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

Behavioral Health Services

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

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

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

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

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

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

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

Behavioral Health Treatment ("BHT") for Members with Autism Spectrum Disorder (includes Aspergers, Autism and Pervasive Development) requires prior authorization and is covered when prescribed by a Physician or licensed psychologist who is a Plan Provider. A BHT treatment plan must be prescribed by a Participating Provider and BHT services must be provided by Participating Providers. BHT used for the purposes of providing respite, day care, or educational services or to reimburse a parent for participation in the treatment is not covered.

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

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

For more information on Behavioral Health services, please call the L.A. Care's Behavioral Health vendor, Carelon Behavioral Health at **1.877.344.2858/1.800.735.2929** TTY/TDD, if you are deaf or hard of hearing. Someone is available to help you connect to services 24 hours a day, 7 days a week, including holidays.

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If L.A. Care fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at **1-888-466-2219**; or 3) contact the California Department of Managed Health Care through its website at **www.healthhelp.ca.gov** to request assistance in obtaining MH/SUD services.

Crisis Services

L.A. Care covers behavioral health crisis services that are provided by a 988 center, mobile crisis team, or other providers of behavioral health crisis services for medically necessary treatment of a mental health or substance use disorder.

These services can include, but are not limited to, confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week.

Maternal Mental Health

L.A. Care covers services related to maternal mental health conditions that can impact a woman during pregnancy, near birth or after birth. This includes coverage for doula services. All L.A. Care participating health care practitioners providing prenatal and postpartum care must ensure mothers are offered screening or are appropriately screened for maternal mental health conditions. These screenings take place during at least one of the following periods during pregnancy and postpartum:

- Prenatal period (during pregnancy before birth)
- Postpartum period (up to 1 year after giving birth)
- Perinatal period (during pregnancy and postpartum)

Clinical Trials

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

If you have a life-threatening or debilitating condition, or were eligible, but denied coverage for a clinical trial, you have the right to request an Independent Medical

Review for a denial. Go to the, *"When to file an Independent Medical Review"* section.

Cataract Spectacles and Lenses

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

Confidential HIV and STD Testing

You do not need prior authorization from your doctor for confidential HIV and STD testing. A list of services is available. Please call L.A. Care Member Services at **1.844.854.7272** (TTY **711**) to request a copy. You can get confidential HIV and STD testing from the following:

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

Dental Services

Only when medically necessary; no coverage for routine dental services (e.g., cleaning, cosmetic). Routine dental coverage is offered separately and paid through a monthly payroll deduction to SEIU. For information, contact SEIU at **1.877.421.0177**.

Diabetic Care

Supplies, equipment, and services for treatment and/or control of diabetes when medically necessary are covered. This benefit also covers outpatient diabetes education programs for self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications.

Diagnostic X-Ray and Laboratory Services

- Laboratory tests for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).
- Diagnostic laboratory services, diagnostic and therapeutic radiological (x-ray) services necessary to evaluate, diagnose, treat, and follow-up on the care of members including
- Imaging Services that are Preventive Care Services:
- Preventive mammograms
- Preventive aortic aneurysm screenings
- Bone density CT scans
- Bone density DEXA scans
- All other CT scans, and all MRIs and PET scans are covered.
- Nuclear medicine is covered

Laboratory tests:

- Laboratory tests to monitor the effectiveness of dialysis
- Fecal occult blood tests, fecal immunochemical tests and Multitarget Stool DNA Testing
- Routine laboratory tests and screenings that are Preventive Care Services, such as preventive cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, and HIV tests
- Biomarker testing for advanced metastatic stage 3 or 4 cancer or testing for cancer progression or recurrence in patients with advanced metastatic stage 3 or 4 cancer is covered without preauthorization.
- Biomarker testing that is not for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer requires prior authorization.
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)
- Routine preventive retinal photography screenings
- All other diagnostic procedures provided by participating providers who are not physicians (such as EKGs and EEGs)
- Radiation therapy
- Ultraviolet light treatments
- Laboratory costs for processing home test kits for sexually transmitted diseases when the test is ordered for you by your in-network provider.

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

Durable Medical Equipment (DME)

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

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

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

Examples include:

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

Exclusions:

- Coverage for comfort or convenience items
- Disposable supplies except ostomy bags and urinary catheters and supplies consistent with L.A. Care's coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature such as sauna baths and elevators
- Modifications to the home or car
- Deluxe equipment
- More than one piece of equipment that serves the same function.

Emergency Care Services

L.A. Care covers emergency care services 24 hours a day, 7 days a week, including holidays. Emergency care services are medically necessary covered services, including ambulance and behavioral health services, which a reasonable person, in good faith, would have considered necessary to stop or relieve:

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

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

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

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

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

If you are admitted to a non-participating hospital or to a hospital that your PCP or other participating provider

cannot work at, L.A. Care has the right to transfer you to a participating hospital as soon as it is medically safe.

Your PCP must provide the follow-up care for emergency services. You will be reimbursed for all charges paid by you for covered emergency services, including medical transportation services (including ambulance and air ambulance), provided by non-participating providers. The amount you pay will not exceed the cost-sharing amount you would pay for the same covered services from a participating provider.

Emergency Services Out of the Service Area

If an emergency occurs while out of the service area, you may receive emergency services at the nearest emergency facility (doctor, clinic or hospital). You must report such services to L.A. Care within 48 hours, or as soon as capable. Any treatment given that is not authorized by your PCP or L.A. Care, and which is later determined by L.A. Care not to be for emergency services as defined in the *Subscriber Agreement & Member Handbook* will not be covered. Your PCP must provide the follow-up care after receipt of emergency services. You will be reimbursed for all charges paid by you for covered emergency services, including medical transportation services, provided by non-participating providers.

Post-Stabilization and Follow-up Care After an Emergency

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

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

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

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

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

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

If you feel that you were improperly billed for post-stabilization services that you received from a non-contracted hospital, please contact L.A. Care Member Services at 1.844.854.7272 (TTY 711).

Eye Exam/Vision Services

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

Family Planning Services

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

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

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

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

- Abortions or
- Vasectomy

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

Fertility preservation

Services to preserve fertility to offset medically created infertility (iatrogenic infertility) are covered. This can include:

- Cryopreservation of eggs or sperm
- Radiation shielding

Any other services to treat infertility are not covered, such as:

- Intrauterine insemination
- In vitro fertilization
- Medications intended to increase fertility or encourage embryo implantation.

Health Education Services

L.A. Care's health education services program is called *Health in Motion*™ *Health in Motion*™ services include an array of fun wellness workshops and group appointments to help you stay healthy and manage your chronic conditions. Come learn the skills you need to meet your health goals in an interactive and exciting way! Wellness workshops and group appointments are offered in English and Spanish at places and times convenient for you. Free interpreters can be there for other languages. If you cannot make it to a workshop, an L.A. Care Certified Health Coach and/or Registered Dietician will call you and talk to you over the phone. Health topics include asthma, diabetes, heart health, chronic condition support, nutrition and exercise, among others.

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

All health education services and resources are free. Call L.A. Care for more information at **1.855.270.2327** (TTY **711**) or go to **lacare.org.**

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

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

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

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

Exclusions:

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

Home Health Services

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

- Registered Nurses,
- Licensed Vocational Nurses and home health aides,

- Physical, occupational and speech therapy, if medically necessary, and
- Respiratory therapy

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

Exclusions: Custodial care

Hospice

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

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

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

The hospice benefit includes medical treatment to relieve pain and other symptoms related to the terminal illness, but does not include efforts to cure the illness.

The hospice election may be stopped at any time.

Hospital Services – Inpatient

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

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

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

Hospital Services – Outpatient

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

- Operating room,
- General anesthesia,
- Treatment room,
- Ancillary services, and

- Medications which are given by the hospital or facility for use during the member's treatment at the facility.

Human Papillomavirus Screening Test and Vaccine

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

Medical Nutrition Therapy (MNT)

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

Medical Transportation

Emergency

Emergency transportation to the first hospital which accepts the member for emergency care is covered.

This includes ambulance and ambulance transportation services provided through the 911 emergency response system.

Non-Emergency

The benefits below are covered when

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

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

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

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

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

Transportation Exclusions

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

Mental Health Services

See Behavioral Health Services

Physical, Occupational, and Speech Therapy

This benefit covers short-term neuromuscular rehabilitative services, including physical, occupational, speech, and inhalation therapies for the treatment of acute conditions or the acute phase of chronic conditions as medically necessary. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. L.A. Care may require periodic evaluations as long as medically necessary therapy is provided.

Pregnancy and Maternity Care

Coverage for prenatal and postnatal PCP office visits and delivery which are medically necessary, professional and hospital services including prenatal and postnatal care, and care for complications of pregnancy. Alpha

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

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

L.A Care does not restrict its inpatient hospital care to less than 48 hours following a normal vaginal delivery and not less than 96 hours following a cesarean section delivery. However, coverage of inpatient hospital care may be less than a 48-96 hour time period if the following two conditions are met:

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

Prescription Drug Program

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

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

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

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

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

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

L.A. Care HEALTH PLAN®

How to Get Your Prescription Drugs

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

For New Prescriptions

If you are filling a prescription for the first time, you must go to a pharmacy that works with L.A. Care. L.A. Care partners with pharmacies throughout Los Angeles County (including Albertson's /Sav-On, CVS, Rite Aid, Target, Vons, Wal-Mart, and Walgreens). A list of pharmacies that work with your health plan is in L.A. Care's Provider Directory, or you may call L.A. Care Member Services toll-free at **1.844.854.7272** (TTY **711**), 24 hours a day, 7 days a week, including holidays for a pharmacy close to you.

For Prescription Refills

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

How to Get a Prescription Filled at the Pharmacy

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

Preventive Care Services

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

- A variety of voluntary family planning services
- Prenatal care
- Sexually transmitted disease (STD) tests, including Human Immunodeficiency Virus (HIV) tests and home test kits when ordered by your in-network provider.
- Acquired Immune Deficiency Syndrome (AIDS) vaccine
- HIV Pre-Exposure Prophylaxis (PrEP) and associated necessary services, including those for initial care and follow-up care.
- Hearing tests, hearing aids and services: Hearing evaluation to measure the extent of hearing loss and a hearing and evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid: monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords, and other ancillary equipment. Visits for fittings, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid
- Cytology exam, on a reasonable and periodic basis
- Health education
- Cancer screening: All generally medically accepted cancer screening tests, including those listed below

– General Cancer Screening

– Cervical Cancer Screening

– Human Papilloma Virus (HPV) screening

– HPV vaccinations including, but not limited to, Gardasil® for girls and young women ages 9 through 26

- Mammography for breast cancer screening
- Prostate cancer screening
- Diethylstilbestrol services
- Colorectal cancer screening, including Fecal Immunochemical Test (FIT), Fecal Occult Blood Test (FOBT), Multitarget Stool DNA Test, and colonoscopy.*
- Adverse Childhood Experience (ACEs) screening.

* In the event that a colorectal cancer screening test (other than a colonoscopy) yields a positive result, a follow-up colonoscopy will be required. This subsequent colonoscopy will also be covered as a preventive service at no charge.

Exclusions:

- Members will only receive exams related to their medical needs. For example, a parent's desire for physical exam will not be covered.
- Immunizations required for travel.
- Tests prescribed by a provider who is not part of the L.A. Care provider network.
- The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, charges for a hearing aid which exceed specification prescribed for correction of a hearing aid purchase, and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Replacement parts for hearings aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of 36 months, and surgically implanted hearing devices.

Professional Services

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

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

This benefit does not include:

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

Prosthetics and Orthotics

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

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

Reconstructive Surgery

Reconstructive surgery repairs abnormal body parts, improves body function, or creates a normal appearance. This benefit includes reconstructive surgery to restore and achieve symmetry due to mastectomy.

This includes medically necessary surgery to repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to the extent possible.

Transgender Services

These services are provided when medically necessary and may include:

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

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

Skilled Nursing Care

Services prescribed by an L.A. Care physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24 hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

Exclusion: Custodial care

Substance Use Disorder Treatment

See Behavioral Health Services

Transplants

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

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

Exclusions and Limitations

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

- Acupuncture services;
- Biofeedback, unless the treatment is medically necessary and prescribed by a licensed physician, surgeon or licensed psychologist
- Chiropractic Services;

- Conception by artificial means including gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), invitro fertilization (IVF), or any other process that involves the harvesting or manipulation (physical, chemical, or by any other means) of the human ovum to treat infertility. Any service, procedure, or process that prepares the member to receive conception by artificial means is not covered
- Contraceptives and contraceptive devices that do not require a prescription (unless deemed medically necessary by Plan physician);
- Convenience items such as telephones, TVs, guest trays, private room in a hospital and personal items;
- Cosmetic Services (i.e., surgery that is performed to alter or reshape normal structures of the body in order to improve appearance); except cosmetics or cosmetic surgery provided when medically necessary for Mental Health / Substance Use Disorder treatment.
- Custodial care incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, or to control or change a person's environment;
- Routine dental care services or appliances (e.g. teeth cleaning, cosmetic);
- Emergency facility services for non-emergency conditions;
- Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standard or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the time or service in question is recommended or prescribed. If L.A. Care denies your request for services based on the determination that the services are experimental or investigational, you may request an Independent Medical Review. For information about the Independent Medical Review (IMR) process, please refer to the *"Grievance and Appeals"* section of this Member Handbook.
- Hearing aids/services; are subject to the limitations set forth in the *"Preventive Care Services"* section of this member handbook.
- Home/vehicle improvements including any modifications or attachments made to dwellings, property, or motor vehicles including ramps, elevators, stair lifts, swimming pools, air filtering systems, environmental control equipment, spas, hot tubs, or automobile hand controls;
- Implants, except those that are medically necessary and are not cosmetic, experimental or investigational in nature; however, prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy are not excluded;
- Infertility treatments (except treatments for medical conditions of the reproductive system if deemed medically necessary by a Plan physician); treatments such as in-vitro fertilization, GIFT (Gamete Interfallopian Transfer) or any other form of induced fertilization, artificial insemination or services incident to or resulting from procedures for or the services of a surrogate mother are not covered services;
- Long Term Care;
- Medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices that are either:

– Experimental or investigational in nature or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question; or

– If services are denied due to the experimental or investigational nature of the treatment, you may immediately have this decision reviewed by the Department of Managed Health Care (DMHC) through the IMR process. You do not need to participate in the Plan's Grievance Process before having your case heard through DMHC's IMR process. You may apply directly to DMHC for participation in the IMR process;

- Non-skilled care that can be performed safely and effectively by family members (whether or not such family members are available to provide such

services) or persons without licensure certification or the presence of a supervising licensed nurse, except for authorized homemaker services for hospice care, and except for Behavioral Health Treatment that is provided by a qualified Autism service professional or qualified Autism service paraprofessional for the treatment of Autism Spectrum Disorder (includes Asperger's Syndrome, Autism and Pervasive Development Disorder);

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

  Also, L.A. Care may recover the cash value of its benefits from the member, up to an amount equal to what was actually paid by the Plan, to the extent that such Benefits would have been covered or paid for as Workers' Compensation Benefits if the member had diligently tried to establish his or her rights thereto.

Questions? Call **L.A. Care Member Services at 1.844.854.7272** (TTY 711).

General Information

Benefit Program Participation

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

Notifying You of Changes in Benefits

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

Termination of Benefits

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

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

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

If you believe that your membership was terminated or not renewed because of your health status or requirements for health care services, you may request a review of such cancelation by the Director of the Department of Managed Health Care.

Continuation Coverage and New Options

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

- COBRA/Cal-COBRA Continuation Coverage
- Covered California

COBRA Continuation Coverage

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

"Qualifying events" are events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage.

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

- Termination of the PASC-SEIU worker employment for any reason other than "gross misconduct"; or

- Reduction in the PASC-SEIU workers hours of employment.

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

Duration of continuation coverage

Maximum periods

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

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

Early termination

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

You fail to pay the required premium on a timely basis;

PASC-SEIU ceases to maintain any group health plan to any PASC-SEIU worker:

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

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

How to obtain COBRA continuation coverage

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

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

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

Member cost for COBRA continuation coverage

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

Payment of COBRA Premiums

To pay your premium:

1. Make payments for COBRA continuation coverage on a monthly basis.
   - There must be no lapse in your coverage.
   - The first premium payment will cover the period of coverage from the date of the COBRA Election Form to the date coverage ended under the group health plan.
   - The initial premium payment must be made within 45 days after the date you sign the COBRA Election Form. Failure to submit the correct premium amount will disqualify you from COBRA continuation coverage.

- Consider including your initial premium payment with the COBRA Election Form. This will allow you to obtain health benefits with no interruption.
- After the first or initial premium payment, all premium payments are due on the first of the month.
- If payment is not received by the first of the month, you have a 30-day grace period to submit payment. However, you are not eligible for coverage until payment is received.

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

2. L.A. Care offers several payment options. **Cash is not accepted**. You may pay by:
   - Personal checks
   - Money orders
   - Cashier's checks
   - Business checks
   - e-Check (Automated Clearing House) – electronic fund transfer system
   - Visa, Mastercard, and Discover debit/credit cards

   To pay by mail:

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

   To pay online:

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

   To pay by phone:

   Call L.A. Care's Member Services Department toll free at **1.844.854.7272** (TTY **711**)

Please call L.A. Care Member Service at **1.844.854.7272** (TTY **711**) if you have questions or need assistance.

Cal-COBRA Continuation Coverage

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

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

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

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

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

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

Termination of Cal-COBRA continuation coverage

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

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

Covered California

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

You must apply during an open or special enrollment period. Open enrollment is scheduled annually by Covered California, starting on November 1st and ending the following January 31st, as defined by state law. A special enrollment period is triggered by a life change such as marriage, divorce, a new child, or loss of a job.

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

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

To qualify for help paying for insurance, you must:

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

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

How a Provider Gets Paid

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

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

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

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

Reimbursement Provisions – If You Receive a Bill

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

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

You can call L.A. Care Member Services at **1.844.854.7272** (TTY **711**). This call is free.

Independent Contractors

L.A. Care physicians, PPGs, hospitals, and other health care providers are not agents or employees of L.A. Care. Instead, they are independent contractors. Although

L.A. Care regularly credentials the doctors who provide services to members, L.A. Care does not, itself, provide these services. As such, L.A. Care is not responsible for the actions or omissions of any person who does provide these services to members. This includes any doctor, hospital, or other provider or their employees.

Review by the Department of Managed Health Care (DMHC)

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

The member can call the DMHC toll-free at **1.888.466.2219**.

Duplicate Coverage

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

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

Coordination of Benefits

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

- Other health benefits, such as California Children's Services (CCS),
- Health benefits under another contract, or
- Another government program.

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

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

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

Third Party Liability

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

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

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

Public Policy Participation

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

- Attend Board of Governors meetings
- Offer public comment at the Board of Governors meeting
- Take part in establishing policies that assure the comfort, dignity and convenience of members, their families, and the public when seeking health care services. (Health and Safety Code 1369)

Regional Community Advisory Committees (RCACs)

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

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

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.

Notice of Information Practices

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

Governing Law

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

New Technology

L.A. Care follows changes and advances in health care. We study new treatments, medicines, procedures, and devices. We call all of this "new technology." We review scientific reports and information from the government and medical specialists. Then we decide whether to cover the new technology. Members and providers may ask L.A. Care to review new technology.

Natural Disasters, Interruptions, Limitations

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

Definitions

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

DEFINIITONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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 patients, to find out if a new treatment or drug is safe and works with the type of illness that you have.

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

Continuity of Care is your right to continue seeing your doctor or using a hospital, in certain cases, even if your doctor or or hospital leaves your health plan.

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

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

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

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

Covered Services (Benefits) see Benefits.

Credential is a certificate showing that a person is authorized to treat members.

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

Curative is having the ability to cure or heal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Plan refers to L.A. Care.

Health Care Services include some of the following:

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

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

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

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

Hospital provides inpatient and outpatient care from doctors or nurses.

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

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

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

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

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

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Intraocular Lens is the lens within your eyeball.

Involuntary/Involuntarily is when something is done without choice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pharmacy is a place to get prescribed drugs.

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

Plan means L.A. Care.

Physician is a doctor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Phone Numbers

California State Services

Service	Phone
California State Department of Health Care Services (DHCS)	1-800-541-5555
Department of Managed Health Care (DMHC)	1-888-466-2219
Department of Public and Social Services (DPSS)	1-866-613-3777
Supplemental Social Income (SSI)	1-800-772-1213
Children's Services and Programs State Services	
Access for Infants and Mothers (AIM)	1-800-433-2611
California Children's Services (CCS)	1-800-288-4584
Child Health and Disability Prevention (CHDP)	1-800-993-CHDP (1-800-993-2437)
Medi-Cal	1-800-541-5555

Disability Services

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

L.A. Care Health Plan Services

Service	Phone
L.A. Care Member Services	1-844-854-7272
Authorizations	1-877-431-2273
Pharmacy	1-844-268-9787
L.A. Care Behavioral Health Hotline	1-877-344-2858
L.A. Care Nurse Advice Line	1-800-249-3619
L.A. Care Compliance Helpline	1-800-400-4889

Los Angeles County Services

Service	Phone
Los Angeles County Department of Health Services	1-213-240-8101
Los Angeles County Department of Mental Health	1-800-854-7771
Women, Infant and Children (WIC) Program	1-888-942-9675

Service	Phone
PASC	1-877-565-4477
SEIU - Dental Services	1-877-565-4477

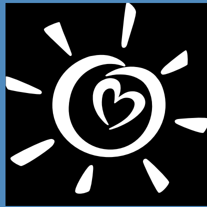
Service Area Map

PASC-SEIU Service Areas

Los Angeles

Lancaster
Palmdale
Van Nuys
Glendale
Pasadena
Pomona
Whittier
Torrance
Long Beach
Fullerton
Anaheim
Garden Grove
Santa Ana
Huntington Beach
Irvine
Orange

8 miles



Toll Free: **1.844.854.7272** | TTY: **711**

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