L.A. Care Covered™
For All of L.A.

L.A. Care *Covered*™

2018

A Helpful Guide to Your Health Care Benefits

January 1, 2018 - December 31, 2018

CHANGES TO MAIL ORDER PHARMACY VENDOR

Dear Member,

L.A. Care recently made a change to your mail order pharmacy vendor. Costco will no longer fill mail order prescriptions for L.A. Care Health Plan members (as noted on pages 14-15 of your enclosed New Member Kit). The new mail order pharmacy vendor is **Kroger Mail Order Pharmacy**. Kroger Mail Order Pharmacy can provide you convenient and prompt mail order pharmacy services at your doorstep. Kroger Mail Order Pharmacy provides this service through Postal Prescription Services (PPS).

To utilize the mail order pharmacy service through Kroger Mail Order, chose one of the following options:

Online: Visit the Kroger Mail Order Pharmacy's website at www.ppsrx.com and register your new member account.

Mail: Complete the Customer New Prescription Request form available online at lacare.org (under For Members, Member Services, and then Pharmacy Services). Forms are also available in Spanish.

Mail to:
PPS – Postal Prescription Services
P.O. Box 2718
Portland, Oregon 97208-2718

For questions about Kroger Mail Order Pharmacy, please read the Frequently Asked Questions (FAQs) and answers found on the Kroger Mail Order Pharmacy home page. You can access the Kroger Mail Order Pharmacy home page through the L.A. Care Pharmacy & Formulary website.

Phone: Call Kroger Mail Order Pharmacy Member Services at 1.800.552.6694. Customer Service hours are Monday-Friday, 6 a.m.-6 p.m. PST, and Saturday, 9 a.m. -2 p.m. PST.

If you have any questions, call L.A. Care Member Services at **1.855.270.2327** or **(TTY 711).** The call is free. You can call anytime between 7 a.m. and 7 p.m. You can get this letter for free in other languages.

Sincerely,

L.A. Care Health Plan

Discrimination is Against the Law

L.A. Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. L.A. Care Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

L.A. Care Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Member Services Department at 1-855-270-2327 (TTY 711).

If you believe that L.A. Care Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance/complaint with the Civil Rights Coordinator of L.A. Care Health Plan. You have two options in which you may file a grievance/complaint:

You may call in a grievance/complaint at:

Member Services Department – 1-855-270-2327 (TTY 711)

Or you may send in a written grievance/complaint to:

Civil Rights Coordinator
c/o Compliance Department
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Email: civilrightscoordinator@lacare.org.

You can file a grievance/complaint in person, by mail, by telephone, or by email. If you need help filing a grievance/complaint, the Civil Rights Coordinator via the Member Services Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 1-800–537–7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Getting Help in Other Languages

English
To request free interpreting services, information in your language or in another format, call L.A. Care at **1-855-270-2327** or TTY **711**.

Spanish
Para solicitar servicios de interpretación gratuitos o información en su idioma o en otro formato, llame a L.A. Care al **1-855-270-2327** o al **711** para TTY.

L.A. Care Covered

Silver 94 HMO

Summary of Benefits

The Summary of Benefits sets forth the Member's share-of-costs for Covered Services under this benefit plan and represents only a brief description of the benefit plan. Please read the Evidence of Coverage carefully for a complete description of provisions, benefits, exclusions, prior authorizations and other important information pertaining to this benefit plan.

See the end of this Summary of Benefits for footnotes providing important additional information.

Summary of Benefits — HMO Plan

Member Calendar Year Deductible (Medical Plan Deductible)[1]	Deductible Responsibility	
	Services by Preferred, Participating, and Other Providers[1]	**Services by Non-Preferred and Non-Participating[2]**
Calendar Year Medical Deductible	$75 per Member/$150 per Family	100% of all charges

Member Calendar Year Pharmacy Deductible[3]	Member Deductible Responsibility	
	Participating Pharmacy[1]	**Services by Non-Preferred and Non-Participating[2]**
Per Member/Per Family Does not apply to contraceptive Drugs and devices.	None	100% of all charges

Member Maximum Calendar Year Out-of-Pocket Amount[1,4]	Member Maximum Calendar Year Out-of-Pocket Amount	
	Services by Preferred, Participating, and Other Providers[1]	**Services by Non-Preferred and Non-Participating[2]**
Calendar Year Out-of-Pocket Maximum (includes deductible)	$1,000 per Member / $2,000 per Family	100% of all charges

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Member Maximum Lifetime Benefits	Maximum L.A. Care Payment
	Services by Preferred, Participating, and Other Providers[1]
Lifetime Benefit Maximum	No maximum

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
Acupuncture Benefits	
Acupuncture Services	
Covered Services by a certified acupuncturist	$5 per visit
Covered Services by a Doctor of Medicine.	$5 per visit
Allergy Testing and Treatment Benefits	
Allergy serum purchased separately for treatment	10%
Office visits (includes visits for allergy serum injections)	$8 per visit
Ambulance Benefits[6]	
Emergency or authorized transport	$30 after deductible
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.	
Ambulatory Surgery Center Outpatient Surgery Facility Fee	10%
Ambulatory Surgery Center Outpatient Surgery Physician/Surgeon fee	10%
Bariatric Surgery Benefits **Prior authorization is required.**	
Hospital Inpatient Facility Fee	10% after deductible
Inpatient Bariatric Surgery Physician/Surgeon Fee	10% after deductible
Hospital Outpatient Services	10%
Chiropractic Benefits	
Chiropractic Services Covered Services rendered by a chiropractor.	Not covered
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits	
Clinical Trial for Treatment of Cancer or Life Threatening Services Covered Services for Members who have been accepted into an approved clinical trial for cancer when prior authorized by L.A. Care. (Note: The cost-share indicated is in connection with Inpatient services. If services in connection with this benefit are performed in an Outpatient setting an Outpatient facility fee will be assessed).	10% after deductible
Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment See Dental Services section in the EOC for more information	
Ambulatory Surgery Center Outpatient Surgery Facility Services	10%
Inpatient Hospital Services	10% after deductible
Office location	$5

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
Outpatient department of a Hospital	10%
Diabetes Care Benefits	
Devices, equipment and supplies Diabetic equipment includes: blood glucose monitor; insulin pumps; podiatric devices, including orthopedic shoes; and, visual aids, excluding eyewear. Diabetes-related medications and diabetic testing supplies are covered under Outpatient Drugs benefit. (Note: This definition is to clarify differences between this benefit and Outpatient Prescription Drugs benefit-as follow.) Outpatient Drugs benefit: Formulary diabetes-related medications, diabetic disposable syringes and needles, and diabetic testing supplies are covered under the drug benefit. Please refer to the L.A. Care Formulary for more information. Diabetic testing supplies- which include lancets, blood and urine testing strips and test tables are covered. These over-the-counter items must be ordered by a physician for coverage.	10%
Diabetes self-management training provided by a Physician in an office setting[7]	No charge
Diabetes self-management training provided by a registered dietician or registered nurse that are certified diabetes educators[7]	No charge
Medical nutrition therapy[7]	No charge
Dialysis Benefits	
Inpatient dialysis care	10% after deductible
Outpatient Dialysis Services Note: Dialysis Services may also be obtained from a Hospital. Dialysis Services obtained from a Hospital will be paid at the Participating provider level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	10%
Durable Medical Equipment Benefits	
Breast pump	No charge
Other Durable Medical Equipment Includes but not limited to: insulin pumps, peak flow meters, blood glucose monitors, IV poles	10%
Emergency Room Benefits	
Emergency Room Physician Fee	No charge
Emergency Room Facility Fee	$50 per visit (copay waived if admitted)
Family Planning Benefits Note: Copayments listed in this section are for Outpatient Physician Services only. If services are performed at a facility (Hospital, Ambulatory Surgery Center, etc.), the facility Copayment listed under the appropriate facility benefit in the Summary of Benefits will also apply except for insertion and/or removal of intrauterine device (IUD), an intrauterine device (IUD), and tubal ligation.	
Counseling and consulting (Including Physician office visits for diaphragm fitting, injectable contraceptives or implantable contraceptives)	No charge
Diaphragm fitting procedure When administered in an office location, this is in addition to the Physician office visit Copayment.	No charge
Abortion	10%
Implantable contraceptives	No charge

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
Infertility Services	Not covered
Injectable contraceptives	No charge
Insertion and/or removal of intrauterine device (IUD)	No charge
Intrauterine device (IUD)	No charge
Tubal ligation	No charge
Vasectomy	10%
Home Health Care Benefits Up to a combined Benefit maximum of 100 visits per Member, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. If your benefit plan has a Calendar Year Medical Deductible, the number of days starts counting toward the maximum when the services are first provided even if the Calendar Year Medical Deductible has not been met. • **Home Health Care agency services**, including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist • **Home Infusion/Home Injectable Therapy Benefits** (e.g., blood factor and other home infusion products) o Home visits by an infusion nurse (Home infusion agency nursing visits are not subject to the Home Health Care and Home Infusion/Home Health Injectable Services Calendar Year visit limitation.) o Medical supplies associated with infusion/injectable therapy o Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit and standard member copayments apply	$3
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program All Hospice Program Benefits must be prior authorized by L.A. Care and must be received from a Participating Hospice Agency.	
24-hour Continuous Home Care	No charge
General Inpatient care	No charge
Inpatient Respite Care	No charge
Pre-hospice consultation	No charge
Routine home care	No charge
Hospital Benefits (Facility Services)	
Inpatient Facility Fee Semi-private room and board, and Medically Necessary Services and supplies, including Subacute Care.	10% after deductible
Inpatient Physician/Surgeon Fee[8]	10% after deductible
Inpatient Medically Necessary skilled nursing Services including Subacute Care Up to a maximum of 100 days per Member, per Calendar Year, maximum except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your benefit plan has a Calendar Year Medical Deductible, the number of days starts counting toward the maximum when the Services are first provided even if the Calendar Year Medical Deductible has not been met.	10% after deductible

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
Outpatient Facility Fee	10%
Outpatient Physician/Surgeon Fee	10%
Outpatient visit includes but not limited to chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services[9]	10%
Outpatient Laboratory and Pathology: Diagnostic Laboratory services are covered per service or per test when provided to diagnose illness or injury.	$8
Outpatient X-Ray and Diagnostic Imaging: Outpatient X-Ray services including Mammogram. Diagnostic X-Ray and Imaging services are covered per service or per test when provided to diagnose illness or injury.	$8
Mental Health and Substance Use Disorder Benefits **(All Services provided through Beacon Health Options (Beacon))**	**Services by Beacon Participating Providers**
Mental Health and Substance Use Disorder Benefits[10,11]	
Mental Health – Inpatient Care • Inpatient Facility Fee (e.g. hospital room) • Inpatient Physician Fee • Crisis Residential Program (Short-term treatment in a crisis residential program licensed psychiatric treatment facility with 24 hour-a day monitoring by clinical staff for stabilization for an acute psychiatric crisis.) • Inpatient non-Medical Transitional Residential Recovery Services – Mental Health • Psychiatric Observation	10% after deductible
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. • Outpatient Partial Hospitalization [14] • Outpatient Mental Health Care • Mental Health Intensive Outpatient Treatment Programs (short-term multidisciplinary treatment in an intensive psychiatric treatment program) • Electroconvulsive Therapy (ECT) • Outpatient Transcranial Stimulation • Other outpatient items and services[12]	10%
Mental Health - Outpatient Visits Services obtained during a provider office visit, outpatient hospital visit or urgent care visit. This includes: • Office visits, individual evaluation and treatment • Treatment in a group setting, evaluation and treatment • Medication Management • Crisis Intervention (Short-term treatment in a crisis residential program licensed psychiatric treatment facility with 24 hour-a day monitoring by clinical staff for stabilization for an acute psychiatric crisis.)	15% up to $5
Psychological Testing	$0
Substance Use Disorder – Inpatient Care	10% after deductible

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
• Inpatient Facility Fee (e.g. hospital room) • Inpatient Physician Fee • Inpatient non-Medical Transitional Residential Recovery Services[13] • Inpatient Services to treat acute medical complications of detoxification	
Substance Use Disorder – Outpatient Facility-Based Care Services outside of an office setting, such as a treatment center or home, that involve daily or weekly treatment delivered over several hours. • Outpatient Substance Use Care • Day Treatment • Intensive Outpatient Treatment Programs • Other outpatient items and services[12]	10%
Substance Use Disorder – Outpatient Visits Services obtained during a provider office visit, outpatient hospital visit or urgent care visit. This includes: • Office visits, individual evaluation and treatment • Treatment in a group setting, evaluation and treatment • Medical Treatment for Withdrawal • Opioid Replacement Therapy	15% up to $5
Behavioral Health Treatment for Autism Spectrum Disorder (including Aspergers, Autism, and Pervasive Development) • Individual evaluation and treatment • Evaluation and treatment in a group setting	$0
Ostomy and Urological Supplies Prescribed in accordance with our soft goods formulary guidelines L.A. Care selects the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.	10%
Outpatient Prescription Drug Benefits [15,16,17,18,19,20]	**Participating Pharmacy[1]**
Retail Prescriptions (up to a 30 day supply)	
Contraceptive Drugs and Devices[21]	No charge
Tier 1 (Most Generics)	$3
Tier 2 (Preferred Brand)	$10
Tier 3 (Non-Preferred Brand)	$15
Tier 4 (Specialty Drugs) Prior authorization is required	10% up to $150 per script
Mail Service Prescriptions (up to a 90 day supply)	
Contraceptive Drugs and Devices [21]	No charge
Tier 1 (Most Generics)	$6
Tier 2 (Preferred Brand)	$20
Tier 3 (Non-Preferred Brand)	$30
Outpatient X-Ray, Imaging, Pathology, and Laboratory Benefits Note: Benefits in this section are for diagnostic, non-preventive health Services and for diagnostic radiological procedures, such as CT scans, MRIs, MRAs and PET scans, etc. Diagnostic X-Ray, Laboratory, Imaging, and Scan services are covered per service or per test. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits.	
Outpatient diagnostic laboratory and pathology including Papanicolaou test performed in an Outpatient Laboratory Center or Outpatient Hospital	$8

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
Outpatient diagnostic X-ray and imaging, including mammography performed in an Outpatient Radiology Center or Outpatient Hospital	$8
Imaging Services including CT, PET scans and MRIs performed in the Outpatient department of a Hospital or free-standing outpatient center Prior authorization is required.	$50
Nuclear Medicine Imaging Prior authorization is required	$50
Pediatric Services	
Asthma care – nebulizers	10%
Asthma care – inhaler spacers, peak flow meters	10%
Asthma care education	No charge
PKU Related Formulas and Special Food Products Benefits	
PKU	$ 15
Podiatric Benefits	
Podiatric Services provided by a licensed doctor of podiatric medicine	$5
Routine Foot Care	$5
Pregnancy and Maternity Care Benefits	
Preconception and Prenatal Physician office visits, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy	No charge
All necessary Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	10% after deductible
All necessary Inpatient Professional Services for normal delivery, Cesarean section, and complications of pregnancy	10% after deductible
Postnatal Physician office visits	$5
Routine newborn circumcision performed in the office, ASC or outpatient hospital	10%
Preventive Health Benefits	
Preventive Care, Screenings and Immunizations Including preventive general cancer screenings, cervical cancer screenings (HPV screenings and vaccinations), mammography for breast cancer screenings, prostate specific antigen tests, fecal blood occult test, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, HIV tests, Diethylstillbestrol services, aortic aneurysm screenings, retinal photography screenings, bone density DEXA and CT scans. See additional information in the preventive care section of the EOC.	No charge
Routine Physical Exam	No charge
Well Child Preventive Exam (up to age 23 months)	No charge
Professional (Physician) Benefits	
Physician office visits Note: For other services with the office visit, you may incur an additional Benefit Copayment as listed for that service within this Summary of Benefits. This additional Benefit Copayment may be subject to the Calendar Year Medical Deductible.	$5
Other practitioner office visit[22]	$5
Specialist office visits[23]	$8

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
Urgent Care visits	$5
Prosthetic and Orthotic Benefits	
Office visits	$5
Prosthetic equipment and devices[24]	10%
Reconstructive Surgery Benefits	
Physician office visits	$8
Ambulatory Surgery Center Outpatient Surgery Facility Services	10%
Inpatient Hospital Services	10% after deductible
Outpatient department of a Hospital	10%
Rehabilitation and Habilitation Services Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings:	
Office location	$5
Outpatient department of a Hospital	$5
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	10% after deductible
Skilled Nursing Facility Benefits	
Services by a free-standing Skilled Nursing Facility Up to a Benefit maximum of 100 days per Member, per Calendar Year. These Services have a Calendar Year day maximum except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your benefit plan has a Calendar Year Medical Deductible, the number of days starts counting toward the maximum when the services are first provided even if the Calendar Year Medical Deductible has not been met.	10% after deductible
Speech Therapy Benefits Speech Therapy Services by a Doctor of Medicine or licensed speech pathologist or certified speech therapist in the following settings:	
Office location – Services by a Doctor of Medicine	$5
Office location – Services by a licensed speech pathologist or certified speech therapist	$5
Outpatient department of a Hospital	$5
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	10% after deductible
Skilled Nursing Facility Rehabilitation Unit for Medically Necessary days Up to a Benefit maximum of 100 days per Member, per Calendar Year. These Services have a Calendar Year day maximum except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year facility Deductible, the number of days starts counting toward the maximum when the Services are first provided even if the Calendar Year medical Deductible has not been met.	10% after deductible

Benefit	Member Copayment[5]
	Services by Preferred and Participating Providers[1]
Transplant Benefits L.A. Care covers medically necessary transplants of organs, tissue, or bone marrow, which are not experimental or investigational in nature. We cover transplants of organs, tissue, or bone marrow if your physician provides a written referral for care to a transplant facility.	
Hospital Services	10% after deductible
Pediatric Vision Benefits[25] (members up to age 19)	
Well vision exam (1 visit per calendar year)	No charge
Prescription Glasses Includes frames and lenses (one pair per year)	No charge
Contact lenses and Medically necessary contact lenses for the treatment of: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism	No charge
Laser vision correction[25]	Not Covered
Pediatric Dental Benefits[26,27]	
Diagnostic and Preventive Services includes oral exam, preventive cleaning and x-ray, sealants per tooth, topical fluoride application and space maintainers-fixed	No charge
Basic Services includes Restorative Procedures and Periodontal Maintenance Services	See 2018 Dental Copay Schedule
Major Services Crowns and Casts	See 2018 Dental Copay Schedule
Endodontics	See 2018 Dental Copay Schedule
Periodontics (other than maintenance)	See 2018 Dental Copay Schedule
Prosthodontics	See 2018 Dental Copay Schedule
Oral Surgery	See 2018 Dental Copay Schedule
Orthodontics[28] medically necessary orthodontics	$1000

Summary of Benefits
Footnotes:

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2) Member is responsible for all charges when receiving out-of-network care, unless services rendered are deemed a medical emergency or services rendered are approved by the Plan. 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 you have been authorized to receive care.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out-of-pocket contribution is limited to the individual's annual out-of-pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $35 copayment, the lesser amount is the applicable cost-sharing amount.
6) Coverage for transportation by airplane, passenger car, taxi or other form of public transportation is not covered.
7) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education, and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
8) The cost sharing for hospice services applies regardless of the place of service.
9) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
10) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services
11) Initial outpatient/office visit to diagnose or determine treatment does not require prior authorization. Routine office-based outpatient care to diagnose or treat mental health or substance use disorders does not require pre-authorization when rendered by an in-network provider. There is no limit on the number of outpatient/office visits. For Silver, Bronze, and Catastrophic plans, the following MH/SUD benefits have been classified as Outpatient, Other Items and Services: Outpatient partial hospitalization; psychiatric observation, substance use disorder day treatment; substance use disorder and mental health intensive outpatient treatment programs; behavioral health treatment for autism spectrum disorder (including Asperger's, autism, and pervasive development); outpatient transcranial stimulation; and electroconvulsive therapy.
12) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
13) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.

14) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services
15) Outpatient Partial Hospitalization Services include short-term hospital-based intensive outpatient care. For Outpatient Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute an episode of care. If the patient needs to be readmitted at a later date, then this would constitute another episode of care
16) For drugs to treat an illness or condition the copay or co-insurance applies to an up to 30-day prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance can be collected. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.

17) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs
	2) Preferred brand name drugs and;
	3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies or;
	2) Drugs that require the enrollee to have special training, clinical monitoring or;
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply or;

*Some drugs may be subject to zero cost-sharing under the preventive services rules.

18) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted
19) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary
20) Member cost-share for oral anti-cancer drugs shall not exceed $200 for a script up to 30 days per state law (Health and Safety Code §1397.656 Insurance Code §10123.206).
21) If a provider authorizes a Brand Name drug that is not deemed medically necessary by the Plan, the Member has the choice of accepting a Generic Drug alternative, or the Member is responsible for the difference between the cost to L.A. Care for the Brand Name drug equivalent.
22) There is no co-payment or Coinsurance for contraceptive drugs and devices, however, if a Brand Name contraceptive drug is requested when a Generic Drug equivalent is available, the Member is responsible for the difference between the cost to L.A. Care for the Brand Name contraceptive drug equivalent. In addition, select contraceptives may require prior authorization to be covered without a co-payment or Coinsurance.

23) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
24) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than specialist for a service provided by one of these practitioners. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral Health or Substance Use Disorder outpatient services.
25) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.
26) This includes pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints
27) Well vision exam, frames and lenses available once per calendar year. Lenses include single vision, lined bifocal or lenticular, polycarbonate, plastic or glass covered in full, UV and scratch covered in full. Frames from a Pediatric Exchange Collection covered in full. Contact lenses, in lieu of glasses are covered in full. Standard, one pair annually. Monthly (6-month supply), Bi-weekly (3-month supply) and Dailies (1-month supply). Limitations include the following: two pairs of glass instead of bifocals, replacement of lenses, frames or contacts, medical or surgical treatment, orthoptics, vision training or supplemental testing. Items not covered under contact lens coverage: insurance policies or service agreements, artistically painted or non-prescription lenses, additional office visits for contact lens pathology and contact lens modification, polishing or cleaning. Laser vision correction discount, 15% off of regular price or 5% off of promotional price; discounts only available from contracted facilities.
28) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
29) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2018 Dental Copay Schedule.
30) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Learn About Your Coverage

When you first join L.A. Care, and then every year after, you will get a package of important information about your health care coverage. Please read it and call us if you have any questions. You can visit L.A. Care's website at lacare.org for the information listed below and more:

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 your primary care physician (PCP)
- How to get information about doctors
- How to get care from your PCP
- How to get a referral for specialty care, behavioral healthcare services, 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
- How your health plan evaluates new technology to decide if it should be a covered benefit
- How to get language assistance services and auxiliary aids

Special Programs

L.A. Care has the following special programs:

- **Quality Improvement Programs** to 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
- **Care Management Programs** for members who have difficult medical problems
- **Programs to better manage diseases**, like diabetes and/or asthma

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).
- 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.

How Decisions Are Made About Your Care

- How our doctors and staff make decisions about your care based only on need and be nefits. 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, including external independent review

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
- How to get help if you speak a different language

If you would like paper copies of your Evidence of Coverage (Subscriber Agreement & Member Handbook), please call us at **1.855.270.2327** (TTY **711**), 24 hours a day, 7 days a week and holidays.

L.A. Care Covered™ Member Handbook

Subscriber Agreement & Combined Evidence of Coverage and Disclosure Form

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Customer Service

Customer Service

Welcome!

Welcome to **L.A. Care Health Plan** (L.A. Care). L.A. Care is a public entity whose official name is the 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 (referred to as Member or Enrollee) quality health care services.

What is this publication?

This publication is called a Subscriber Agreement & Combined Evidence of Coverage and Disclosure Form (also called the *Subscriber Agreement & Member Handbook*). It is a legal document that explains your health care plan and should answer many important questions about your benefits. This document contains some words and terms that you may not be familiar with. Please refer to the Definitions Section at the end of this Member Handbook to be sure you understand what these words and phrases mean.

Whether you are the primary Enrollee of coverage or enrolled as a family member, your *Subscriber Agreement & Member Handbook* is a key to making the most of your membership. You'll learn about important topics like how to select a Primary Care Physician and what to do if you need hospitalization.

Term of this Subscriber Agreement, Renewal & Amendment

Term of this Subscriber Agreement & Member Handbook

This *Subscriber Agreement & Member Handbook* is effective from January 1, 2018 (or your membership effective date, if later), through December 31, 2018, unless this *Subscriber Agreement & Member Handbook* is:

- Revised under the "Amendment Process" below; or
- Terminated under the Termination Section

Renewal Section

If you comply with all the terms of this *Subscriber Agreement & Member Handbook*, we will offer to renew this *Subscriber Agreement & Member Handbook* effective January 1, 2018. We will either send you a new agreement/handbook (or post the new document on our website if you have opted to receive these documents online) to become effective immediately after the termination of this *Subscriber Agreement & Member Handbook*, or we will extend the term of this *Subscriber Agreement & Member Handbook*, in accordance with amendment process below.

Amendment Process

We may amend this *Subscriber Agreement & Member Handbook* at any time by sending you written notice at least 30 days before the effective date of the amendment (we will send the notice by e-mail if you have opted to receive these documents and notices electronically). This includes any changes in benefits, exclusions or limitations. All such amendments are deemed accepted, unless you (the Enrollee) give us written notice of non-acceptance within 30 days of the date of the notice, in which case this *Subscriber Agreement & Member Handbook* terminates on the day before the effective date of the amendment. Please refer to the Notices Section for additional information on how to send us written notice if you disagree with any amendment.

What if I still need help?

If after you become familiar with your benefits you still need assistance, please call our Member Services Department at **1.855.270.2327** (TTY **711)** if you are deaf or hard of hearing.

Note: Your *Subscriber Agreement & Member Handbook* provides the terms and conditions of your coverage with L.A. Care. Individuals have a right to view these documents prior to enrolling with L.A. Care. Persons with special health needs should pay special attention to those sections that apply to them. You may contact or visit L.A. Care if you have specific questions

about our L.A. Care Covered™ benefit plans and services. Our information is listed below:

L.A. Care Health Plan
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017
1.855.270.2327 (TTY **711**)
lacare.org

By enrolling in and accepting health services under L.A. Care Covered™, Enrollees agree to abide by all terms and conditions of this *Subscriber Agreement & Member Handbook*.

Health Information Privacy

At L.A. Care, we value the trust you (referred to as Member or Enrollee) 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 and your family private, L.A. Care:

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

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

L.A. Care needs some information about you so that we can give you good health care services. The routine collection, use and disclosure of your protected health information and other kinds of private information include:

- Name
- Gender
- Date of birth
- Sexual orientation
- Gender identity
- Education level
- Language you speak, read and write
- Race
- Ethnicity
- Home address
- Home or work telephone number
- Cell phone number
- Health history

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

- You
- Covered California™
- Another health plan
- Your doctor or providers of health care services
- Your application for the health care coverage
- Your health records

We may share your information as allowed by law. This may happen when:

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

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

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

Sometimes, we may also give your health information to:

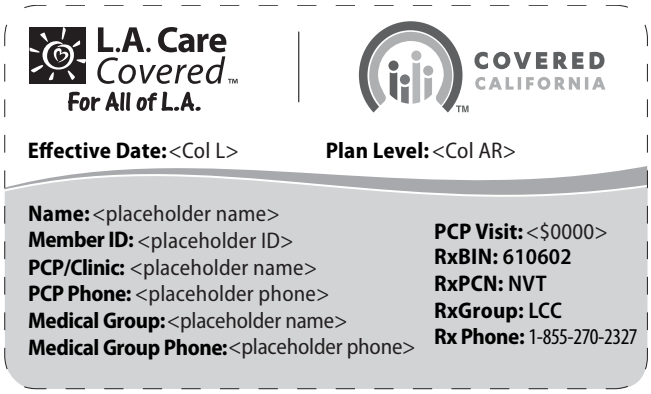
- Groups who license health care providers
- Public agencies
- Investigators
- Probate courts
- Organ donation groups
- Federal or state agencies as required by law
- Disease management programs

If you have any questions or would like to know more about 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 **1.855.270.2327** (TTY **711**).

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.

Front



Back

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.

To better understand the information on your ID card, please visit **www.lacare.org/members/la-care-covered/your-member-id-card**

The Provider Listing & Directory

L.A. Care maintains a current list of all doctors, hospitals, pharmacies, and mental health services in L.A. Care's network on its website at **lacare.org.** You may search for providers by area, specialty, language spoken and other provider characteristics. You can also request a provider directory by calling L.A. Care's Member Services Department at **1.855.270.2327** (TTY **711)**.

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

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

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call our Member Services Department at **1.855.270.2327** (TTY **711)** to ensure that you can obtain the health care services that you need.

Language Services and Aids for People with Disabilities

L.A. Care may ask about your language preference, format for written communication, as well as race/ethnicity information to help you get access to services that meets your needs and receive better care.

The information will be used to provide written materials in your preferred language and format, as well as no-cost interpreting services, including American Sign Language, for your doctor appointment.

L.A. Care will never use this information to deny you coverage and benefits. L.A. Care protects your privacy and is only allowed to use or disclose it for limited purposes. We do not use individual member demographic data to perform underwriting, rate setting or determine benefits. And L.A. Care does not give your information to unauthorized users.

Written information in your language and format

You have the right to receive written materials from L.A. Care in any of the following languages: Spanish and English. You can also request to receive written materials in large print, audio or another format. Please call L.A. Care Member Services at **1.855.270.2327** (TTY **711)**, for documents in your language or another format.

No-cost interpreting services

You have the right to no-cost interpreting services when getting health care services. L.A. Care offers

no-cost interpreting services in your language, including American Sign Language. These services are available 24 hours a day, seven (7) days a week. It is important to use a professional interpreter at your doctor appointment to help you communicate with your doctor so that you understand your health and how to take care of yourself. The professional interpreter is trained and knows medical words and will interpret everything that is said between you and your doctor, correctly and completely. The interpreter keeps your conversation with your doctor confidential and private. You should not use friends or family, especially children to interpret for you.

Call L.A. Care's Member Services Department at **1.855.270.2327** (TTY **711)** if you need interpreting services. We can assist you in your language over the phone and make sure that you have an interpreter for your next appointment. To request an interpreter:

Step 1: Make your appointment with your doctor

Step 2: Call L.A. Care at **1.855.270.2327** (TTY **711)** at least ten business days before your appointment with the following information:

- Your name
- Your member ID number
- Date and time of your appointment
- Doctor's name
- Doctor's address and phone number

If your appointment with your doctor is changed or canceled, call L.A. Care Member Services at **1.855.270.2327** (TTY **711**) as soon as possible.

Access information for people with disabilities

Many doctors' offices and clinics have accommodations that make medical visits easier for people with disabilities such as accessible parking spaces, ramps, large exam rooms, and wheelchair friendly scales. You can find doctors with such accommodations in the Provider Directory. L.A. Care Member Services can also help you locate a doctor who can meet your special needs.

A doctor's office, clinic or hospital cannot deny you services because you have disabilities. Call L.A. Care Member Services at **1.855.270.2327** (TTY **711)** if you cannot get the services you need or if services you need are difficult to get.

Remember: Tell your doctor's office if you may require additional time during your visit, because you need extra help.

Complaints

You have the right file a complaint if:

- You feel that you were denied services because of a disability or you do not speak English
- You cannot get an interpreter
- You have a complaint about the interpreter
- You cannot get information in your language
- Your cultural needs are not met

You can learn more about this in the "*Grievances and Appeals*" section of this *Subscriber Agreement & Member Handbook*.

Service Area

The Service Area for L.A. Care Covered™ is Los Angeles County (excluding Catalina Island). You and your Eligible Dependents must live in the Service Area and must select or be assigned to a PCP who is located sufficiently close to your home or workplace to ensure reasonable access to care, as determined by L.A. Care. Upon change of residence outside L.A. Care's Service Area, your coverage under L.A. Care Covered™ will terminate as required by Covered California™.

If you travel outside of Los Angeles County

As a member of L.A. Care Covered™, your service area is Los Angeles County (excluding Catalina Island). All locations outside of Los Angeles County (including outside the United States) are out of your service area.

Routine care is not covered out of service area. Emergency and urgent care services are covered outside of Los Angeles County.

Outside of Los Angeles County?

If you have an emergency when you are not in Los Angeles County, you can get emergency services at the nearest emergency facility (doctor's office, clinic, or hospital). Emergency services do not require a referral or an okay from your PCP.

If you are admitted to a hospital not in L.A. Care's network or to a hospital your PCP or other doctor does not work at, L.A. Care has the right to move you to a network hospital as soon as medically safe.

Your PCP must provide follow-up care when you leave the hospital.

Please see the "Emergency Services" section for more details on emergency care.

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.

If you have a problem getting timely access to care, you should call L.A. Care Covered™ at the phone number located on your ID Card. If L.A. Care Covered™ is not able to resolve your problem, contact the DMHC Help Center at **www.HealthHelp.ca.gov** of **1.888.466.2219**

Appointment Wait Times

Health plan members have the right to appointments within the following time frames:

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

Telephone Wait Times

- You can call 24-hours-a-day, 7 days a week to talk to a qualified health professional to decide if your health problem is urgent. If someone needs to call you back, they must call you within 30 minutes. Look for the phone number on your ID card.
- If you call your plan's customer service phone number, someone should answer the phone within 10 minutes during normal business hours.

Exceptions

- The purpose of the timely access law is to make sure you get the care you need. Sometimes you need appointments even sooner than the law requires. In this case, your doctor can request that the appointment be sooner.
- Sometimes waiting longer for care is not a problem. Your provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health.
- If you can't get a timely appointment in your area because there are not enough providers, your health plan must help you get an appointment with an appropriate provider.

Please contact L.A. Care's Nurse Advice Line at **1.800.249.3619,** 24 hours a day, 7 days a week to access triage or screening services by telephone.

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

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

- Find a doctor
- Request to change your doctor
- Learn about your benefits
- Learn about options to pay your premium
- Request member documents and forms
- 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 to L.A. Care Connect. (Be sure to have your member ID card ready as we ask for your member ID number). You can access your L.A. Care Connect account by visiting **lacare.org** and doing the following:

- Click on **Member Sign in**
- Click on **Eligibility** to check eligibility.
- Click on **Change My Doctor** to change your doctor.

Member Bill of Rights

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

Respectful and courteous treatment. You have the right to be treated with respect, dignity and courtesy by L.A. Care providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about your care. You have the right to be free from restraint (including physical and mechanical restraints and drugs), used as a means of coercion, discipline, convenience or retaliation.

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, its services, its 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 website or provider directory. You also have the right to get appointments within a reasonable amount of time. You have a right to talk with your doctor about any care your doctor provides or recommends. You have the right to a second opinion. You have a right to information about treatment regardless of the cost or what your benefits are. You have the right to say "no" to treatment. You have a right to decide in advance how you want to be cared for in case you have a life-threatening illness or injury.

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, urgent and or services in certain facilities 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 the right to request an interpreter at no charge instead of using a family member or friend to interpret for you. You should not use children to interpret for you. You have the right to request other member materials in a language or format (such as large print or audio) you understand.

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

As a Member of L.A. Care, 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, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment you both agree on.

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

Report wrongdoing. You are responsible for reporting health care fraud or wrongdoing to L.A. Care. You can report without giving your name by calling the L.A. Care Compliance Helpline toll-free at **1-800.400.4889**.

How to Get Care

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

Primary Care Physician (PCP)

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 Member ID card. Except for emergency services, your PCP will arrange all 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 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.

What is the difference between an Enrollee and an Enrolled Dependent?

While both are Members of L.A. Care, there's a difference between an Enrollee and an Enrolled Dependent. An Enrollee is the Member who enrolled with L.A. Care after being determined eligible by Covered California™. The Enrollee pays the monthly premiums to L.A. Care for his or her health care coverage for him- or herself and any Enrolled Dependent(s). An Enrolled Dependent is someone, such as a child, whose dependent status with the Enrollee allows him or her to be a Member of L.A. Care.

Why point out the difference? Because Enrollees often have special responsibilities, including sharing benefit updates with any Enrolled Dependent(s). Enrollees also have special responsibilities that are noted throughout this publication. If you're an Enrollee, please pay attention to any instructions given specifically for 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 and 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 call your PCP office to confirm his/her hours or you may check our online provider directory at **lacare.org**.

If you need medical advice during clinic/doctor office hours, you may call your PCP and speak to her/him or call L.A. Care's Nurse Advice line at **1.800.249.3619**. If you need care when your PCP's office is closed (such as after normal business hours, on the weekends or holidays), call your PCP's office. Ask to speak to your PCP or to the doctor on call. A doctor will call you back.

You can also call the Nurse Advice Line number that is on your Member ID card. This service 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 nurse will answer your questions and help you decide if you need to come into the clinic/doctor's office.

For urgent care (this is when a condition, illness or injury is not-life threatening, but needs medical care right away), call or go to your nearest urgent care center. Many of L.A. Care's doctors have urgent care hours in the evening, on weekends or during holidays.

If you cannot come in for your appointment, you should call as far ahead as possible to let the clinic or 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 will provide or arrange for 24 hours a day, 7 days a week, triage or screening services by telephone. Telephone triage or screening services waiting time will not exceed 30 minutes.

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

How to change your PCP

Each member of your household that is enrolled with L.A. Care Covered™ may select a different PCP. Upon enrollment, you should contact L.A. Care's Member Services Department at **1.855.270.2327** (TTY **711)**. to select a PCP. If you and your Enrolled Dependent(s) did not actively select a PCP after enrolling, L.A. Care assigned a PCP to each of you based on the following criteria:

- The language you speak;
- The distance to a PCP office near your house. We try to assign you a PCP within 10 miles; and
- The PCP's specialty most appropriate for the Member's age.

If you would like to change your or your Enrolled Dependent's PCP, please call L.A. Care's Member Services Department at **1.855.270.2327** (TTY **711)**. You may also make this change by visiting our website at **lacare.org**. and do the following:

- Click on **Member Sign in**
- Click on **Change My Doctor**
- Follow the instructions to change your doctor.
- The 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 PPG, this may also change the hospitals, specialists, and other health care providers from whom you may receive health care.

How to Get Information about Doctors and Specialists Who Work with L.A. Care

We are proud of our doctors and their professional training. If you have questions about the professional qualifications of network doctors and specialists, call L.A. Care at **1.855.270.2327** (TTY **711**). L.A. Care can tell you about the medical school they attended, their residency, or board certification.

Health Appraisal

When you enroll with L.A. Care Covered™, it is important that we understand how we can be of assistance to you. Your Welcome Packet contains a form called Health Appraisal (HA). The HA includes questions that help us to better know your health care needs and how we can be of assistance to you. The information you provide will be kept confidential and shared only with your PCP or your care team. **It is important that you complete the Health Appraisal in the first four (4) months or 120 days of becoming a L.A. Care Covered™ Member. Adults who successfully complete their HA within 120 days, may be eligible to receive a $25 Target GiftCard®.**

You can complete your Health Appraisal online by logging into your online member account at **lacare.org**. For more information about how to complete your HA, please call our Member Services Department at **1.855.270.2327** (TTY **711**).

New Member Check Up

It is important for new Members to get a checkup even if they are not sick. **Be sure to schedule a checkup within the first three (3) months of becoming a L.A. Care Covered™ Member. Please call your PCP today to make an appointment for a "new member checkup."** This visit is also called a "well visit" or "preventive health visit". There is no co-pay for this visit. Your PCP's telephone number is on your L.A. Care ID card.

This first visit is important. Your PCP looks at your medical history, finds out what your health status is today, and can begin any new treatment you might need. You and your PCP will also talk about preventive care. This is care that helps "prevent" you from getting sick or keeps certain conditions from getting worse. Remember, children need to get a checkup every year, even when they are not sick, to make sure they are healthy and growing properly.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Member may arrange for obstetrical and/ or gynecological (OB/GYN) services by an obstetrician/ gynecologist or family practice physician who is not her designated personal physician. A referral from your PCP or from the affiliated PPG is not needed. However, the obstetrician/gynecologist or family practice physician must be in the same PPG your PCP is in. Obstetrical and gynecological services are defined as:

- Physician services related to prenatal, perinatal, and postnatal (pregnancy) care,
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia,
- Physician services for treatment of disorders of the breast,
- Routine annual gynecological examinations.

It is important to note that services by an OB/GYN or family practice physician outside of the PCP's medical group without authorization will not be covered under this benefit plan. Before making the appointment, you should call your PCP office or Member Services at the telephone number indicated on your Member ID card to confirm that the OB/ GYN is in the PPG. The OB/GYN physician services are separate from the specialist services described below under "*Referrals to Specialty Physicians*".

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 must be approved by your PCP's PPG before you get them. This is called prior authorization. Prior authorization is required for some in-network and all out-of-network providers.

There are different types of referral requests with different timeframes as follows:

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

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

The following services do not require a prior authorization:

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

All health care services are reviewed, approved, or denied according to medical necessity. Call L.A. Care's Member Services Department if you would like a copy of the policies and procedures used to decide if a service is medically necessary. The number is **1.855.270.2327** (TTY **711**).

Some Mental Health and Substance Use Disorder services require prior authorization, including the benefits listed below:

- Crisis Residential Program
- Inpatient Mental Health and Inpatient Substance Use Disorder Services
- Inpatient non-Medical Transitional Residential Recovery Services for Mental Health and Substance Use
- Inpatient Professional (Physician) Services
- Inpatient Services to treat acute medical complications of detoxification
- Outpatient Partial Hospitalization
- Psychological Testing
- Psychiatric Observation
- Substance Use Disorder Day Treatment
- Substance Use Disorder Intensive Outpatient Treatment Programs
- Mental Health Intensive Outpatient Treatment Programs
- Substance Use Disorder Medical Treatment For Withdrawal
- Behavioral Health Treatment for Autism Spectrum Disorder (includes Aspergers, Autism, and Pervasive Development Disorder)
- Outpatient Transcranial Magnetic Stimulation
- Electroconvulsive Therapy (ECT)

The following Mental Health and Substance Use Disorder services do not require a prior authorization:

- Emergency Room Services
- Individual Therapy
- Group Therapy
- Diagnostic Evaluation
- Outpatient Medication Management
- Opioid Replacement Therapy
- Outpatient Mental Health and Substance Use Care
- Crisis Intervention

For more information on services accessible without a prior authorization and the general process for obtaining prior authorization for all other Mental Health and Substance Use Disorder services, please call the Behavioral Health Hotline at **1.877.344.2858/1.800.735.2929** TTY.

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 and 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.

Behavioral Health Services

Behavioral Health Services includes treatment for Mental Health and Substance Use Disorder conditions. Your PCP will provide you with some Behavioral Health Services 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. 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 required for most outpatient Behavioral Health Services.

Referral to 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 length 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 needs prior authorization. With a standing referral, you will not need authorization every time you want 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 show 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 services. The specialist will provide health services in his or her area of expertise and training and based on the treatment plan.

Second Opinions

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. You have the right to ask for and to get a second opinion and to ask for timeliness for making routine and urgent opinions available.

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.

How to Find a Pharmacy

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

To find a pharmacy near you:

Visit the L.A. Care website at **lacare.org** to find a pharmacy in your neighborhood. Click on each of the following:

- **For Members**
- **Pharmacy Services**
- **Search Now** in the **Find a Pharmacy** section

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

You may also call our Member Services Department at **1-855-270-2327** (TTY 711) or the Pharmacy Help Desk toll free number listed on the back side of your Plan ID Card for assistance.

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

Some medications are subject to limited distribution by the U.S. Food and Drug Administration or require special handling, provider coordination, or special education that cannot be provided at your local pharmacy. Antineoplastic and biologic agents are examples of such specialty medications and are identified in the Formulary with a special code SP or MSP - Specialty Pharmacy Availability or Mandatory Specialty Pharmacy. You may refer to the Formulary by visiting L.A. Care's website lacare.org for information on whether a medication must be filled at a specialty pharmacy. Click on each of the following:

- **For Members**
- **Pharmacy Services**
- **L.A. Covered Complete Formulary** in the Resources section

You may also call Member Services at **1.855.270.2327** (TTY **711**).

Mail Order Pharmacy

Mail-order service allows you to get up to a 90-day supply of your maintenance medications. Maintenance medications are drugs that may need to be taken for a long-term health condition, such as high blood pressure or diabetes. To set up a mail-order account or to order refill(s) for an unexpired prescription, access Kroger Mail Order Pharmacy by calling **1.855.270.2327** (TTY **711**) or visiting L.A. Care's website, **lacare.org.** Click on each of the following

- **For Members**
- **Pharmacy Services**
- **Kroger Rx Mail Order Pharmacy Forms**

If the medication(s) has no refill(s) remaining, you need to obtain a new prescription from your doctor or other prescriber. This is an optional and free service to members. Some medications require special handling and require that they be processed and mailed to you by an L.A. Care contracted specialty pharmacy.

What drugs are covered?

L.A. Care uses an approved list of drugs called the Formulary to make sure that the most appropriate, safe, and effective prescription medications are available to you. L.A. Care covers all medically necessary drugs on the Formulary if your doctor or other prescriber says you need them to get better or stay healthy, and you fill the prescription at a L.A. Care network pharmacy. Drugs that are not on the Formulary require that your doctor or other prescriber get approval before you fill the prescription. Please refer to the section Non-Formulary Drugs. The Formulary is reviewed and approved by a committee of physicians and pharmacists on a quarterly basis and includes generic, brand name, and specialty drugs covered under the prescription drug benefit. You can view the Formulary on L.A. Care's website, lacare.org, and

- Click on **For Members**
- Click on **L.A. Care Covered™** in the **Member Materials** section

You can also call L.A. Care Member Services at **1.855.270.2327** (TTY **711**) to ask for a copy of the formulary. You may also request a copy of the formulary in your preferred language or format such as large print or audio.

Pharmacy Co-Payments

L.A. Care covers generic, brand name, and specialty drugs. You are responsible for a co-payment for each drug filled at the pharmacy. The amount of your co-payment depends on the drug category and/or Tier indicated on the formulary (example: Tier 1, 2, 3, 4) and your benefit plan (example: Gold, Silver or Bronze). Please refer to the "*Summary of Benefits"* for pharmacy co-payments, deductibles, integrated deductibles and/or out-of-pocket limits that may apply.

The L.A. Care formulary includes:

- Approved prescription drugs
- Diabetic supplies: Insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices, EpiPens, and Anakits
- Inhaler spacers and extender devices,
- Emergency Contraceptive Drugs: You may get emergency contraceptive drugs from your doctor or pharmacy with a prescription from your doctor at no cost to you. You may also get emergency contraceptive drugs from a certified pharmacist without a prescription.

For information on pharmacies offering emergency contraceptive drugs from certified pharmacists without a prescription, please call L.A. Care Member Services at **1.855.270.2327** (TTY **711**).

Emergency contraceptive drugs are covered also 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.

Non-formulary drugs

Sometimes, doctors may prescribe a drug that is not on the Formulary. This will require that the doctor get authorization from L.A. Care before you fill the prescription. 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 for urgent requests or 72 hours for standard requests after getting the requested medical information. Urgent circumstances exist when a health condition may seriously jeopardize life, health, or the ability to regain maximum function or when undergoing a current course of treatment using a non-formulary drug.

The doctor or pharmacist will let you know if the drug is approved. After approval, you can get the drug at a Plan Pharmacy, please refer to the section *"How to Find a Pharmacy"* section on page 16.

If the non-formulary drug is denied, you have the right to appeal. (Please refer to the *"Grievance and Appeals"* section for more information.)

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, 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 by your doctor or other prescriber in the form of a prior authorization. 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.

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 doctor is not available, another doctor may answer your call. A doctor is available by phone 24 hours a day, 7 days a week, and also on the weekends and holidays.
3. Tell them about your condition and follow their instructions.

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

Emergency services

Emergency services are covered 24-hours a day, 7 days a week, anywhere. Emergency care is a service that a member reasonably believes is necessary to stop or relieve:

- A serious illness or symptom,
- An injury, severe pain, or active labor,
- A condition that needs immediate diagnosis and treatment

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

Examples of emergencies include but are not limited to:

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

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

What to do in an emergency:

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

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

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

Post Stabilization and Follow-up Care After an Emergency

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

If the hospital where you received emergency services is not part of L.A. Care'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 only be responsible for the Member's cost-sharing portion of the hospital stay, subject to the applicable Deductible. Please note, however, that if any cost sharing is based on a percentage of billed charges, the cost is generally higher at non-contracted hospitals. 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, your spouse or legal guardian do not agree to you being transferred, the non-contracted hospital must give you, your spouse or legal guardian 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 1.855.270.2327 (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 prudent lay 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 PCP stops working with L.A. Care. We will notify 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 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 the rest of the pregnancy and immediate postpartum care.
- Terminal illnesses/conditions – For the length of the illness.
- Children 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, ask your doctor if you can keep seeing him/her. You can also call L.A. Care Member Services at **1.855.270.2327** (TTY **711**). on 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, then L.A. Care is not required to provide the services through that doctor.

Grievance & Appeals

L.A. Care Grievance Process

What should I do if I am unhappy with my service??

If you are not happy, are having problems or have questions about the service or care given to you, you can let your PCP know. Your PCP 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 before filing a grievance with L.A. Care.

What is a grievance?

A grievance is an expression of dissatisfaction, or a complaint by a member. The grievance can be made in writing or made verbally. You have the right to file a grievance.

You must file your grievance within 180 calendar days from the day you became unhappy. 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 in English or in Spanish through L.A. Care's website at **lacare.org**.
- Please contact L.A. Care as listed below if you need a grievance form in a language other than Spanish or English, or in another format (large print or audio).

  L.A. Care Health Plan
  Member Services Department
  1055 W. 7th Street, 10th Floor
  Los Angeles, CA 90017
  1.855.270.2327 TTY **711**
  lacare.org

- Fill out a grievance form at your doctor's office L.A. Care can help you fill out the grievance form over the phone or in person. If you need interpreting services, we will work with you to make sure we can communicate with you in your preferred language.

For Members with hearing or speech loss, you may call L.A. Care's TTY telephone number for Member Services at **711**.

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 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 about your grievance within 24 hours. A decision will be made by L.A. Care within three calendar days from the day your grievance was received.

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

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

If you do not hear from L.A. Care within three calendar days, or 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 to appeal a prescription drug prior authorization decision

If you do not agree with the outcome of an exception-to-coverage decision, you, a representative, or your provider have the right to appeal the decision. You, a representative, or your provider may also request that the exception-to-coverage request be re-assessed by an external reviewer through an *Independent Review Organization (IRO)*. You, a representative, or your provider may also request that the exception-to-coverage decision be re-assessed by the Department of Managed Health Care (DMHC) through an *Independent Medical Review (IMR)*. Please refer to the section Independent Medical Review. You will receive information on how to file an appeal, external review, and/or an IMR with your denial letter.

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. Grievance Resolution letters also include information about requesting an IMR and a copy of the IMR Request form/envelope addressed to the DMHC will be attached to the Grievance Resolution letter. You may reach DMHC toll-free at **1-888-HMO-2219** or **1.888.466.2219**.

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

When to File an Independent Medical Review (IMR)

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

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

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

Non-urgent cases

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

Urgent cases

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

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

Examples of urgent cases include:

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

Independent Medical Review for Denials of Experimental/ Investigational Therapies

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

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

Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against L.A. Care, you should first telephone L.A. Care at **1.855.270.2327** (TTY **711**) and use L.A. Care's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any 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 L.A. Care, 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 IMR. If you are eligible for an IMR, the IMR process will provide an impartial view 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 and urgent medical services. The Department of Managed Health Care has a toll-free telephone, **1.888.HMO.2219**, to receive complaints regarding health plans. The hearing and speech impaired may use the department's TTY line **1.877.688.9891** to contact DMHC. DMHC's internet website **www.hmohelp.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 preclude your use of any other remedy provided by law.

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

Eligibility and Enrollment

Requirements for Member Eligibility

In order to be eligible to participate in L.A. Care Covered™, you and your dependents must meet all eligibility requirements, as determined by Covered California™, including those listed below:

- Legal Resident of California
- Reside in Los Angeles County

Dependent Coverage

An enrolled dependent child who reaches age 26 during a benefit year may remain enrolled as a dependent until the end of that benefit year. The dependent coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible.

An enrolled dependent child age 26 and older may remain on your L.A. Care Covered™ plan. Provided that he or she meets both of the following criteria, L.A. Care will not terminate your dependent's coverage:

1. Your child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition;
2. Your child is chiefly dependent upon the subscriber for support and maintenance.

Eligibility for Tax Credits and Cost Sharing Reductions

Covered California™ will use a single application to determine your eligibility and enrollment in this L.A. Care Covered™ Plan and to assess if you qualify for financial assistance that can lower the cost of your health insurance. There are two new types of programs available beginning 2014. 1) Tax Credits: will lower the cost of your monthly premium; and 2) Cost Sharing Reductions: will reduce your out-of-pocket costs. These programs are available to individuals and families who meet certain income requirements and do not have access to other affordable insurance. Please contact Member Services at **1.855.270.2327** (TTY **711**) or Covered California™ at **1.888.975.1142** for more information about the eligibility requirements for these programs.

Special Rules Governing Native American Indians and Alaskan Natives

In accordance with the Affordable Care Act Native American Indians and Alaskan Natives (AI/AN) as determined eligible by Covered California™ may qualify for benefit plans with no cost sharing obligation for essential health benefits.

AI/AN eligible members with incomes above 300% federal poverty level (FPL), also known as a limited cost share plan, have no cost sharing on essential health benefits if a participating provider provides the services and that participating provider is also a provider of the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

AI/AN members with incomes below 300% FPL also known as the zero cost share plan, have no cost sharing on essential health benefits if a participating provider provides those services or if services are rendered by the Indian Service, an Indian Tribe, Tribal Organization or Urban Indian Organization. To qualify for this benefit, you must provide proper documentation to Covered California™. Please call our Member Services Department at **1.855.270.2327** (TTY **711**) or Covered California™ at **1.888-975.1142** if you would like to know more information about this program.

Covered California™ will make all eligibility determinations for health benefit coverage and subsidy level(s), including advance premium tax credits and cost-sharing subsidies. Any changes to a Member's eligibility status, including termination, plan change, and subsidy level, will be processed by L.A. Care only after confirmation from Covered California™.

Please report all income level changes, household size changes, address changes, citizenship and legal residence status changes, loss or gain of employer sponsored health insurance, and other demographic changes to Covered California™ at **1.800.300.1506** (TTY/TDD **1.888.889.4500)**. These changes will help redetermine your eligibility and the amount of premium assistance or subsidy you qualify for.

Open Enrollment Period

The open enrollment period for our QHP Members begins November 1, 2017 for coverage beginning January 1st of the following calendar year. Open enrollment periods are subject to change yearly based on Federal and State guidance. During this time, our existing Members may add eligible dependents, report demographic changes, change carriers, or change Benefit Plans by updating their application with Covered California™. To do so, you may go to **www.coveredca.com**, contact Covered California™ at **1.800.300.1506** (TTY/TDD **1.888.889.4500**), or contact the L.A. Care Covered™ Enrollment Support Services at **1.855.222.4239** (TTY **711**). We will notify you when your enrollment period begins and the actions you need to take, if any.

Newborn Coverage

A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 30th day of life. In order for coverage to continue beyond the 30th day of life, you must enroll the child within 31 days of birth by submitting an Enrollment Application to Covered California™ and pay any applicable subscription charges. If you do not enroll the child within 31 days of birth, your child will be eligible to enroll under a special enrollment period within sixty (60 days) of birth.

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you can only enroll if you become eligible because you have experienced certain qualifying life events, as defined by Covered California™ in accordance with applicable Federal and State laws, rules and regulations (45 C.F.R. § 155.420). Examples of qualifying life events include: a qualified individual or dependent

loses minimum essential coverage or an individual not previously a U.S. citizen, U.S. national or lawfully present in the U.S. individual gains such status. Please visit **www.coveredca.com** for a list of all qualifying life events or call Covered California™ at **1.800.300.1506** (TTY/TDD **1.888.889.4500**).

There are also monthly special enrollment periods for Native American Indians or Alaskan Natives. Please contact our L.A. Care Covered™ Enrollment Support Services at **1.855.222.4239** (TTY **711**) if you have questions regarding these special enrollment periods or about other qualifying life events.

To qualify for special enrollment period, you must apply for coverage within sixty (60) days of the qualifying life event.

Application Process

To apply for L.A. Care Covered™, individuals may contact L.A. Care, Covered California™, or one of the many Certified Assister Entities in Los Angeles County (a full list is posted on Covered California's website at **www.coveredca.com**). Individuals may also complete an electronic application at **www.coveredca.com** without assistance.

Starting Date of Coverage

Only Covered California™ can approve applications and the effective date of coverage. The initial premium payment may be submitted upon successful completion of application or you may choose to wait to receive a bill from L.A. Care Health Plan. Once the application has been approved and full payment has been received for the first month, L.A. Care will send you a New Member Welcome Packet and an L.A. Care Member ID Card that includes the effective date of coverage. Premium payments after the initial month must be made payable to L.A. Care Covered™ to the address listed on the monthly invoice.

Adding Dependents to Your Coverage

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll your dependents, provided that you request enrollment within sixty (60) days after the marriage, birth, adoption or placement for adoption. All dependents must meet eligibility criteria, as determined by Covered California™, and must be approved by Covered California™ before coverage can be started by L.A. Care. Please contact our Member Services Department at **1.855.270.2327** (TTY **711**) or Covered California™ at **1.888.975.1142** if you need additional information.

Payment Responsibilities

What are Premiums (Prepayment Fees)?

Premiums are monthly fees an Enrollee pays to cover the basic costs of the health care package for himself or herself and any Enrolled Dependent(s). An Enrollee must pay the health plan premiums directly to L.A. Care when due.

Monthly Premiums

Your monthly premium is based on three major factors: 1) the benefit plan you selected (Silver, Gold, etc); 2) your age and where you reside; 3) the amount of your tax credit (the amount depends on your income level). Please refer to your eligibility approval from Covered California™ or your L.A. Care premium bill to see the amount that you must pay each month.

Once you are enrolled in L.A. Care Covered™, you will receive a monthly premium bill in the mail.If you prefer, you cancancan receive your bill notification through e-mail, you must first create an online payment account and select the paperless billing option. Please visit **lacare.org** to learn more about how to make your premium payments. Your payment will be due to L.A. Care on or before the twenty-sixth (26th) of each month to commence coverage as of the first (1st) day of the following month. You have 60 days from your effective date to submit your first payment. If your first premium payment is not received by this time, your payment will be considered past due and you will be sent a cancellation notice.

L.A. Care offers a variety of options and methods by which you may pay your monthly premium. Please call our Member Services Department at **1.855.270.2327** (TTY **711**) to discuss these options or visit our website at **lacare.org**.

Payments can also be made via U.S. mail by cashier's check, money order, or a personal check to the address below. Make your premium payments payable to: **L.A. Care Health Plan.**

L.A. Care Health Plan
P.O. Box 2168
Omaha, NE 68103

L.A. Care will not increase your premium during the calendar year 2018 unless authorized by Covered California™ due to a reported demographic change which may affect your eligibility and premium amount.

Important: If your address changes, or if you would prefer to receive your premium invoice notification via e-mail, please notify L.A. Care immediately by calling our Member Services Department at **1.855.270.2327** (TTY **711**) and Covered California™ at **1.888.975.1142** (TTY **1.888.889.4500**).

What are Co-payments (Other Charges)?

Aside from the monthly premium, you may be responsible for paying a charge when you receive a covered service. This charge is called a co-payment and is outlined in the Summary of Benefits. If you review your Summary of Benefits, you'll see that the amount of the co-payment depends on the service you receive. An Enrollee must always be prepared to pay the co-payment during a visit to the Enrollee's PCP, Specialist, or any other provider.

Note: Co-payments are not required for preventive care services, prenatal care or for pre-conception visits. Preventive care includes, but is not limited to:

- Immunizations
- Well-child visits
- Please see the Exclusions and Limitations section in this Member Handbook for more information regarding what services are covered at no charge or call our Member Services Department at **1.855.270.2327** (TTY **711**).

Cost Sharing

General rules, examples, and exceptions

The cost sharing is the amount you are required to pay for a covered service, for example: the deductible, co-payment, or coinsurance. Your cost sharing for covered services will be the cost sharing in effect on the date you receive the services, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Subscriber Agreement & Member Handbook*,

you pay the cost sharing in effect on your admission date until you are discharged if the services were covered under your prior Health Plan coverage and there has been no break in coverage. However, if the services were not covered under your prior Health Plan coverage, or if there has been a break in coverage, you pay the cost sharing in effect on the date you receive the services.

- For items ordered in advance, you pay the cost sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription group.

Receiving a bill

In most cases, we will ask you to make a payment toward your cost sharing at the time you check in. Keep in mind that this payment may cover only a portion of the total cost sharing for the covered services you receive. The provider of service will bill you for any additional cost sharing amounts that are due. The following are examples of when you may get a bill:

- You receive services during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive treatment for an existing condition, at check-in we will ask you to pay the cost sharing that applies to these services. If during your visit your provider finds another problem with your health, your provider may perform or order additional unscheduled services, such as lab tests or other diagnostic tests. You may have to pay separate cost sharing amounts for each of these additional unscheduled services, in addition to the cost sharing amount you paid at check-in for the treatment of your existing condition.
- You receive services from a second provider during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive a diagnostic exam, at check-in we will ask you to pay the cost sharing that applies to these services. If during your diagnostic exam your provider confirms a problem with your health, your provider may request the assistance of another provider to perform additional unscheduled services (such as an outpatient procedure). You may have to pay separate cost sharing amounts for the unscheduled services of the second provider, in addition to the cost sharing amount you paid at check-in for your diagnostic exam.
- You go in for Preventive Care Services and receive non-preventive services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in we will ask you to pay the cost sharing that applies to these services (the cost sharing may be "no charge"). If during your routine physical maintenance exam your provider finds a problem with your health, your provider may order non-preventive services to diagnose your problem (such as laboratory tests). You may have to pay separate cost sharing amounts for the non-preventive services performed to diagnose your problem, in addition to the cost sharing amount you paid at check-in for your routine physical maintenance exam.
- If you receive covered services from a health facility within L.A. Care's provider network, but the covered services are provided by an individual health professional outside of our network::
- Your cost shares for covered services that you receive outside L.A. Care's provider network will not exceed the cost sharing that you would pay for the same covered services received within L.A. Care's provider network.

The Annual Deductible

The annual deductible is the amount that you must pay during the calendar year for certain covered services before L.A. Care will cover those services at the applicable co-payment or co-insurance in that calendar year. The deductible is based on L.A. Care's contracted rates with its participating providers and applies to certain service categories as defined in the"*Summary of Benefits"*. A Member who has Enrolled Dependent(s) must satisfy the lower individual deductible amount, but the deductibles paid by each of the Enrolled Dependent(s) are added together to satisfy the family deductible for all Members in the family. For example, if the deductible for one individual is $2,000 and the deductible for a family of two or more is $4,000, and if you had spent $2,000 for services subject to the deductible, then you will not have to pay any cost sharing during the rest of the calendar year.

However, your Enrolled Dependents will have to continue paying the cost sharing during the calendar year until your family reaches the $4,000 family deductible.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum (also called the "out-of-pocket limit") is the highest amount you or your family (if you have Enrolled Dependent(s) receiving health coverage) are/is required to pay during one benefit year. The benefit year for L.A. Care Covered™ Members starts January 1st and ends December 31st. Please refer to the Summary of Benefits for your "Out-of-Pocket limit on expenses."

Payments that count toward the maximum

Any cost sharing payments you make for in-network services accumulate toward the maximum out-of-pocket expense. Any amounts you pay for covered services that are subject to the deductible, also apply towards the annual out-of-pocket maximum.

Keeping track of the maximum

Step 1: We will keep track of your out-of-pocket payments, as reported to us by your providers of health care. However, because there are delays in reporting visits and payments, please request and save all receipts for payments you make to your health care providers for covered services.

Step 2: I you believe you have already met your annual out-of-pocket maximum for the current calendar year, please make a copy of your receipts, save the copy for your records, and send the originals to:

L.A. Care Health Plan
Attention: Member Services
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by the Plan for covered services provided under this Benefit Plan.

Member Liability

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

Members are only eligible to receive health care services that are covered services in the Qualified Health Plan (QHP) for Individuals and Families. Even if your doctor recommends that you get health care services that are not covered services, these health care services are not covered plan benefits for Members. Members are only able to get covered services as described in this *Member Agreement & Handbook*. If you have any questions about what are covered services, please call L.A. Care Member Services at **1.855.270.2327** (TTY **711**).

Termination of Benefits

An Enrollee will be disenrolled from L.A. Care *Covered*™ for the following reasons:

- The Enrollee fails to pay premiums upon due date
- The Enrollee moves out of Los Angeles County
- The Enrollee requests disenrollment from Covered California™
- The Enrollee requests transfer to another QHP
- Covered California™ notifies L.A. Care that the Enrollee no longer meets California Legal Residency requirements
- Covered California™ notifies L.A. Care that the Enrollee no longer qualifies for a QHP benefit plan
- L.A. Care's contract or health plan with Covered California™ is terminated
- The death of the Enrollee

Request to Terminate Upon Written Notice

L.A. Care may request that Covered California™ terminate Enrollee's coverage upon written notice for the following reasons:

- Fraud or deception in obtaining, or attempting to obtain, benefits under this Plan; and
- Knowingly permitting fraud or deception by another person in connection with this Plan, such as, without limitation, permitting someone else to seek benefits under this Plan, or improperly seeking payment from L.A. Care for benefits provided.

Cancellation of coverage under this Section will terminate effective upon mailing the notice of termination to the Enrollee.

Under no circumstances will an Enrollee be terminated due to health status or the need for health care services. Any Enrollee who believes his or her enrollment has

been terminated due to the Enrollee's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information contact our Member Services Department at **1-855.270.2327** (TTY **711**).

Termination due to withdrawal of this Benefit Plan:

L.A. Care may terminate this Benefit Plan. In such instances you will be given ninety (90) days written notice and the opportunity to enroll in any other individual and family benefit plan without regard to health status-related factors.

Written Notice of Termination

When a written notice of termination or non-renewal is sent to the Enrollee pursuant to this section, it shall be dated, sent to the last-known address of the Enrollee and state:

a. a. The cause of termination or non-renewal with specific reference to the section of this *Agreement & Member Handbook* giving rise to the right of termination or non-renewal;
b. b. That the cause for termination or non-renewal was not the Enrollee's health status or requirements for health care services;
c. The effective date and time of termination or non-renewal; and
d. a. That notwithstanding the Member Appeals (Grievance) procedure set forth in this *Subscriber Agreement & Member Handbook*, if Enrollee believes that his or her Health Plan membership has been terminated because of his or her health status or requirements for healthcare services, Enrollee may request a review before the Director of the Department of Managed Health Care for the State of California.

NOTE: *If an Enrollee is terminated by L.A. Care, notice to the Enrollee is sufficient if sent to Enrollees' last known address.*

Termination by L.A. Care for Nonpayment of Dues:

L.A. Care may terminate your coverage for failure to pay the required premium when due. If your coverage is being terminated because you failed to pay the required premium, then coverage will end thirty (30 days) after the date for which the premium is due. We will send you written notice of the termination at least thirty (30 days) before the termination date. You will be liable for all premiums accrued while coverage under this Benefit Plan continues in force including those accrued during this thirty (30) day grace period. The Notice Confirming Termination of Coverage will inform you of the following:

a. That your coverage has been terminated, and the reasons for termination;
b. The specific date and time when coverage for you and all your Enrolled Dependent(s) ended; and
c. Your right to request review of the termination. The notice will also inform you that if you believe that your or your Dependent(s)' health plan enrollment has been improperly terminated, you may request a review from the Director of the Department of Managed Health Care (DMHC). All contact information for the DMHC will be included in the letter.

Grace Period for Nonpayment of Premiums for Individuals Receiving Advance Tax Credits

If you and/or your Enrolled Dependent(s) are receiving advance premium tax credits to defray the cost of your monthly premium, but fail to pay the Member's portion of the monthly premium to L.A. Care by the due date, L.A. Care will send you a past due notice notifying you that your coverage will be terminated for non-payment of premium effective as of the last day of the first (1st) month of grace period ("Grace Period"). The notice will explain you have a three (3) month Grace Period to make your payments in full before termination. The three (3) month Grace Period is offered only to individuals who are receiving advance premium tax credits.

L.A. Care will provide covered services to you only during the first month of the Grace Period. During months two (2) and three (3) of the Grace Period your coverage will be suspended. This means that L.A. Care will not provide coverage for any services you received during months two (2) and three (3) of the Grace Period. You may be billed for and have to pay for any services you receive during months two (2) and three (3) if you do not pay all of your three (3) months of overdue premiums by the last day of the three (3) month Grace Period.

If you have not paid your full premiums by the last day of the third month, within five (5) business days of terminating your coverage, L.A. Care will mail you a Notice Confirming Termination of Coverage with the information listed in the section above (items a-c).

Reinstatement of Coverage. If you pay all of the overdue three (3) months of premiums by the last day of the three (3) month Grace Period, your coverage will

be reinstated back to the first (1st) day of the first (1st) month of the Grace Period. If you do not reinstate your coverage on or before the end of the 3rd month of the Grace Period, you will be financially responsible for the cost of any services received during months two (2) and three (3) of the Grace Period.

If your coverage is terminated outside of the regular Covered California™ enrollment period and you do not qualify for special enrollment, you may lose your right to reinstate coverage.

If you pay in full by the end of your three (3) month Grace Period, you may submit a claim to be reimbursed for medical and pharmacy services rendered during months two (2) and three (3) of grace period. For more information on how to submit a claim for reimbursement, contact our Member Services Department at **1.855.270.2327** (TTY **711**).

If you are unable to make full premium payment by the end of the grace period and have sent partial premium payments, you may qualify for reimbursement. L.A. Care Health Plan will automatically calculate any overpayments and refund you. You may also contact Member Services at **1.855.270.2327** (TTY **711**) to obtain a Request for Reimbursement Form.

Disenrollment and Cancellation

If you would like to be disenrolled from L.A. Care Covered™, please contact Covered California™ at **1-800-300-1506** (TTY **1-888-889-4500**) or log into your application at **www.coveredca.com**. If you voluntarily disenroll and have made advance premium payments, you may qualify for a reimbursement. L.A. Care Health Plan will automatically calculate any overpayments and refund you. You may also contact Member Services at **1.855.270.2327** (TTY **711**) to obtain a Request for Reimbursement Form.

Cancellation by L.A. Care for Nonpayment of Dues

If you apply for coverage successfully with L.A. Care Health Plan through Covered California™, you will be responsible for paying your first premium payment in order to become a Member and begin using your health benefits. If you do not send us your first premium payment by the due date, your coverage will be cancelled. You will receive a notice in the mail letting you know that your coverage has been cancelled due to non-payment of the first premium payment. If your coverage is cancelled during the open enrollment period, you will be able to apply again. If your coverage is cancelled after the open enrollment period closes, you will be able to apply for coverage if you experience a qualifying life event as described in this member handbook.

Plan Benefits

Please refer to the Summary of Benefits for member cost share information

Acupuncture Services

Are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and participating physician services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the medical group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A participating physician who is a specialist in bariatric care determines that the surgery is medically necessary For covered services related to bariatric surgical procedures that you receive, you will pay the cost sharing you would pay if the services were not related to a bariatric surgical procedure. For example, see "Hospital Stay" in the *Summary of Benefits* for the cost sharing that applies for hospital inpatient care.

Travel is also covered if the member lives more than 50 miles from the facility to which the patient is referred to. We will not, however, reimburse you for any travel if you were offered a referral to a facility that is less than 50 miles from your home.

Cancer Services

Cancer Screening

L.A. Care covers 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
- Diethylstillbestrol services

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy or lymph node dissection, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. You and your doctor decide how long you need to stay in the hospital after the surgery based on medical necessity. These benefits will be provided subject to the same cost sharing applicable to other medical and surgical benefits provided under this plan.

Cancer clinical trials

If you have cancer, you may be able to be part of a cancer clinical trial. A cancer clinical trial is a research study with cancer patients to find out if a new cancer treatment or drug is safe and treats a member's type of cancer. Cancer clinical trials must meet certain requirements, when referred by your L.A. Care doctor or treating provider. It must have a meaningful potential to benefit you and must be approved by one of the following:

- The National Institute of Health (NIH)
- The Food and Drug Administration (FDA)
- The Centers for Disease Control and Prevention
- The Agency for Health Care Research and Quality
- The Centers for Medicare & Medicaid Services
- A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
- A qualified non-governmental research entity as defined by the National Institutes of Health for center support grants; or

- The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that meets the U.S. Secretary of Health and Human Services requirements.

If you are part of an approved cancer clinical trial, L.A. Care will provide coverage for all routine patient care cost related to the clinical trial.

For covered services related to a clinical trial, you will pay the cost sharing you would pay if the services were not related to a clinical trial.

The following clinical trials services are not covered:

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial

If you have a life-threatening or weakened condition, or were eligible but denied coverage for a cancer clinical trial, you have the right to request an IMR on the denial. You can learn more about this in the "*What should I do if I am unhappy?*" section.

Substance Use Disorder Services

Inpatient detoxification

We cover hospitalization in a participating hospital only for medical management of withdrawal symptoms, acute medical complications due to detoxification, including room and board, inpatient professional services, participating physician services, drugs, dependency recovery services, education, and counseling.

Outpatient Substance Use Disorder Services

We cover the following services for treatment of Substance Use Disorder:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group Substance Use Disorder evaluation, counseling, and treatment
- Medical treatment for withdrawal symptoms

Additional Specialty Group Substance Use Disorder

We cover opioid replacement therapy treatment for all Enrollees when medically necessary at a licensed treatment center approved by the medical group.

Transitional residential recovery Services

We cover Substance Use Disorder treatment in a nonmedical transitional residential recovery setting approved in writing by the medical group. These settings provide counseling and support services in a structured environment.

Substance Use Disorder services exclusion

Exclusions do not apply to evidenced based services performed by Mental Health professionals permitted by California law for Behavioral Health Services

- Alternative Therapies, unless the treatment is newly approved as evidence based practice
- Biofeedback, unless the treatment is medically necessary and prescribed by a licensed physician and surgeon or by a licensed psychologist
- Services performed by unlicensed people

Dental and Orthodontic Services

We do not cover dental and orthodontic services for adults age 19 or older, but we do cover some dental and orthodontic services as described in this "*Dental and Orthodontic Services*" section.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a participating physician provides the services or if the medical group authorizes a referral to a participating dentist.

Dental anesthesia

For dental procedures at a participating facility, we provide general anesthesia and the facility's services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other services related to the dental procedure, such as the dentist's services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services, if they meet all of the following requirements:

- The services are an integral part of a reconstructive surgery for cleft palate that we are covering under *"Reconstructive Surgery"* in this *"Plan Benefits"* section
- A participating physician provides the services or the medical group authorizes a referral to a participating dentist or orthodontist

Cost Sharing for dental and orthodontic services

Dental and orthodontic services covered under this "*Dental and Orthodontic Services*" section include:

- Hospital inpatient care
- Outpatient consultations, exams, and treatment
- Outpatient surgery: if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

Diabetic Care

These services are covered for diabetics when medically necessary:

- Diabetes urine-testing supplies and insulin-administration devices: We cover ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing.
- Insulin-administration devices: We cover the following insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).
- Prescription drugs: see drugs section below
- Podiatric devices (such as special footwear or shoe inserts) to prevent or treat diabetes-related complications when prescribed by a participating physician or by a participating provider who is a podiatrist
- Training and health education for self-management
- Family education for self-management

Diagnostic X-Ray and Laboratory Services

Diagnostic X-Ray, Laboratory, Imaging, and Scan services are covered per service or per test.

- 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
- 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
- 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

Dialysis Care

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our service area.

Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

The following are covered services related to dialysis:

- Inpatient dialysis care
- Hemodialysis treatment at a plan facility
- All other outpatient consultations, exams, and treatment

Exclusions:

- Comfort, convenience, or luxury equipment, supplies and features
- Non-medical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is medically necessary equipment that is ordered by your physician and for use in the home. Inside our service area, we cover the durable medical equipment specified in this section for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines.

DME for home use is an item that is:

- Intended for repeated use
- Primarily and customarily used to serve a medical purpose
- Generally not useful to a person who is not ill or injured
- Appropriate for use in the home.

Covered DME (including repair or replacement of covered equipment, unless due to loss or misuse) is provided. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Examples of DME include:

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- Peak flow meters
- IV pole
- Bone stimulator
- Cervical traction (over door)

Durable medical equipment exclusion
Comfort, convenience, or luxury equipment or features

Emergency Care Services

L.A. Care covers emergency care services 24 hours a day, 7 days a week. Emergency room visits are covered and the co-pay, if applicable, is waived if you are admitted to the hospital. Emergency care services are medically necessary covered services, including ambulance and Mental Health services, which a member reasonably believes are necessary to stop or relieve:

- A serious illness or symptom,
- An injury, severe pain, or active labor,
- 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.

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
- Broken bones

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.

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, provided by non-participating providers.

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 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 this *Subscriber Agreement & Member Handbook*, will not be covered.

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 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, your spouse or legal guardian do not agree to you being transferred, the non-contracted hospital must give you, your spouse or legal guardian 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 **1.855.270.2327** (TTY **711**).

Family Planning

Family planning services are provided to Enrollees of child¬bearing age to help them choose the number and spacing of children. These services include all methods of birth control approved by the Food and Drug Administration (FDA). You may receive family planning services and FDA-approved contraceptives (including a 12-month supply of self-administered hormonal contraceptives dispensed at one time) from any participating health care provider that is licensed to provide these services. Services related to outpatient contraceptives and devices such as device insertion and/or removal, follow up care for side effects, and counseling for continued adherence are also covered at no charge ($0 co-payment). Examples of family planning providers include:

- Your PCP
- Clinics
- Certified Nurse Midwives and Certified Nurse Practitioners
- Ob/Gyn specialists

Family planning services also include counseling, patient education on contraception, female sterilization and surgical procedures for the termination of pregnancy (called an abortion). Please call L.A. Care's Member Services Department at **1.855.270.2327** (TTY **711**) if you need more information about the centers that perform these services.

Health Education Services

Health In Motion™

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 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.

My *Health In Motion*™

My *Health In Motion*™ is our online version of Health In Motion™. You can get health and wellness tools at your fingertips from the comfort of your own home. Log in any time day or night to fit your needs. Complete your Health Appraisal to see your personalized wellness report. You can also connect with a virtual Health Coach, view healthy recipes, watch videos, and sign up for online wellness workshops. Go to lacare.org and click on "Member Sign In." Click on the "*My Health In Motion*™" tab to see all the tools that can help you stay healthy.

The *My Health In Motion*™ Rewards Program

L.A. Care Covered™ offers the My *Health In Motion*™ Rewards Program. Participants will be rewarded for taking steps to improve their health. There are four ways to earn points to be redeemed for gift cards through the My *Health In Motion*™ site:*

- Taking your Health Appraisal survey
- Signing up for Health Coaching
- Completing an online tobacco cessation workshop
- Competing an online Healthy Weight workshop

To qualify for rewards, you must be:

- At least 18 years old
- Actively enrolled in L.A. Care Covered™; and
- Current with premium payments.

*Each reward is limited to one per member per lifetime. All activities must be completed by 12/31/2018 at 11:59 pm PST to receive the reward.

More information on the My *Health In Motion*™ Rewards Program, points accumulation, and how to redeem gift cards can be found on the My *Health in Motion*™ site.

L.A. Care's Health Education Audio Reference Library is also available to you and has pre-recorded messages on topics that provide information you need to help:

- Prevent illness
- Identify warning signs
- Administer self-care

Health care questions and concerns are present even when symptoms are not. The Health Education Audio Reference Library is available to help you and your family to educate yourselves about common or chronic illnesses and diseases—24 hours a day, 7 days a week. More information can be found on **lacare.org** under the Healthy Living and Health Resources tab.

Health education resources include written materials, community referrals, online information 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, including programs provided online, counseling over the phone, individual counseling when the office visit is solely for health education, and health education materials. Health education provided during an outpatient consultation or exam shall have no additional cost share to you beyond the cost share already required for the visit. Call L.A. Care for more information at **1-855-270-2327** (TTY **711**) or go to **lacare.org**.

Human Immune-Deficiency Virus (HIV) Services

HIV Testing

You can get confidential HIV testing from any health care provider licensed to provide these services. You do not need a referral or okay from your PCP or health plan for confidential HIV testing. Examples of where you can get confidential HIV testing include:

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

Please call L.A. Care at **1.855.270.2327** (TTY **711**) to request a list of testing sites.

Home Health Care

"Home health care" means services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A participating provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the services can be safely and effectively provided in your home
- The services are provided inside our service area

Services are limited to those authorized by L.A. Care to 100 visits per year, 3 visits per day, up to 2 hours per visit (nurse, social worker, physical/ occupational/ speech therapist) or 3 hours for a home health aide. If a service can be provided in more than one location, L.A. Care will work with the provider to choose the location.

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than 2 hours, then each additional increment of 2 hours counts as a separate visit. If a visit by a home health aide lasts longer than 3 hours, then each additional increment of 3 hours counts as a separate visit.. Also, each person providing services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same 2 hours that counts as two visits.

Exclusions:

- Custodial care
- Care that an unlicensed family member or layperson could provide safety/effectively
- Care in the home if home does not have a safe and effective treatment setting

Hospice

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice services listed below when all of the following requirements are met:

- A participating provider has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The covered services are provided inside our service area
- The services are provided by a licensed hospice agency that is a participating provider
- The services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice services, which are available on a 24-hour basis if necessary for your hospice care:

- Participating physician services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness in accord with our drug formulary guidelines. You must obtain these drugs from plan pharmacies.
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
  - Short-term inpatient care required at a level that cannot be provided at home

Hospital Inpatient Care

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 without authorization.

- Room and board, including a private room if medically necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of participating physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section)

- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Services not covered under this *"Hospital Inpatient Care"* section

The following types of inpatient services are covered only as described under the following headings of this *"Plan Benefits"* section:

- Bariatric Surgery
- Clinical Trials
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Skilled Nursing Facility Care
- Transplant Services

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

Skilled Nursing Care

We cover up to 100 days of inpatient skilled nursing care provided by a participating skilled nursing facility. The skilled inpatient services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

We cover the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a participating provider as part of your plan of care in the participating Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the participating Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Respiratory therapy

Services not covered under this "*Skilled Nursing Facility Care*" section

Coverage for the following services is described under these headings in this "*Plan Benefits*" section:

- Outpatient Imaging & Laboratory

Exclusion: Custodial care

Maternity Care

- All preconception and prenatal visits are covered by L.A. Care.
- Delivery and inpatient services are covered.
- Maternity care includes the following:
  - Regular doctor visits during your pregnancy (called prenatal visits)
  - Ambulatory care services
  - Diagnostic and genetic testing including, but not limited to: 1) Alpha-fetoprotein testing; 2) Screening for gestational diabetes
  - Nutrition counseling, breastfeeding support, and supplies and counseling
  - Labor and delivery care
  - Health care six (6) weeks after delivery (called postpartum care)
  - Inpatient hospital care for at least 48 hours after normal vaginal deliveries or for at least 96 hours after a Cesarean section. Coverage for inpatient hospital care may be less than 48 hours or 96 hours if: 1) The decision is made by the mother and treating physician, and 2) A post-discharge follow-up visit for the mother and newborn is made within 48 hours of discharge
- Urgently needed services necessary to prevent serious deterioration to the health of your fetus, based on reasonable belief that your pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

If you are pregnant, call L.A. Care at **1.855.270.2327** (TTY **711**) right away. We want to make sure you get the care you need. L.A. Care will help you choose your maternity care doctor from a doctor in your network. Ask your doctor to find out more.

After giving birth, you will receive breastfeeding education and special equipment if needed. Ask your doctor, or call L.A. Care at **1.855.270.2327** (TTY **711**) if you have any questions.

Medical Nutrition Therapy (MNT)

MNT is intense nutrition counseling with a registered dietitian over the phone. MNT is used to treat serious health problems such as diabetes, pre-end-stage renal disease, and obesity.

Physician referral required. Some members may not qualify.

Medical Transportation

Ambulance Services - Emergency

Emergency transportation for a member that believes it is necessary to stop or relieve sudden serious illnesses or symptoms, or injury or conditions requiring immediate diagnosis and treatment. Ambulance 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.

Ambulance Services – Non-emergency

Inside the service area, we cover non-emergency ambulance and psychiatric transport van services if a Plan or Plan-contracted physician determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from covered services.

Non-emergency transportation for the transfer of a member from a hospital to another hospital or facility or facility to home is covered when:

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

Ambulance Services Exclusion

Coverage for transportation by airplane, passenger car, taxi or other form of public transportation is excluded, other than a licensed ambulance or psychiatric transport van), 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 Care

We cover services specified in this *"Mental Health Care"* section only when the services are for the diagnosis or treatment of mental disorders. A "mental disorder" is a Mental Health condition identified as a "mental disorder" within the 4th edition of the *"Diagnostic and Statistical Manual of Mental Disorders,"* (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder." For example, the DSM identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

Inpatient Mental Health Services

Any psychiatric hospital may be used in case of a psychiatric emergency without authorization. Psychiatric emergency conditions are defined as when you have thoughts or actions about hurting yourself or someone else.

"Mental Disorders" include the following conditions:

- Severe Mental Illness (SMI) of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" within the most recent edition of the DSM, other than a primary Substance Use Disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning,

family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment

- the child displays psychotic features, or risk of suicide or violence due to a mental disorder
- the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Inpatient Mental Health Services

We cover the following inpatient mental health services:

- Inpatient Mental Health hospitalization in participating hospitals
- Inpatient non-medical transitional residential care for Mental Health Disorders
- • Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis

Coverage includes room and board, drugs, and inpatient professional services of participating physicians and other providers who are licensed health care professionals acting within the scope of their license.

Outpatient Mental Health Services

We cover the following services when provided by participating physicians or other participating providers who are licensed health care professionals acting within the scope of their license:

- Mental Health evaluation, treatment and care
- Individual and group therapy
- Psychological testing when clinically necessary to evaluate a mental health disorder
- Medication Management
- Outpatient partial hospitalization
- Psychiatric Observation for an acute psychiatric crisis

Behavioral Health Treatment for Autistic Spectrum Disorder

BBehavioral Health Treatment ("BHT") for members with Autistic Spectrum Disorder (including Aspergers, Autism and Pervasive Developmental DisorderDisorder) 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.

Behavioral Health Treatment 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" is defined as follows: 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. For additional information, please call the Behavioral Health Hotline at **1.877.344.2858/1.800 735.2929** TTY.

Exclusions and Limitations

- Alternative Therapies, unless the treatment is newly approved as evidenced based practice and prescribed by a licensed physician and surgeon or by a licensed psychologist as Behavioral Health Treatment for Autistic Spectrum Disorders and such treatment is provided pursuant to a treatment plan administered by qualified autism providers.
- Biofeedback, unless the treatment is medically necessary and prescribed by a licensed physician and surgeon or by a licensed psychologist.
- 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 pervasive developmental disorders or autism.

Outpatient and other Mental Health and Substance Use Disorder treatment

We cover the following Outpatient and other Mental Health Substance Use Disorder treatment:

- Partial Hospitalization (Short-term hospital-based intensive outpatient care)
- Mental Health Intensive Outpatient Treatment

(Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program)
- Psychiatric observation for an acute psychiatric crisis
- Outpatient Transcranial Magnetic Stimulation
- Electroconvulsive Therapy (ECT)

Please reference the Summary of Benefits for the Outpatient and other Mental Health and Substance Use Disorder treatment described above.

Ostomy and Urological Supplies

Inside our service area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs. These include:

- Adhesives – liquid, brush, tube, disc or pad
- Belts – ostomy
- Belts – hernia
- Catheters
- Drainage Bags/Bottles – bedside and leg
- Dressing Supplies
- Lubricants
- Miscellaneous Supplies: urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs, and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches – urinary, drainable, ostomy
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof

Our formulary guidelines allow you to obtain non-formulary ostomy and urological supplies (those not listed on our soft goods formulary for your condition) if they would otherwise be covered and the medical group determines that they are medically necessary.

Ostomy and urological supplies exclusion: Comfort, convenience, or luxury equipment or features

Outpatient Services Hospital and Outpatient Facility Services

The following outpatient services are covered when authorized by L.A. Care and provided at a participating hospital or outpatient facility, such as an Ambulatory Surgery Center (ASC). 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.

General anesthesia for dental procedures is covered when performed at a hospital or surgery center because of a Member's medical condition, clinical status, or the severity of the dental procedure. L.A. Care will coordinate such services with the member's dental plan. Services of the dentist or oral surgeon are not covered by L.A. Care.

Pediatric Services

Pediatric Asthma Care

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

Pediatric Dental Care

L.A. Care covers the following dental care benefits for members up to the age of 19. The annual deductible is waived.

Dental benefits are provided by Liberty Dental through its extensive network of dental providers. Members can contact Liberty Dental regarding provider information at **1.888.700-5243** (TTY/TDD **1.877.855-8039**).

Covered benefits include:

- Preventive and diagnostic care including oral exam, preventive cleanings, sealants and topical fluoride application
- Basic and Major dental services including amalgam fillings, root canal and extraction services
- Orthodontia Services

Coordination of Pediatric Dental Care Benefits

For members who purchase a supplemental pediatric dental benefit plan on the Health Benefits Exchange, your pediatric dental benefits covered by L.A. Care will be paid first. Your supplemental pediatric plan covers non-covered pediatric dental services and any cost sharing as described in your supplemental pediatric dental plan Evidence of Coverage (EOC).

Pediatric Vision Care

L.A. Care covers the following vision care benefits for members up to the age of 19. The annual deductible is waived.

Vision benefits are provided through VSP. Its extensive nationwide network of providers offers professional vision care to members covered under group vision care plans. If you are not able to locate an accessible provider, please call VSP toll-free at **1.800.877.7195**, and a customer service representative will help you find another provider. Covered benefits include the following:

- Eye exam, includes dilation if indicated and refraction
- 1 (one) pair of prescription glasses per year, including both lenses and frames, or contacts. Single vision, conventional bifocal, conventional trifocal, and lenticular lenses in all lens powers may be obtained. A choice of glass, plastic, or polycarbonate lenses is available. Polycarbonate lenses may be obtained at no additional cost share.
- Medically necessary contact lenses for the treatment of: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism.
- Low vision services

Prenatal Care

Scheduled prenatal exams and the first post partum follow-up consult is covered at no charge. Other prenatal benefits include:

- Prenatal supplements
- Diagnostic and genetic testing

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this section when prescribed as follows and obtained at a Plan Pharmacy or through our mail-order service:

- Items prescribed by Plan Physicians in accord with our drug formulary guidelines
- Items prescribed by the following Non-Plan Providers; unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
    - o Dentists if the drug is for dental care
    - o Non-Plan Physicians if the Medical Group authorizes a written referral to the Non-Plan Physician and the drug, supply, or supplement is covered as part of that referral
    - o Non-Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care

How to obtain covered items

YYou must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "*Emergency Care Services*" section.

Please refer to the "*How to Find a Pharmacy*" section for the locations of Plan Pharmacies in your area.

If L.A. Care's coverage is amended to exclude a drug that we have been covering and providing to you under this Evidence of Coverage, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Food and Drug Administration.

Outpatient contraceptive drugs and devices

We cover a variety of Food and Drug Administration (FDA) approved prescription contraceptive methods including the following contraceptive drugs and devices at no charge ($0 copayment):

- Oral contraceptives
- Emergency contraception pills
- Contraceptive rings
- Contraceptive patches
- Cervical caps
- Diaphragms

Coverage also includes a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time.

If a covered contraceptive drug or device is unavailable or deemed medically inadvisable by your medical practitioner, you can request an authorization of a non-covered contraceptive drug or device as prescribed by your medical practitioner. If your authorization is approved by the Plan, the contraceptive drug or device will be provided at no charge ($0 co-payment).

Preventive drugs and supplements

We cover the following preventive items at no charge ($0 co-payment) when prescribed by a Plan Provider:

- Aspirin
- Folic acid supplements for pregnant women

- Iron supplements for children
- Fluoride supplements for children
- Tobacco cessation drugs and products

All other outpatient drugs, supplies, and supplements

We cover the following outpatient drugs, supplies, and supplements:

- Drugs that require a prescription by law and certain drugs that do not require a prescription if they are listed on our drug formulary
- Needles and syringes needed to inject covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Cost sharing for outpatient drugs, supplies, and supplements

For Members in the Platinum 90 HMO, Gold 80 HMO, and Silver HMO plans (70, 94, 87, and 73) the cost share for a 30 day prescription drug supply may not exceed $250 per script. For the Silver plans the cost-share applies after the Member's deductible has been satisfied for the year.

For Members in the Bronze 60 HMO plan the cost share for a 30 day prescription drug supply may not exceed $500 per script after the deductible has been satisfied for the year.

For Members in the Minimum Coverage HMO plan the cost share for a 30 day prescription drug supply is subject to deductible.

The cost-shares indicated above are applicable to the American Indian and Alaskan Native plans.

Please refer to the "Summary of Benefits" for pharmacy co-payments, deductibles, integrated deductibles and/or out-of-pocket limits that may apply.

Note: If charges for the drug, supply, or supplement are less than the co-payment, you will pay the lesser amount.

For an explanation of the Drug Deductible, see "Drug Deductible" in this section:

Drug Deductible: In any calendar year, you may be responsible for paying charges for covered drugs. If your benefit plan includes a Drug Deductible, you are responsible for paying all costs to meet the Drug Deductible each Calendar Year before L.A. Care Covered™ Health Plan will cover the prescription at the applicable co-payment (refer to "*Cost Sharing for Outpatient Drugs, Supplies, and Supplements section*").

If a drug requires administration or observation by medical personnel and is administered to you in a Plan Medical Office or during home visits; you do not need to meet the Drug Deductible for the following items:

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Cancer chemotherapy drugs and certain critical adjuncts following a diagnosis of cancer
- Certain drugs for the treatment of life-threatening ventricular arrhythmias
- Diaphragms and cervical caps
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Emergency contraceptive pills
- Hematopoietic agents for dialysis and for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- In connection with a transplant, immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus
- Low molecular weight heparin for acute therapy for life-threatening thrombotic disorders
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end-stage renal disease

The only payments that count toward this Drug Deductible are those you make under this Evidence of Coverage for covered drugs that are subject to this Drug Deductible. After you meet the Drug Deductible, you pay the applicable co-payments or co-insurance for these items for the remainder of the calendar year.

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) and the supplies and equipment required for their administration. Note: Injectable drugs and insulin are not covered in this section (refer to the "Outpatient drugs, supplies, and supplements" section).

Diabetes urine-testing supplies and insulin-administration devices

We cover at no charge ($0 copayment):

- Ketone test strips
- Acetone test tablets
- Taps for diabetes urine testing

Outpatient prescription drugs, supplies, and supplements exclusions:

- Experimental or investigational drugs, unless accepted for use by professionally recognized standards of practice
- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold.

Preventive Care Services

Co-payments are not required for Preventive Care Services, prenatal care or for pre-conception visits. We cover a variety of Preventive Care Services. Periodic health exams include all routine diagnostic testing and laboratory services. These include, but are not limited to:

- Periodic health maintenance exams, including well-woman exams
- Immunizations, consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP).
- Sexually Transmitted Disease (STD) tests
- Cytology exams on a reasonable periodic basis
- Other age appropriate immunizations
- Acquired Immune Deficiency Syndrome (AIDS) vaccine
- Osteoporosis Services
- Eye examinations:
  - Routine exam
  - Eye refractions to determine the need for corrective lenses
  - Dilated retinal eye exams
- Health education
- All generally medically accepted cancer screening tests including, but not limited to:
  - Breast Cancer Screening
  - Prostate Cancer Screening
  - General Cancer Screening
  - Mammography Services
  - Cervical Cancer Screening
  - Diesthlybestrol Services
- Well baby care during the first two years of life, including:
  - Newborn hospital visits newborn screenings
  - Newborn health examinations, and other office visits, consistent with the most current recommendations for Preventive Pediatric Health Care as adopted by the American Academy of Pediatrics; and consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).

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.

Professional Services, Office Visits and Outpatient Services

We cover medically necessary services and consultations by physicians or other licensed health care providers acting within the scope of his or her license, professional office, inpatient hospital, skilled nursing, home, hospice, and urgent care visits, when medically necessary. Your cost sharing will vary based on the type of provider you see, the location where you receive the services, and the scope of services that you receive.

- Most specialist consultations, exams, and treatment
- Other practitioner consultations (Physician Assistant; Nurse Practitioner)
- Routine physical maintenance exams
- Well-child preventive exams (through age 23 months)
- Urgent care consultations
- Physical Therapist – Home Health
- Physical Therapist – Hospital Outpatient

Prosthetic and Orthotic Devices

We do not cover most prosthetic and orthotic devices, but we do cover devices as described in this "*Prosthetic and Orthotic Devices*" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select

Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the cost sharing that you would pay for obtaining that device.

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseo-integrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this section. We cover these devices.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a medically necessary mastectomy, including:
  - Custom-made prostheses when medically necessary
  - Up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a participating physician or by a participating provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or aphakia. Medically necessary services for aphakia are not subject to age restrictions.

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "*Prosthetic and Orthotic Devices*" section
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "*Prosthetic and Orthotic Devices*" section for diabetes-related complications

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 (see definition below) 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)

Reconstructive Surgery

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a participating physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
- Following medically necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Additional covered reconstructive surgery services include:

- Outpatient consultations, exams, and treatment
- Outpatient surgery: if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.
- Hospital inpatient care (including room and board, drugs, and participating physician services)

Services not covered under this "Reconstructive Surgery" section

Coverage for the following services is described under these headings in this section:

- Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate (refer to "*Dental and Orthodontic Services*")
- Outpatient imaging and laboratory (refer to *"Outpatient Imaging and Laboratory, and Special Procedures"*)
- Outpatient prescription drugs (refer to "*Outpatient Drugs, Supplies, and Supplements*")
- Prosthetics and orthotics (refer to "*Prosthetic and Orthotic Devices*")
- Cosmetic surgery (i.e. surgery that is performed to alter or reshape normal structures of the body in order to improve appearance)

Therapy – Physical, Occupational, Speech, and Other

- Physical therapy uses exercise to improve and maintain a patient's ability to function after an illness or injury.
- Occupational therapy is used to improve and maintain a patient's daily living skills because of a disability or injury.
- Speech therapy is used to treat speech problems.
- Water therapy and massage therapy are covered as medically necessary.

Therapy is covered and 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.

Transplants

L.A. Care covers medically necessary transplants of organs, tissue, or bone marrow, which are not experimental or investigational in nature. We cover transplants of organs, tissue, or bone marrow if your physician provides a written referral for care to a transplant facility. After the referral to a transplant facility, the following applies:

- If either your medical group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover services you receive before that determination is made
- • Health Plan, participating hospitals, your medical group, and participating physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- • In accord with our guidelines for services for living transplant donors, we provide certain donation-related services for a donor, or an individual identified by the medical group as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for you, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling our Member Services Department
- We provide or pay for donation-related services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor services)

If your transplant is denied on the basis that it is experimental or investigational in nature, please refer to the "*Grievance & Appeals*" section for information about your right to an "Independent Medical Review for Denials of Experimental/Investigational Therapies."

For covered transplant services that you receive, you will pay the **cost sharing you would pay if the services were not related to a transplant.** For example, see "*Hospital Inpatient Care*" in this section for the cost sharing that applies for hospital inpatient care.

California Children's Services (CCS)

Children needing specialized medical care may be eligible for the California Children's Services (CCS) program.

CCS is a California medical program that treats children with certain physical conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial

and residential eligibility requirements. Services provided through the CCS program are coordinated by the local county CCS office.

If a member's PCP suspects or identifies a possible CCS eligible condition, he/she may refer the member to the local county CCS program. The CCS program (local or the CCS Regional Office) will determine if the member's condition is eligible for CCS services.

If determined to be eligible for CCS services, a L.A. Care Covered™ Member continues to stay enrolled in the QHP product. He or she will be referred and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. L.A. Care will continue to provide primary care and prevention services that are not related to the CCS eligible conditions, as described in this document. L.A. Care will also work with the CCS program to coordinate care provided by both the CCS program and the plan. L.A. Care will continue to provide all other medical services not related to CCS diagnosis.

The CCS office must verify residential status for each child in the CCS program. If your child is referred to the CCS program, you will be asked to complete a short application to verify residential status, financial eligibility and ensure coordination of your child's care after the referral has been made.

Additional information about the CCS program can be obtained by calling the Los Angeles County CCS program at **1.800.288.4584** for more information.

Exclusions and Limitations

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all services that would otherwise be covered under this *Subscriber Agreement & Member Handbook* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "*Plan Benefits*" section.

- Adult hearing aids
- Adult routine dental services
- Artificial insemination and conception by artificial means

All services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Biofeedback services

All Biofeedback Services are excluded from coverage, unless the treatment is medically necessary and prescribed by a licensed physician and surgeon or by a licensed psychologist.

Certain exams and services

Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a participating physician determines that the services are medically necessary.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except that this exclusion does not apply to any of the following:

- Services covered under *"Reconstructive Surgery"* in the *"Plan Benefits"* section
- The following devices covered under *"Prosthetic and Orthotic Devices"* in the *"Plan Benefits"* section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part.

Chiropractic services

Chiropractic Services and the services of a chiropractor.

Custodial care

Assistance with activities of daily living (e.g., walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.

Dental and orthodontic services

Dental and orthodontic services such as X-rays, appliances, implants, services provided by dentists or orthodontists, dental services following accidental injury to teeth, and dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to services covered under "*Dental and Orthodontic Services*" in the "*Plan Benefits*" section.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion does not apply to disposable supplies covered under "*Durable Medical Equipment for Home Use*," "*Home Health Care,*" "*Hospice Care,*" "*Ostomy and Urological Supplies,*" and "*Outpatient Drugs, Supplies, and Supplements*" in the "*Plan Benefits*" section.

Hair loss or growth treatment

Items and services when prescribed for the promotion, prevention, or other treatment of hair loss, hair growth, or hair transplant procedures related to the diagnosis of gender dysphoria. In these cases, the appropriate grievance, appeal and IMR processes would be available for members who disagree with such decision.

Infertility Services

Services related to the diagnosis and treatment of infertility.

Items and services that are not health care items and services. For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Long-term care benefits

Includes long-term skilled nursing care in a licensed facility, and respite care. (For short-term skilled nursing care or hospice benefits, see "*Skilled Nursing Care*" under the "*Plan Benefits*" section.)

Non-medically necessary health care services

Any health care services, supplies, comfort items, procedures, or equipment that is not medically necessary. This includes private rooms in a hospital, unless medically necessary.

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "*Outpatient Drugs, Supplies, and Supplements*" in the "*Plan Benefits*" section
- Enteral formula covered under "*Prosthetic and Orthotic Devices*" in the "*Plan Benefits*" section

Other insurance

Services covered by any other insurance or health care service plan. L.A. Care will provide the services at the time of need. (see *"Coordination of Benefits"* section for details.)

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "*Hospice Care*" section, a licensed facility providing residential services covered under "*Inpatient psychiatric hospitalization or intensive psychiatric treatment programs*" in the "*Mental Health Services*" section.

Routine foot care items and services

Routine foot care items and services that are not medically necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion does not apply to any of the following:

- Experimental or investigational services when an investigational application has been filed with the FDA and the manufacturer or other source makes the services available to you or L.A. Care through an FDA-authorized procedure, except that we do not cover services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "*Clinical Trials*" in the "*Plan Benefits*" section

If L.A. Care denies your request for services based on the determination that the services are experimental or investigational, you may request an IMR. For information about the IMR process, please refer to the "*Grievance and Appeals*" section of this *Subscriber Agreement & Member Handbook*.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider. This exclusion does not apply to services provided as part of a behavioral health treatment plan by a Qualified Autism Service Professional or Qualified Autism Service Paraprofessional for the treatment of Autism Spectrum Disorder.

Services received before a member's starting date with L.A. Care.

Services related to a non-covered service

When a service is not covered, all services related to the non-covered service are excluded, except for services we would otherwise cover to treat complications of the non-covered service. For example, if you have a non-covered cosmetic surgery, we would not cover services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "*Surrogacy Arrangements*" under "*Reductions*" in this "*Exclusions, Limitations, Coordination of Benefits, and Reductions*" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any services we cover.

Limitations

We will make a good faith effort to provide or arrange for covered services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of services under this *Subscriber Agreement & Member Handbook*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a participating hospital, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an emergency medical condition, call 911 or go to the nearest hospital, as described under "*Emergency Services*" section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in the *"Benefits Plan"* section.

General Information

Benefit Program Participation

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

Notices

Any notice required or permitted under this *Subscriber Agreement & Member Handbook* must be in writing and either delivered personally or by regular, registered or certified mail, U.S. Postal Service Express Mail or overnight courier, postage prepaid, or by facsimile transmission at the addresses set forth below:

If to L.A. Care:

L.A. Care Health Plan
Attention: Director of Commercial Products
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

If to Member:

Member's last address known to L.A. Care.

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given 48 hours after the notice is addressed and mailed with postage prepaid. Notices delivered by U.S. Postal Service Express mail or overnight courier that guarantees next day delivery shall be deemed given 24 hours after delivery of the notice to the United State Postal Service or courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

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 groups). PPGs cannot, except for collection of co-payments, seek payment from members.

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 **1.855.270.2327** (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.HMO.2219** (**1.888.466.2219**).

Coordination of Benefits

L.A. Care will coordinate benefits for members, even in cases when members are eligible for:

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

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. The purpose of the advisory committees is to:

- Provide input on current and future health plan services and operations
- Discuss member issues and concerns
- Advise the L.A. Care Board of Governors
- Educate the community on health care issues and empower committee members to be advocates

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 unless allowed or required by law. 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 *Subscriber Agreement & 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.

Acceptance of Subscriber Agreement & Member Handbook

Enrollee accepts the terms, conditions and provisions of this *Subscriber Agreement & Member Handbook* upon completion and execution of the enrollment form, by selecting L.A. Care as his/her Qualified Health Plan of choice, and by making the corresponding initial premium payment for submission to L.A. Care, and making direct premium payments to L.A. Care thereafter.

Entire Agreement

This *Subscriber Agreement & Member Handbook*, including all attachments and amendments, contain the entire understanding of Enrollee and L.A. Care with respect to the subject matter hereof, and it incorporates all of the covenants, conditions, promises and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, representations or communications, whether written or oral, between Enrollee and L.A. Care with respect to the subject matter of this Agreement.

Definitions

This list of definitions will help you understand words and phrases used throughout this *Subscriber Agreement and Member Handbook*.

Acute refers to a health effect that is brief and/or of high intensity.

Advance Premium Tax Credits is the payment of the tax credits authorized by 26 U.S.C. 26B and its implementing regulations, which are provided on an advance basis, to an individual enrolled in a Qualified Health Plan (QHP) through Covered California™ in accordance with Section 1412 of the Affordable Care Act.

Affordable Care Act (ACA) is a law that provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act will expand access to high-quality affordable insurance and health care.

Allowable Charges refers to charges in the fee schedule negotiated by the health plan and each participating provider.

Ambulatory Patient Services is medical care provided without need of admission to a health care facility. This includes a range of medical procedures and treatments such as blood tests, X-rays, vaccinations, nebulizing and even monthly well-baby checkups by pediatricians.

Americans with Disabilities Act (ADA) of 1990 is law that protects people with disabilities from discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services. For more information, call the U.S. Department of Justice at **1.800.514.0301** (voice) or **1.800.514.0383** (TTY/TDD).

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

Applicant is a person who applies for L.A. Care Covered™ on his/her own behalf. An applicant is also a person who applies on behalf of a child for whom he or she is responsible. The child or children are called the Enrolled Dependents.

Assisters are those individuals who have been certified by Covered California™ to help eligible individuals and families apply for and enroll in qualified health plans through Covered California™.

Authorize/Authorization is the requirement that covered services be approved.

Behavioral Health Services psychoanalysis, psychotherapy, counseling, medical management, or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, 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 Spectrum 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 by a licensed psychologist and provided under a treatment plan prescribed by 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 qualified autism service (QAS) provider that is reviewed every six months and modified whenever appropriate. The treatment plan is not used to provide respite, day care, or educational services or to reimburse a parent for participation in the treatment.

Benefits, Plan Benefits, or Covered Services are those services, supplies, and drugs a Member is entitled to receive according to the L.A. Care QHP for L.A. Care Covered™.

Benefit Year is the 12-month calendar year, as defined by Covered California™.

California Health Eligibility, Enrollment and Retention System (CalHEERS) is a project jointly sponsored by the California Exchange and the Department of Health Care Services, with the assistance of the Office of Systems Integration to maintain processes to make the eligibility determinations regarding the Exchange and other State health care programs and assist Enrollees in the selection of a health plan.

California Children's Services (CCS) is a statewide health care program open to persons under the age of 19 with a handicapping condition. Call the Los Angeles County CCS program at **626.858.2100** for more information.

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

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

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

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

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

Civil Rights Act of 1964 (Title 6) is a law that protects limited English speaking members by requiring health care providers who receive federal government money to offer language services that include interpreting and translations. For more information, call the U.S. Department of Health and Human Services, Office of Human Rights at **1.800.368.1019** (voice) or **1.800.537.7697** (TTY/TDD).

Co-insurance refers to a percentage of allowable charges that you must pay when you receive covered services from a participating provider.

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

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.

Co-payment is the amount a Member is required to pay for certain covered services after meeting any applicable deductible.

Cost-Sharing Subsidies (also called Cost-Sharing Reductions)) are the reductions in cost-sharing for an eligible individual enrolled in a silver level plan through Covered California™ or for certain Native American Indians or Alaskan Natives enrolled in a through Covered California™.

Covered California™ is the California Health Benefit Exchange, doing business as Covered California™ and an independent entity within the Government of the State of California. Beginning January 2014, Covered California™ will selectively contract with health plans to make available to enrollees of the Exchange health care coverage choices that seek to provide the optimal combination of choice, value, access, quality and service.

Covered Services, Plan Benefits, or Benefits are those services, supplies, and drugs a Member is entitled to receive according to the L.A. Care QHP for L.A. Care Covered™.

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

Custodial Care is a long-term care that does not require skilled nursing.

Deductible is the amount you must pay in a calendar year directly to health care service providers for health care services your health plan covers before your health plan begins to pay. For example, if your deductible is $1,000, your health plan will not pay for any of the services that are subject to the deductible until the $1,000 deductible is met. The deductible amount is based on the contract rates negotiated by L.A. Care with is participating providers. The deductible does not apply to all covered services.

Diagnosis is the decision of the nature of a 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 a physical or mental problem that completely or seriously limits one or more of your major life activities.

Disenrollment is when you leave L.A. Care for any reason.

Drug Formulary (formulary) is a list of drugs approved by L.A. Care. A formulary is a list of drugs that are generally accepted in the medical community as safe and effective.

Durable Medical Equipment (DME) is medical equipment, like hospital beds and wheelchairs, which can be used over and over again.

Eligible/Eligibility means to meet certain requirements, in order to take part in or receive program benefits.

Emergency Care/Services are medically necessary covered services, including ambulance and Mental Health services, which a member believes are necessary to stop or relieve a serious illness or symptom, injury, severe pain, active labor, or conditions requiring immediate diagnosis and treatment.

Emergency Contraceptive Drugs contain the same medication as regular birth control drugs and help prevent pregnancy.

Enrolled Dependent is a member of an Enrollee's family who meets the applicable eligibility requirements set forth by Covered California™ for Dependent coverage and enrollment.

Enrollee is a person who is enrolled in the QHP for Individuals and Families and is responsible for payment of premiums to L.A. Care but has not been effectuated.

Enrollment is the act of beginning your participation in a benefit plan like L.A. Care Covered™

Essential Health Benefits (EHB) are health care service categories that must be covered by certain plans and all Medicaid state plans starting in 2014. Health Plans must cover these benefits in order to be certified and offered in the Exchange under contract with Covered California™.

Evidence of Coverage (also called *"Subscriber Agreement & Member Handbook"*) is the document you are reading. It tells you what services are covered or not covered and how to use L.A. Care's services.

Experimental or Investigational in Nature are medical services that are used on humans in testing and trial centers and will require special authorization from government agencies, like the Federal Food and Drug Administration (FDA).

Family Premium is the monthly family payment.

Federal Poverty Level (FPL) is a measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used by both government and private organizations to determine eligibility for certain programs and benefits. Covered California™ uses this measure to determine if you and your Enrolled Dependent(s), if any, qualify for a federal tax credit (which reduces your monthly premium) or for a federal cost-sharing subsidy (which reduces your cost-sharing out-of pocket costs).

Federally Qualified Health Centers (FQHCs) are health centers that receive a Public Health Services (PHS) grant. FQHCs are located in areas without a lot of health care services.

Formulary is a list of drugs approved by L.A. Care. A formulary is a list of drugs that are generally accepted in the medical community as safe and effective.

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 is the term used when you are not happy with the health care service you receive. A grievance may be administrative or clinical. You may file a grievance over the phone or in writing.

Habilitative Services means medically necessary health care services and health care devices that assist an individual in (partially or fully) acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

Health Benefits Exchange in California is another name for Covered California™. Each state in the country will have an Exchange by 2014, either a State-based Exchange or a Federally Facilitated Exchange. Covered California™ is a State-Based Exchange.

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

Health Insurance Portability and Accountability Act (HIPAA) is a law that protects your rights to get health insurance and to keep your medical records and other personal health information private.

Hospice is care and services provided in a home or facility, by a licensed or certified professional, to relieve pain and provide support to persons who have received a diagnosis for a terminal illness.

Hospital is a place you can get 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 a diminished or absent ability to conceive, and produce offspring after unprotected sexual relations on a regular basis for more than twelve months.

Inpatient care services are services provided to a patient admitted to a hospital.

Integrated Deductible refers to the combined amount you must pay (directly to health care service providers) for health care services in a calendar year for two distinct service categories such as medical and pharmacy services, before your health plan begins to pay. For example, if your integrated deductible for medical and pharmacy is $5,000, your health plan will not pay for any covered medical services or drugs that are subject to the deductible until the $5,000 integrated deductible is met. The integrated deductible does not apply to all covered services.

Interpreter is a trained professional who accurately and impartially expresses a message spoken or signed in one language into a second language and who abides by a code of professional ethics.

Intraocular Lens is the lens within your eyeball.

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 that contracts with Covered California™ to provide health care services to individuals and families who select or are otherwise assigned to L.A. Care through Covered California™.

Liable/Liability is the responsibility of the party; or obligation one is bound by law or justice to perform.

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

Life-threatening tells about a disease or condition that may put a person's life in high danger if the course of the disease is not stopped.

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

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

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 a person who is enrolled and effectuated in L.A. Care Covered™

Member Services Department is the department in L.A. Care that can help Members with questions and concerns.

Mental Health Care is the diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition.

Negligence is the doing of some act which a person of ordinary prudence would not have done under similar circumstances, or failure to act which a person of ordinary prudence would have done under similar circumstances.

Network is the doctors, hospitals, pharmacies, and Mental Health services contracted with L.A. Care to provide covered health care services for Members.

Occupational Therapy is the treatment provided by a licensed professional, using arts, crafts, or other training in daily living skills, to improve and maintain a patient's ability to function after an illness or injury.

Office of Civil Rights handles complaints about discrimination against minorities or the disabled.

Open Enrollment Period is a designated period of time each year – usually a few months – during which insured individuals and their Enrolled Dependent(s) can make changes in health insurance coverage.

Out-of-Pocket Limit is the most you pay during the Benefit Year before your health plan begins paying 100% of the allowed amount for covered services. Any amounts paid for covered services subject to the deductible apply

towards the annual out-of-pocket limit. Co-payments and co-insurance payments that count towards the limit are listed under the section "*Payments that count toward the maximum.*"

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

Outpatient is the medical treatment in a hospital or clinic but you do not have to stay overnight.

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

Participating Physician is a doctor of medicine, who is also a participating primary care physician (PCP) or a participating specialist 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.

Pharmacy is a licensed retail drugstore. It is a place where you can get your prescription filled.

Phenylketonuria (PKU) is a rare disease. PKU can cause mental retardation and other neurological problems if treatment is not started within the first few weeks of life.

Physical Therapy is the treatment provided by a licensed professional, using physical agents, such as ultrasound, heat and massage, and exercise to improve and maintain a patient's ability to function, after an illness or injury.

Physician is a doctor of medicine.

Plan Benefits, Benefits, or Covered Services are those services, supplies, and drugs a Member is entitled to receive according to the QHP for L.A. Care Covered™.

Premium is monthly fee that an Enrollee (Member) must pay to L.A. Care for health coverage.

Prescription is a written order issued by a licensed prescriber.

Primary Care Physician (PCP) is a doctor who acts as your family doctor and manages your health care needs.

Prosthesis is an artificial device, used to replace a missing part of the body.

Provider(s) are the medical professionals and organizations that are contracted with L.A. Care to provide covered health care services for Members. Our health care providers include:

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

Provider Directory is a list of doctors, hospitals, pharmacies, and Mental Health services contracted with L.A. Care to provide covered health care services for Members.

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

Qualified Health Plan (QHP) is a health service plan insurance product that is certified by a Health Benefit Exchange, such as Covered California™, provides the Essential Health Benefits, and is offered by a health plan that 1) is licensed and in good standing; 2) agrees to offer at least one silver and one gold plan; and 3) complies with the requirements of the Secretary of Health and Human Services and the Exchange (such as L.A. Care).

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 diagnosis and treat a disease.

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

Referral is the process by which your PCP directs you to other providers to seek and obtain covered services, which require prior authorization by L.A. Care.

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 the treatment provided by a licensed professional, to improve a patient's breathing function.

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

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

Second Opinion is a visit with another doctor when you:

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

Seriously Debilitating tells about a disease or condition that may not be possible to stop or change and may cause death.

Serious Emotional Disturbance (SED) is a mental condition in children under the age of 19 years. As said by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, children with this disorder have serious problems in at least two of the following areas: self-care, school functioning, family relationships, ability to function in the community; and meets other requirements; and either of the following occur:

a. The child is at risk of being removed or has been removed from the home; or
b. The mental disorder and problems have been present for more than six months or are likely to continue for more than one year without treatment.

Service Area is the geographic area in which L.A. Care is licensed to provide services. L.A. Care's service area is the County of Los Angeles. Catalina Island is excluded for L.A. Care Covered™.

Severe Mental Illnesses (SMI) includes the following mental disorders of a person for any age, schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Skilled Nursing Facility is a facility licensed by the California State Department of Health Services (SDHS) to provide specialized nursing services.

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

Speech Therapy is the treatment provided by a licensed professional, to treat speech problems. This definition is not intended to limit or exclude services provided as part of a Behavioral Health Treatment plan by a Qualified Autism Service Professional or Qualified Autism Service Paraprofessional for the treatment of pervasive developmental disorders or autism.

Standing Referral is a referral approved by your PCP for more than one visit to a specialist or specialty care center for continued or long-term treatment of a medical condition.

State Department of Health Services (SDHS) is a California state agency with the purpose to protect and improve the health status of all Californians.

Subscriber Agreement (also called "*Subscriber Agreement & Member Handbook*") is the document you are reading. It tells you what services are covered or not covered and how to use L.A. Care's services.

Therapeutic Services are the services for the treatment, remediating, or curing of a disorder or disease.

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

Third Party Liability is the liability of a party other than the State of California, L.A. Care, or a Member.

Triage or 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.

Triage or Screening Waiting Time is the time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.

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

Urgent Services are health services needed to prevent an illness or injury from becoming worse with delay of treatment.

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 not limited to:

- severe pain
- potential loss of life, limb, or major bodily function

Venereal relates to or is the result of sexual intercourse.

Vision Impaired is when your ability to see is reduced.

Important Phone Numbers

Children's Services and Programs

Access for Infants and Mothers (AIM) 1-800-433-2611
California Children's Services (CCS) 1-800-288-4584
Child Health and Disability Prevention (CHDP) 1-800-993-CHDP (1-800-993-2437)

Covered California™

Covered California™ 1-800-300-1506
Covered California™ TTY/TDD 1-888-889-4500

Disability Services

American Disabilities Act Information 1-800-514-0301
Hearing Impaired users/California Relay Service TTY/TDD 1-800-735-2929
Hearing users/California Relay Services TTY 711

L.A. Care Health Plan Services

Health Plan Services 1-888-4LA-CARE (1-888-452-2273)
L.A. Care Covered™ Enrollment 1-855-222-4239
L.A. Care Covered™ Member Services 1-855-270-2327
L.A. Care Covered™ Member Services TTY/TDD 711
Authorizations 1-877-431-2273
Behavioral Health Hotline (Beacon) 1-877-344-2858
Compliance Helpline 1-800-400-4889
Nurse Advice Line 1-800-249-3619
Pharmacy 1-855-270-2327
Vision Plan (VSP) 1-800-877-7195
Vision Plan (VSP) TTY/TDD 1-800-428-4833
Liberty Dental 1-888-700-5243
Liberty Dental TTY/TDD 1-877-855-8039

Los Angeles County Services

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

California State Services

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

Service Area Map

L.A. Care *Covered*™ Services Areas

This is only a summary. If you would like more details about your coverage and costs, you can get the complete terms in the policy or plan document at **lacare.org/members/member-materials/la-care-covered** or by calling 1-855-270-2327.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$75** member / **$150**family. Physician and specialist office visits, preventive care, and other services not subject to deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$1,000** person / **$2,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of contracted providers, please see **lacare.org** or call **1-855-270-2327**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. 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. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Your Primary Care Physician (PCP) has to refer you	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the specialist.

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Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) In some cases, a non-plan provider may provide covered services at an in-network facility where you have been authorized to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-network facilities where we have authorized you to receive care.
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5	Not covered	
	Other practitioner office visit	$5	Not covered	
	Specialist visit	$8	Not covered	
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	$8 for laboratory tests. $8 for X-rays and diagnostic imaging.	Not covered	
	Imaging (CT/PET scans, MRIs)	$50	Not covered	Prior Authorization is Required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at lacare.org	Tier 1 (Most Generics)	Retail - $3 Mail Order - $6	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy.
	Tier 2 (Preferred Brand)	Retail - $10 Mail Order - $20	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. Subject to Pharmacy deductible.
	Tier 3 (Non-Preferred Brand)	Retail - $15 Mail Order - $30	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. Prior Authorization is Required. Subject to Pharmacy deductible.
	Tier 4 (Specialty Drugs)	10% up to $150 per script	Not covered	Prior Authorization is Required. Subject to Pharmacy deductible. Not available through Mail Order.
If you have outpatient surgery	Surgery facility fee (e.g., ambulatory surgery center)	10%	Not covered	Prior Authorization is Required.
	Physician/surgeon fees	10%	Not covered	
	Outpatient visit	10%	Not covered	
If you need immediate medical attention	Emergency room facility fee	$50	$350	Copay waived if admitted.
	Emergency room physician fee	No charge	No charge	
	Emergency medical transportation	$30	$250	Subject to deductible.
	Urgent care	$5	$30	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10%	Not covered	Prior Authorization is Required. Subject to deductible.
	Physician/surgeon fee	10%	Not covered	Subject to deductible.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health outpatient office visits	15% up to $5	Not covered	
	Psychological Testing	$0	Not covered	Prior Authorization is Required
	Mental/Behavioral Health other outpatient items and services	10%	Not covered	Prior Authorization is Required. Services include Electroconvulsive Therapy, Intensive Outpatient Treatment Programs, Psychiatric Observation, Outpatient Partial Hospitalization, and Transcranial Magnetic Stimulation.
	Mental/Behavioral Health inpatient facility fee (e.g. hospital room)	10%	Not covered	Prior Authorization is Required. Subject to deductible.
	Mental/Behavioral Health inpatient physician fee	10%	Not covered	Prior Authorization is Required. Subject to deductible.
	Substance Use Disorder outpatient office visits	15% up to $5	Not covered	Prior Authorization is Required for Substance Use Disorder Medical Treatment for Withdrawal.
	Substance Use Disorder other outpatient items and services	10%	Not covered	Prior Authorization is Required. Services include Intensive Outpatient Treatment Programs, Outpatient Partial Hospitalization, and Substance Use Disorder Day Treatment.
	Substance Use Disorder inpatient facility fee (e.g. hospital room)	10%	Not covered	Prior Authorization is Required. Subject to deductible.
	Substance Use Disorder inpatient physician fee	10%	Not covered	Prior Authorization is Required. Subject to deductible.
If you are pregnant	Prenatal care and preconception visits	No charge	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	10% Hospital 10% Professional	Not covered	Subject to deductible.
If you need help recovering or have other special health needs	Home health care	$3	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. Prior Authorization is Required.
	Outpatient Rehabilitation services	$5	Not covered	Prior Authorization is Required.
	Outpatient Habilitation services	$5	Not covered	Prior Authorization is Required.
	Skilled nursing care	10%	Not covered	Up to a maximum of 100 days per Calendar Year per Member. Subject to deductible. Prior Authorization is Required.
	Durable medical equipment	10%	Not covered	Prior Authorization is Required.
	Hospice service	No charge	Not covered	Prior Authorization is Required.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Deductible waived
	Glasses	No charge	Not covered	1 pair of glasses per year (or contact lenses in lieu of glasses)
	Dental check-up – Preventive and Diagnostic (includes oral exam, preventive cleaning and x-ray, sealants per tooth, topical fluoride application and space maintainers-fixed)	No charge	Not covered	

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs
- Routine eye care (Adult)
- Most coverage provided outside the United States.
- Chiropractic care

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

- Acupuncture
- Services related to Abortion
- Bariatric surgery
- Routine foot care

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact us at **1-855-270-2327**. You may also contact your state insurance department at 1-888-466-2219.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-888-466-2219.

Language Access Services:

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-855-270-2327. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1- 855-270-2327. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de Ayuda de HMO al 1-888-466-2219.

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o sa planong pangkalusugan. Upang makakuha ng isang tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa Tagalog, mangyaring tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-800-XXX-XXXX. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng dagdag na tulong, tawagan ang Sentro na Tumutulong ng HMO sa 1-888-466-2219.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-466-2219.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-466-2219.]

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,722.50
- **Patient pays** $817.50

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$75
Co-pays	$0
Coinsurance	$742.50
Total	**$817.50**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,161.50
- **Patient pays** $238.50

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$75
Co-pays	$41
Coinsurance	$122.50
Total	**$238.50**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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Individual Out of Pocket Maximum: $1,000 per 2018 Calendar Year
Family Out of Pocket Maximum: $2,000 per 2018 Calendar Year

✓ Members must be assigned to a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will determine a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the recommended covered services are dentally necessary and outside the scope of a general dentist.

✓ This Benefit Schedule represents the Children's Dental HMO benefits covered as part of your Health Plan offered through LA Care. Any Co-payment for covered dental services will accrue towards the Health Plan's Calendar Year Out-of-Pocket Maximum (which is provided above for your reference). To verify your Out-of-Pocket Maximum you can refer to your Health Plan's Evidence of Coverage booklet, visit your health plan's website at www.lacarecovered.org or call Member Services at 1.855.270.2327 (toll-free).

✓ Once your Out-of-Pocket costs for all Medical and Dental covered services reach the combined Out-of-Pocket Maximum, you cannot be charged for covered dental services you receive for the remainder of the calendar year. The LIBERTY Dental Plan contracted dental office will be paid for covered services as contracted directly by LIBERTY. Charges for optional and non-covered services are not included in the calculation for the combined out-of-pocket maximum and would remain your financial responsibility. In a plan with two or more members, the first family Member to meet the individual Out-of-Pocket Maximum cannot be charged for covered services for the remainder of the calendar year. The family Out-of-Pocket Maximum is met by combining eligible expenses of two or more covered family Members.

✓ Member Co-payments are payable to the dental office at the time services are rendered.

✓ This Benefit Schedule does not guarantee benefits. All services are subject to eligibility, exclusions and limitations and must be determined to be dentally necessary at the time you receive the service. Additional requests, beyond the stated frequency limitations shall be considered for prior authorization when documented dental necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

✓ Dental procedures not listed on this Benefit Schedule may be available at the dental office's usual and customary fees.

CDT Code	Description	Copay	Limitation
	Diagnostic Services		
D0120	Periodic oral evaluation	no charge	1 every 6 months per provider
D0140	Limited oral evaluation	no charge	1 per patient per provider
D0145	Oral evaluation under age 3	no charge	
D0150	Comprehensive oral evaluation	no charge	1 per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	no charge	1 per patient per provider
D0170	Re-evaluation, limited, problem focused	no charge	up to 6 in a 3 month period, no more than 12 in 12 months
D0171	Re-evaluation, post operative office visit	no charge	
D0180	Comprehensive periodontal evaluation	no charge	only be billed as D0150
D0210	Intraoral, complete series of radiographic images	no charge	1 every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	no charge	20 of (D0220, D0230)PA's in a 12 month period by the same provider
D0230	Intraoral, periapical, each add 'l radiographic image	no charge	
D0240	Intraoral, occlusal radiographic image	no charge	2 every 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	no charge	1 per date of service
D0251	Extra-oral posterior dental radiographic image	no charge	1 per date of service
D0270	Bitewing, single radiographic image	no charge	1 per date of service
D0272	Bitewings, two radiographic images	no charge	1 every 6 months per provider
D0273	Bitewings, three radiographic images	no charge	downcode to D0270 and D0272
D0274	Bitewings, four radiographic images	no charge	1 every 6 months per provider, age 10 and over
D0277	Vertical bitewings, 7 to 8 radiographic images	no charge	downcode to D0274
D0310	Sialography	no charge	
D0320	TMJ arthrogram, including injection	no charge	3 per date of service
D0322	Tomographic survey	no charge	2 every 12 months per provider
D0330	Panoramic radiographic image	no charge	1 every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	no charge	2 every 12 months per provider
D0350	2D oral/facial photographic image, intra-orally/extra-orally	no charge	4 per date of service
D0351	3D photographic image	no charge	
D0460	Pulp vitality tests	no charge	
D0470	Diagnostic casts	no charge	1 per provider, only a benefit with covered Orthodontic services, for permanent dentition
D0502	Other oral pathology procedures, by report	no charge	
D0601	Caries risk assessment and documentation, low risk	no charge	
D0602	Caries risk assessment and documentation, moderate risk	no charge	
D0603	Caries risk assessment and documentation, high risk	no charge	
D0999	Unspecified diagnostic procedure, by report	no charge	
	Preventive Services		
D1110	Prophylaxis, adult	no charge	1 of (D1110, D1120, D4346) every 6 months. Additional requests, beyond the stated frequency limitations, for prophylaxis procedures (D1110 and D1120) shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.
D1120	Prophylaxis, child	no charge	
D1206	Topical application of fluoride varnish	no charge	1 of (D1206, D1208) every 6 months. Additional requests, beyond the stated frequency limitations, for fluoride procedures (D1206 and D1208) shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.
D1208	Topical application of fluoride, excluding varnish	no charge	
D1310	Nutritional counseling for control of dental disease	no charge	
D1320	Tobacco counseling, control/prevention oral disease	no charge	
D1330	Oral hygiene instruction	no charge	

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CDT Code	Description	Copay	Limitation
	Preventive Services (continued)		
D1351	Sealant, per tooth	no charge	1 of (D1351,D1352) every 36 months 1st, 2nd, 3rd molars
D1352	Preventive resin restoration, permanent tooth	no charge	
D1353	Sealant repair, per tooth	no charge	1 every 36 months 1st, 2nd, 3rd molars
D1510	Space maintainer, fixed, unilateral	no charge	1 of (D1510, D1520) per quadrant per patient, under age 18
D1515	Space maintainer, fixed, bilateral	no charge	1 of (D1515, D1525) per arch under age 18
D1520	Space maintainer, removable, unilateral	no charge	1 of (D1510, D1520) per quadrant per patient under age 18
D1525	Space maintainer, removable, bilateral	no charge	1 of (D1515, D1525) per arch under age 18
D1550	Re-cement or re-bond space maintainer	no charge	1 per quad/arch every 12 months under age 18
D1555	Removal of fixed space maintainer	no charge	
D1575	Distal shoe space maintainer, fixed, unilateral	no charge	
	Restorative Services		
D2140	Amalgam, one surface, primary or permanent	$25	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months
D2150	Amalgam, two surfaces, primary or permanent	$30	
D2160	Amalgam, three surfaces, primary or permanent	$40	
D2161	Amalgam, four or more surfaces, primary or permanent	$45	
D2330	Resin-based composite, one surface, anterior	$30	
D2331	Resin-based composite, two surfaces, anterior	$45	
D2332	Resin-based composite, three surfaces, anterior	$55	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$60	
D2390	Resin-based composite crown, anterior	$50	primary teeth - 1 per tooth every 12 months permanent teeth - 1 per tooth every 36 months
D2391	Resin-based composite, one surface, posterior	$30	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months
D2392	Resin-based composite, two surfaces, posterior	$40	
D2393	Resin-based composite, three surfaces, posterior	$50	
D2394	Resin-based composite, four or more surfaces, posterior	$70	
D2710	Crown, resin-based composite (indirect)	$140	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D2712	Crown, ¾ resin-based composite (indirect)	$190	
D2721	Crown, resin with predominantly base metal	$300	
D2740	Crown, porcelain/ceramic	$300	
D2751	Crown, porcelain fused to predominantly base metal	$300	
D2781	Crown, ¾ cast predominantly base metal	$300	
D2783	Crown, ¾ porcelain/ceramic	$310	
D2791	Crown, full cast predominantly base metal	$300	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$25	1 per tooth every 12 months per provider
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$25	
D2920	Re-cement or re-bond crown	$25	after 12 months of initial placement with same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$95	1 of (D2929, D2930) per tooth every 12 months
D2930	Prefabricated stainless steel crown, primary tooth	$65	
D2931	Prefabricated stainless steel crown, permanent tooth	$75	1 per tooth every 36 months
D2932	Prefabricated resin crown	$75	primary - 1 of (D2932, D2933) per tooth every 12 months permanent - 1 of (D2932, D2933) per tooth every 36 months
D2933	Prefabricated stainless steel crown with resin window	$80	
D2940	Protective restoration	$25	1 per tooth every 6 months per provider
D2941	Interim therapeutic restoration, primary dentition	$30	
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention, per tooth, in addition to restoration	$25	1 per tooth
D2952	Post and core in addition to crown, indirectly fabricated	$100	1 per tooth
D2953	Each additional indirectly fabricated post, same tooth	$30	
D2954	Prefabricated post and core in addition to crown	$90	1 per tooth
D2955	Post removal	$60	
D2957	Each additional prefabricated post, same tooth	$35	
D2971	Additional procedure to construct new crown, existing partial denture frame	$35	
D2980	Crown repair necessitated by restorative material failure	$50	after 12 months of initial crown placement with same provider
D2999	Unspecified restorative procedure, by report	$40	
	Endodontic Services		
D3110	Pulp cap, direct (excluding final restoration)	$20	
D3120	Pulp cap, indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration)	$40	1 per primary tooth
D3221	Pulpal debridement, primary and permanent teeth	$40	1 per tooth
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$60	1 per tooth
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$55	1 of (D3230, D3240) per tooth
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$55	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	1 of (D3310, D3320, D3330) per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3333	Internal root repair of perforation defects	$80	

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CDT Code	Description	Copay	Limitation
	Endodontic Services (continued)		
D3346	Retreatment of previous root canal therapy, anterior	$240	1 of (D3346-D3348) after 12 months of initial treatment
D3347	Retreatment of previous root canal therapy, premolar	$295	
D3348	Retreatment of previous root canal therapy, molar	$365	
D3351	Apexification/recalcification, initial visit	$85	1 per tooth
D3352	Apexification/recalcification, interim medication replacement	$45	1 per tooth
D3410	Apicoectomy, anterior	$240	
D3421	Apicoectomy, premolar (first root)	$250	
D3425	Apicoectomy, molar (first root)	$275	
D3426	Apicoectomy, (each additional root)	$110	
D3427	Periradicular surgery without apicoectomy	$160	
D3430	Retrograde filling, per root	$90	
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3999	Unspecified endodontic procedure, by report	$100	
	Periodontal Services		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$150	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$50	
D4249	Clinical crown lengthening, hard tissue	$165	
D4260	Osseous surgery, four or more teeth per quadrant	$265	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4261	Osseous surgery, one to three teeth per quadrant	$140	
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	
GUIDELINE: No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$55	1 of (D4341, D4342) per site quad, every 24 months, age 13 and over
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$30	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$220	1 of (D1110, D1120, D4346) every 6 months
D4355	Full mouth debridement	$40	
D4381	Localized delivery of antimicrobial agent/per tooth	$10	
D4910	Periodontal maintenance	$30	1 every 3 months
D4920	Unscheduled dressing change (other than treating dentist or staff)	$15	1 per patient per provider, age 13 and over
D4999	Unspecified periodontal procedure, by report	$350	
	Removable Prosthodontic Services		
D5110	Complete denture, maxillary	$300	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture.
D5120	Complete denture, mandibular	$300	
D5130	Immediate denture, maxillary	$300	1 of (D5130-D5140, D5221-D5224) per arch per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5140	Immediate denture, mandibular	$300	
D5211	Maxillary partial denture, resin base	$300	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture.
D5212	Mandibular partial denture, resin base	$300	
D5213	Maxillary partial denture, cast metal, resin base	$335	
D5214	Mandibular partial denture, cast metal, resin base	$335	
D5221	Immediate maxillary partial denture, resin base	$275	1 of (D5130-D5140, D5221-D5224) per arch per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5222	Immediate mandibular partial denture, resin base	$275	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$330	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$330	
D5410	Adjust complete denture, maxillary	$20	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider
D5411	Adjust complete denture, mandibular	$20	
D5421	Adjust partial denture, maxillary	$20	
D5422	Adjust partial denture, mandibular	$20	
D5511	Repair broken complete denture base, mandibular	$40	1 per arch per date of service per provider, 2 per arch every 12 months per provider
D5512	Repair broken complete denture base, maxillary	$40	1 per arch per date of service per provider, 2 per arch every 12 months per provider
D5520	Replace missing or broken teeth, complete denture	$40	up to 4 per arch per date of service per provider, 2 per arch every 12 months per provider
D5611	Repair resin denture base, mandibular	$40	1 per arch per date of service per provider, 2 per arch every 12 months per provider
D5612	Repair resin denture base, maxillary	$40	
D5621	Repair cast framework, mandibular	$40	1 per arch per date of service per provider, 2 per arch every 12 months per provider
D5622	Repair cast framework, maxillary	$40	
D5630	Repair or replace broken clasp, per tooth	$50	3 per arch per date of service per provider, 2 per arch every 12 months per provider
D5640	Replace broken teeth, per tooth	$35	4 per arch per date of service per provider, 2 per arch every 12 months per provider
D5650	Add tooth to existing partial denture	$35	3 per arch per date of service per provider, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	$60	3 per date of service per provider, 2 per arch every 12 months per provider

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CDT Code	Description	Copay	Limitation
	Removable Prosthodontic Services (continued)		
D5730	Reline complete maxillary denture, chairside	$60	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5731	Reline complete mandibular denture, chairside	$60	
D5740	Reline maxillary partial denture, chairside	$60	
D5741	Reline mandibular partial denture, chairside	$60	
D5750	Reline complete maxillary denture, laboratory	$90	
D5751	Reline complete mandibular denture, laboratory	$90	
D5760	Reline maxillary partial denture, laboratory	$80	
D5761	Reline mandibular partial denture, laboratory	$80	
D5850	Tissue conditioning, maxillary	$30	2 of (D5850, D5851) per arch every 36 months
D5851	Tissue conditioning, mandibular	$30	
D5862	Precision attachment, by report	$90	
D5863	Overdenture, complete, maxillary	$300	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture.
D5864	Overdenture, partial, maxillary	$300	
D5865	Overdenture, complete, mandibular	$300	
D5866	Overdenture, partial, mandibular	$300	
D5899	Unspecified removable prosthodontic procedure, by report	$350	
	Maxillofacial Prosthetic Services		
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	2 every 12 months
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	under age 18
D5952	Speech aid prosthesis, pediatric	$350	under age 18
D5953	Speech aid prosthesis, adult	$350	age 18 and over
D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	2 every 12 months
D5960	Speech aid prosthesis, modification	$145	2 every 12 months
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	
	Implant Services		
D6010	Surgical placement of implant body, endosteal	$350	Only a Plan Benefit when exceptional medical conditions are met
D6011	Second stage implant surgery	$350	
D6013	Surgical placement of mini implant	$350	
D6040	Surgical placement: eposteal implant	$350	
D6050	Surgical placement: transosteal implant	$350	
D6052	Semi-precision attachment abutment	$350	
D6055	Connecting bar, implant supported or abutment supported	$350	
D6056	Prefabricated abutment, includes modification and placement	$135	
D6057	Custom fabricated abutment, includes placement	$180	
D6058	Abutment supported porcelain/ceramic crown	$320	
D6059	Abutment supported porcelain fused to high noble crown	$315	

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LIBERTY Dental Plan of California, Inc.
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CDT Code	Description	Copay	Limitation
	Implant Services (continued)		
D6060	Abutment supported porcelain fused to base metal crown	$295	Only a Plan Benefit when exceptional medical conditions are met
D6061	Abutment supported porcelain fused to noble metal crown	$300	
D6062	Abutment supported cast metal crown, high noble	$315	
D6063	Abutment supported cast metal crown, base metal	$300	
D6064	Abutment supported cast metal crown, noble metal	$315	
D6065	Implant supported porcelain/ceramic crown	$340	
D6066	Implant supported porcelain fused to high noble crown	$335	
D6067	Implant supported metal crown	$340	
D6068	Abutment supported retainer, porcelain/ceramic FPD	$320	
D6069	Abutment supported retainer, metal FPD, high noble	$315	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$290	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$300	
D6072	Abutment supported retainer, cast metal FPD, high noble	$315	
D6073	Abutment supported retainer, cast metal FPD, base metal	$290	
D6074	Abutment supported retainer, cast metal FPD, noble	$320	
D6075	Implant supported retainer for ceramic FPD	$335	
D6076	Implant supported retainer for porcelain fused metal FPD	$330	
D6077	Implant supported retainer for cast metal FPD	$350	
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$30	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$30	
D6085	Provisional implant crown	$300	
D6090	Repair implant supported prosthesis, by report	$65	
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$40	
D6092	Re-cement or re-bond implant/abutment supported crown	$25	
D6093	Re-cement or re-bond implant/abutment supported FPD	$35	
D6094	Abutment supported crown, titanium	$295	
D6095	Repair implant abutment, by report	$65	
D6100	Implant removal, by report	$110	
D6110	Implant/abutment supported removable denture, maxillary	$350	
D6111	Implant/abutment supported removable denture, mandibular	$350	
D6112	Implant/abutment supported removable denture, partial, maxillary	$350	
D6113	Implant/abutment supported removable denture, partial, mandibular	$350	
D6114	Implant/abutment supported fixed denture, maxillary	$350	
D6115	Implant/abutment supported fixed denture, mandibular	$350	
D6116	Implant/abutment supported fixed denture for partial, maxillary	$350	
D6117	Implant/abutment supported fixed denture for partial, mandibular	$350	
D6190	Radiographic/surgical implant index, by report	$75	
D6194	Abutment supported retainer crown, FPD, titanium	$265	
D6199	Unspecified implant procedure, by report	$350	
	Fixed Prosthodontic Services		
D6211	Pontic, cast predominantly base metal	$300	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D6241	Pontic, porcelain fused to predominantly base metal	$300	
D6245	Pontic, porcelain/ceramic	$300	
D6251	Pontic, resin with predominantly base metal	$300	
D6721	Retainer crown, resin with predominantly base metal	$300	
D6740	Retainer crown, porcelain/ceramic	$300	
D6751	Retainer crown, porcelain fused to predominantly base metal	$300	
D6781	Retainer crown, ¾ cast predominantly base metal	$300	
D6783	Retainer crown, ¾ porcelain/ceramic	$300	
D6791	Retainer crown, full cast predominantly base metal	$300	
D6930	Re-cement or re-bond fixed partial denture	$40	
D6980	Fixed partial denture repair, restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	
	Oral & Maxillofacial Services		
GUIDELINE: The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists			
D7111	Extraction, coronal remnants, primary tooth	$40	
D7140	Extraction, erupted tooth or exposed root	$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$120	
D7220	Removal of impacted tooth, soft tissue	$95	
D7230	Removal of impacted tooth, partially bony	$145	
D7240	Removal of impacted tooth, completely bony	$160	
D7241	Removal impacted tooth, complete bony, complication	$175	
D7250	Removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization, accident	$185	1 per arch

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CDT Code	Description	Copay	Limitation
	Oral & Maxillofacial Services (continued)		
D7280	Exposure of an unerupted tooth	$220	
D7283	Placement, device to facilitate eruption, impaction	$85	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$180	1 per arch per date of service
D7286	Incisional biopsy of oral tissue, soft	$110	up to 3 per date of service
D7290	Surgical repositioning of teeth	$185	1 per arch, for active orthodontic treatment only
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	1 per arch, for active orthodontic treatment only
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$85	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$50	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$120	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$65	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$350	1 per arch per 5 year period
D7350	Vestibuloplasty, ridge extension	$350	1 per arch
D7410	Excision of benign lesion, up to 1.25 cm	$75	
D7411	Excision of benign lesion, greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion, up to 1.25 cm	$95	
D7414	Excision of malignant lesion, greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor, up to 1.25 cm	$105	
D7441	Excision of malignant tumor, greater than 1.25 cm	$185	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$180	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$330	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$155	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis, maxilla or mandible	$140	1 per quadrant
D7472	Removal of torus palatinus	$145	1 per lifetime
D7473	Removal of torus mandibularis	$140	1 per quadrant
D7485	Reduction of osseous tuberosity	$105	1 per quadrant
D7490	Radical resection of maxilla or mandible	$350	
D7510	Incision & drainage of abscess, intraoral soft tissue	$70	1 per quadrant, same date of service
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$70	1 per quadrant, same date of service
D7520	Incision & drainage of abscess, extraoral soft tissue	$70	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$80	
D7530	Remove foreign body, mucosa, skin, tissue	$45	1 per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	1 per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	1 per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla, open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla, closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible, open reduction (teeth immobilized, if present)	$350	
D7640	Mandible, closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch, open reduction	$350	
D7660	Malar and/or zygomatic arch, closed reduction	$350	
D7670	Alveolus, closed reduction, may include stabilization of teeth	$170	
D7671	Alveolus, open reduction, may include stabilization of teeth	$230	
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	$350	
D7710	Maxilla, open reduction	$110	
D7720	Maxilla, closed reduction	$180	
D7730	Mandible, open reduction	$350	
D7740	Mandible, closed reduction	$290	
D7750	Malar and/or zygomatic arch, open reduction	$220	
D7760	Malar and/or zygomatic arch, closed reduction	$350	
D7770	Alveolus, open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones, complicated reduction with fixation and multiple approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	

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CDT Code	Description	Copay	Limitation
	Oral & Maxillofacial Services (continued)		
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy, diagnosis, with or without biopsy	$350	
D7873	Arthroscopy: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7881	Occlusal orthotic device adjustment	$30	
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture, up to 5 cm	$55	
D7912	Complicated suture, greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7940	Osteoplasty, for orthognathic deformities	$160	
D7941	Osteotomy, mandibular rami	$350	
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy, segmented or subapical	$275	
D7945	Osteotomy, body of mandible	$350	
D7946	LeFort I (maxilla, total)	$350	
D7947	LeFort I (maxilla, segmented)	$350	
D7948	LeFort II or LeFort III, without bone graft	$350	
D7949	LeFort II or LeFort III, with bone graft	$350	
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$120	1 per arch per date of service
D7963	Frenuloplasty	$120	1 per arch per date of service
D7970	Excision of hyperplastic tissue, per arch	$175	1 per arch per date of service
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	1 per quadrant per date of service
D7979	Non – surgical sialolithotomy	$155	
D7980	Surgical sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft, mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	1 per arch per date of service
D7999	Unspecified oral surgery procedure, by report	$350	
	Orthodontic Services		
For Pediatric Dental, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000 per course of treatment, regardless of plan year	age 13 and over
D8210	Removable appliance therapy		1 per patient, age 6 through 12
D8220	Fixed appliance therapy		1 per patient, age 6 through 12
D8660	Pre-orthodontic treatment examination to monitor growth and development		1 every 3 months for a maximum of 6
D8670	Periodic orthodontic treatment visit		1 every calendar quarter
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		1 per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment		
D8691	Repair of orthodontic appliance		1 per appliance
D8692	Replacement of lost or broken retainer		1 per arch
D8693	Re-cement or re-bond fixed retainer		1 per provider
D8694	Repair of fixed retainers, includes reattachment		
D8999	Unspecified orthodontic procedure, by report		
	Adjunctive General Services		
D9110	Palliative (emergency) treatment, minor procedure	$30	1 per date of service
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$10	1 per date of service
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	

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CDT Code	Description	Copay	Limitation
	Adjunctive General Services (continued)		
GUIDELINE: Deep Sedation and IV Conscious Sedation are covered benefits only in conjunction with covered oral surgery procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.			
D9222	Deep sedation/general anesthesia, first 15 minutes	$45	
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$45	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minutes	$60	
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$60	
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$65	
D9310	Consultation, other than requesting dentist	$50	
D9311	Consultation with a medical health care professional	no charge	
D9410	House/extended care facility call	$50	
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit, observation, regular hours, no other services	$20	1 per date of service per provider
D9440	Office visit, after regularly scheduled hours	$45	1 per date of service per provider
D9610	Therapeutic parenteral drug, single administration	$30	4 per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	$40	4 per date of service
D9910	Application of desensitizing medicament	$20	1 per tooth every 12 months, for permanent teeth only
D9930	Treatment of complications, post surgical, unusual, by report	$35	1 per date of service per provider
D9950	Occlusion analysis, mounted case	$120	1 every 12 months, age 13 and over
D9951	Occlusal adjustment, limited	$45	1 per quadrant every 12 months per provider, age 13 and over
D9952	Occlusal adjustment, complete	$210	1 every 12 months, age 13 and over
D9999	Unspecified adjunctive procedure, by report	no charge	

Pediatric Benefits – Children to the age of 19

Payment for services that are Optional or that are not covered under the Policy will not count toward the Out-of-Pocket Maximum, and payment for such services still applies after the annual Out-of-Pocket Maximum is met.

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General Exclusions:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. Experimental procedures 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 standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
5. Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
6. Hospital charges of any kind are not covered by the Dental Plan. Refer to your Health Plan's Evidence of Coverage for benefit information.
7. Major surgery for fractures and dislocations.
8. Loss or theft of dentures or bridgework.
9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
10. Any service that is not specifically listed as a covered benefit.
11. Malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Additional treatment costs incurred because a dental procedure is unable to be preformed in the dentists office due to the general health and physical limitations of the patient.
14. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
15. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

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CALIFORNIA
INDIVIDUAL PLAN
COMBINED EVIDENCE OF COVERAGE (EOC) AND DISCLOSURE FORM

LA Care Covered and LA Care Direct Children's Dental HMO Benefit (EPDB) Plan

LA Care is your Qualified Health Plan (QHP)
LA Care arranges for your Essential Pediatric Dental Benefit coverage provided by LIBERTY Dental Plan of California.

ANNOUNCEMENTS

Availability of Language Assistance: Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. To ask for language services call 1-888-700-5243.

Spanish (Español)
IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-888-700-5243.

Hereinafter in this document, LIBERTY Dental Plan of California, Inc. may be referred to as "LIBERTY" or "the Plan." LA Care Covered and LA Care Direct may be referred to as "LA Care".

This COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM constitutes only a summary of the dental plan. The dental plan contract must be consulted to determine the exact terms and conditions of coverage.

A specimen of the dental plan contract will be furnished upon request.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Section I of this document contains a Benefit Matrix for general reference and comparison of Your Benefits under this plan followed by an Overview of Your Dental Benefit Plan.

Section II of this document contains definitions of terms used throughout this document.

I. GENERAL INFORMATION – OVERVIEW OF YOUR DENTAL BENEFIT PLAN

BENEFITS MATRIX

THE FOLLOWING MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESSCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(A) Deductibles	None. Minimum Coverage Plan Only: Your Children's Dental HMO plan's deductible will be integrated with Your medical plan's deductible. Once Your out-of-pocket expenditures for all covered Medical and Dental services reach the integrated deductible, You may be required to pay a Copayment amount for each procedure as shown in the Description of Benefits and Copayments. The integrated deductible does not apply to preventive and diagnostic services.
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximums	Your Children's Dental HMO plan's out-of-pocket maximum will be integrated with Your medical plan's out-of-pocket maximum. Once Your out-of-pocket expenditures for all covered Medical and Dental services reach the integrated out-of-pocket maximum, all further covered dental procedures will be paid for by LIBERTY. Charges for optional, non-covered or upgraded material services are not included in the calculation for the integrated out-of-pocket maximum. Any payments for dental services accrue toward Your Health Plan medical out of pocket maximum for the applicable metal level plan selected. Minimum coverage plan benefits are covered at 100% by the plan after the member meets the medical plan deductible and Annual Out-of-Pocket Maximum. Please refer to page 5 for information on Annual Out-of-Pocket Maximum.
(D) Professional services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Description of Benefits and Copayments, subject to the Limitations and Exclusions. Copayments range by category of service. Examples are as follows: • Diagnostic Services ..... No Cost • Preventive Services ..... No Cost • Restorative Services ..... No Cost - $350.00 • Periodontic Services ..... $ 40.00 - $350.00 • Prosthodontic Services ..... No Cost - $350.00 • Oral and Maxillofacial Surgery ..... No Cost - $350.00 • Orthodontic Services ..... No Cost - $1,000.00 **Note:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to additional charges. Limitations apply to the frequency with which some services may be obtained. For example: bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6-consecutive month period; Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to $75 per emergency for out-of-area Emergency Services.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered

(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above that is covered under the Program has a specific Copayment, which is shown in the Schedule of Benefits and in the Combined Evidence of Coverage.

OVERVIEW OF YOUR DENTAL BENEFIT PLAN

A. How to Use Your LIBERTY Dental Plan

This booklet is Your Evidence of Coverage (EOC). It explains what LIBERTY covers and does not cover. Your comprehensive Schedule of Benefits (on page 20), which lists copays and other fees. Your LIBERTY Dental Plan is an Individual dental plan. To be eligible for this coverage, You must meet the eligibility requirements as stated in this document.

B. How to Contact LIBERTY

Our Member Services department is here to help You. Call us if You have a question or a problem:

LIBERTY Dental Plan of California, Inc.
P.O. Box 26110
Santa Ana, CA 92799-6110
Member Services (Toll-Free): 1-888-700-5243
Website: www.LIBERTYdentalplan.com

C. LIBERTY's Service Area

This is the area in which LIBERTY provides dental coverage. You must live or work in the Service Area. You must receive all dental service services within the Service Area, unless You need emergency or Urgent Care. If You move out of the Service Area You must tell LIBERTY. **LA Care's Dental Benefit Plan's Service Area is Covered California Region 14 and 15, Los Angeles County.**

D. LIBERTY's Network

Our network is all the Primary Care Providers and Specialists that LIBERTY has contracted with to provide services to our Members. You must get Your dental services from Your Primary Care Provider and other Providers who are in the network. Call 1-888-700-5243 to ask for a LIBERTY Provider Directory or use the website.

If You go to Providers outside the network, You will have to pay all the cost, unless You received pre-approval from LIBERTY or You had an emergency or You needed Urgent Care away from home. If You are new to LIBERTY or LIBERTY ends your Provider's contract, You can continue to see Your current dentist in some cases. This is called *continuity of care (see page 10).*

E. Your Primary Care Provider *(see page 7)*

When You join LIBERTY, You need to choose a Primary Care Provider to whom You will be assigned. The first page of Your Schedule of Benefits indicates if You must choose, and become assigned to a Primary Care Provider. Your Primary Care Provider is usually a General Dentist who provides Your basic care and coordinates the care You need from other dental specialty Providers.

F. Language and Communication Assistance *(see page 18)*

If English is not Your first language, LIBERTY provides interpretation services and translation of certain written materials in Your preferred language. To ask for language services call 1-888-700-5243. If You have a preferred language, please notify us of Your personal language needs by calling 1-888-700-5243.

G. How to Get Dental Care When You Need It

Call Your Primary Care Provider first for all Your care, unless it is an emergency.

- You usually need a referral and pre-approval to get care from a Provider other than Your Primary Care Provider. See the next section.

- The care must be medically necessary for Your health. Your dentist and LIBERTY follow guidelines and policies to decide if the care is medically necessary. If You disagree with LIBERTY about whether a service You want is medically necessary, You can file a Grievance or, in some cases, You may request an Independent Medical Review (see page 16).
- The care must be a service that LIBERTY covers. Covered dental services are also called Benefits. To see what services LIBERTY covers, see the Schedule of Benefits. Your comprehensive Schedule of Benefits is provided with this document at the inception of the contract, and is also available separately upon request from Member Services or via the LIBERTY website.

H. Referrals and Pre-approvals *(see page 9)*

You need a referral from Your Primary Care Provider and pre-approval from LIBERTY for specialty services or to receive a second opinion or to see a dentist who is not in LIBERTY's network. Pre-approval is also called *prior Authorization.*

- Make sure Your Primary Care Provider gives You a referral and gets pre-approval if it is required.
- If You do not have a referral and pre-approval when it is required, You will have to pay all of the cost of the service.

You do **not** need a referral and pre-approval to see Your primary care provider, get Emergency Care or Urgent Care.

I. Emergency Care *(see page 8)*

Emergency Care is covered anywhere in the world. A condition may be considered an emergency if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. You should seek emergency care from Your Primary Care Provider whenever possible. If You are unable to access Your Primary Care Provider or are out of the service area and it is an emergency, call 9-1-1 or go to the nearest hospital or emergency room. Go to Your Primary Care Provider for follow-up care. Do not go back to the emergency room for follow-up care. Coverage for Urgent Care and Emergency Care is explained fully on page 8.

J. Urgent Care *(see page 8)*

Urgent care is care that You need soon to prevent a serious health problem. Urgent care is covered anywhere in the world. Coverage for Urgent Care and Emergency Care is explained fully on page 8.

K. Care When You Are Out of the LIBERTY Service Area *(see page 8)*

Only Emergency and Urgent Care is covered outside of the LIBERTY Service Area.

L. Costs *(SEE THE* "SCHEDULE OF BENEFITS" IN APPENDIX I *AND* "WHAT YOU PAY" ON PAGE 10)

- The Premium is what You pay to Your Qualified Health Plan (QHP) to keep coverage. Premiums are paid to LA Care.
- A Co-pay (Co-payment) is the amount that You must pay for a particular covered procedure. After You pay your Co-payment for that service, LIBERTY pays for the rest of that covered service.
- Your plan has a yearly Out-of-Pocket Maximum. The yearly Out-of-Pocket maximum is the most money You have to pay for Your Covered Services in a year. Out-of-Pocket costs include co-pays, coinsurance, or deductibles for all covered medical and dental services. Any payment for dental services accrue toward Your Health Plan's medical Out-of-Pocket maximum for the applicable metal level plan selected. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket Maximums. To verify Your Out-of-Pocket Maximum You can visit LA Care's website at **www.lacarecovered.org** or call LA Care's Member Services **1-855-270-2327 (toll-free)**. After You have reached the yearly Out-of-Pocket maximum, LIBERTY will pay the rest of the cost of dental services for that year, as long as the service You receive is a covered benefit performed by Your assigned contracted dental Provider or authorized dental Provider.
- IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call member services at 1-888-700-5243 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this evidence of coverage document.

M. If You Have a Complaint About Your LIBERTY Dental Plan *(see page 15)*

LIBERTY provides a Grievance resolution process. You can file a complaint (also called an *appeal* or a *Grievance*) with LIBERTY for any dissatisfaction You have with LIBERTY, Your Benefits, a claim determination, a benefit or coverage determination, Your Provider or any aspect of Your Dental Benefit Plan. If You disagree with LIBERTY's decision about Your complaint, You can get help from the State of California's HMO Help Center. In some cases, the HMO Help Center can help You apply for an Independent Medical Review (IMR) or file a complaint. IMR is a review of Your case by doctors who are not part of Your health plan.

II. DEFINITIONS OF USEFUL TERMS CONTAINED IN THIS DOCUMENT

The following terms are used in this EOC document:

APTC: The **Advanced Premium Tax Credit** is a federal subsidy used to assist qualifying individuals and families obtain health insurance by reducing the monthly Premium amount in order to make coverage more affordable.

Authorization: The notification of approval by LIBERTY that You may proceed with treatment requested

Benefits: Services covered by Your LIBERTY dental plan

Benefit Plan: The LIBERTY dental product that You purchased to provide coverage for dental services

Benefit Year: The year of coverage of Your LIBERTY dental plan

Cal-COBRA: State law requiring an individual in a small group of 2-19 Members to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage

Capitation: Pre-paid payments made by LIBERTY to a Contracted Primary Care Provider to provide services to assigned Members

Charges: The fees requested for proposed services or services rendered

COBRA: Federal law requiring an individual to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage

Contracting Dentist: A dentist who has signed a contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations

Covered Services: Services listed in this document as a benefit of this dental plan

Co-payment: Any amount charged to a Member at the time of service for Covered Services. Fixed Co-payment amounts are listed in the Schedule of Benefits

Deductible: Refers to the medical deductible amount a Member must meet before any Co-payments can be charged. The Member will cover total cost of dental services received until the medical deductible amount has been met.

Dental Records: Refers to diagnostic aid, intraoral and extra-oral radiographs, written treatment record including but not limited to progress notes, dental and periodontal chartings, treatment plans, consultation reports, or other written material relating to an individual's medical and dental history, diagnosis, condition, treatment, or evaluation

Dependent: Any eligible Member of a Subscriber's family who is enrolled in LIBERTY Dental Plan

Dental Necessity or Dentally Necessary: A Covered Service that meets Plan guidelines for appropriateness and reasonableness by virtue of a clinical review of submitted information. Covered Services may be reviewed for Dental Necessity prior to or after rendering. Payment for services occurs for Covered Services that are deemed Dentally Necessary by the Plan

Dental Office: A dental facility and its dentists that are under contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations

Disputed Dental Service: Any service that is the subject of a dispute filed by either Member or Provider

Domestic Partner: A person that is in a committed life-sharing relationship with the Member.

Enrollee: see Member

Emergency Care / Emergency Dental Service: Emergency Dental Service and care include (and are covered by LIBERTY Dental Plan) dental screening, examination, evaluation by dentist or dental Specialist to determine if an emergency dental condition exists. A condition may be considered an emergency if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Emergency Care may include care for a bad injury, severe pain, or

a sudden serious dental illness. Medical emergencies are not covered by LIBERTY Dental Plan if the services are rendered in a hospital setting which are covered by a Medical Plan, or if LIBERTY Dental Plan determines the services were not dental in nature.

EPDB, or Essential Pediatric Dental Benefit: Refers to benefits required by the Affordable Care Act to provide essential pediatric dental Benefits to children.

Exclusion: A statement describing one or more services or situations where coverage is not provided for dental services by the Plan.

General Dentist: A licensed dentist who provides general dental services and who does not identify as a Specialist.

Grievance: Any expression of dissatisfaction; also known as a complaint. See Grievance Section of EOC for pertinent rules, regulations and processes.

Independent Medical Review (IMR): A California program where certain denied services may be subject to an external review. IMR is only available for medical services or services that are available due to enrollment in a related full-service medical plan.

Individual Plan: A dental Benefit Plan providing coverage for an individual person. A spouse or covered Dependent may also be included on the same Individual Plan as the Subscriber.

In-Network Benefits: Benefits available to You when You receive services from a Contracted Provider.

Member: Subscriber or eligible Dependent(s) who are actually enrolled in the Plan. Also known as Enrollee.

Non-Participating Provider: A dentist that has no contract to provide services for LIBERTY.

Open Enrollment Period: A period of time where enrollment in a dental plan may be started or changed.

Out-of-Area Coverage: Benefits provided when You are out of the Plan's Service Area, or away from Your Primary Care Provider.

Out-of-Area Urgent Care: Urgent services that are needed while You are located out of the Service Area or away from Your Primary Care Provider.

Out-of-Pocket Maximum: Refers to the maximum amount You will spend for Covered Services each year. After meeting this amount of expense, all additional Covered Services during the year are covered by Your Plan. Out-of-Pocket costs include co-pays, coinsurance, or deductibles for all covered medical and dental services. Any payment for dental services accrue toward Your Health Plan's medical Out-of-Pocket Maximum for the applicable metal level plan selected. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket Maximums.

Plan: LIBERTY Dental Plan of California, Inc.

Pre-Authorization: A document submitted in your behalf requesting an advance determination and approval to render desired treatment services for You.

Premium: The fee received by LIBERTY, paid by You to Your Qualified Health Plan (QHP) for this Benefit Plan.

Primary Care Provider: A General Dentist affiliated with LIBERTY to provide general dental services to covered Members of the Plan. The Primary Care Provider is responsible to provide or arrange for needed dental services. Primary Care Provider may include one or more General Dentists or Specialists in the same facility.

Professional Services: Dental services or procedures provided by a licensed dentist or approved auxiliaries.

Provider: A contracted dentist providing services under this Plan.

Qualified Health Plan (QHP): A health plan that meets the qualifications to be offered under the Affordable Care Act as qualified by Covered California.

Specialist: A Dentist that has received advanced training in one of the dental specialties approved by the American Dental Association as a dental specialty, and practices as a Specialist. Examples are Endodontists, Oral and Maxillofacial Surgeon, Periodontists and Pediatric Dentist.

Subscriber: Member, Enrollee or "You" are equivalent in this document.

Surcharge: An amount charged in addition to a listed Co-payment for a requested service or feature.

Terminated Provider: A dentist that formerly delivered services under contract that is no longer associated with the Plan.

Service Area: The counties in California where LIBERTY provides coverage.

Urgent Care: See Emergency Care.

Usual Charges: A Dentist's usual charge for a service.

You: pertains to Members who are the beneficiary of this dental Benefit Plan.

III. ACCESS TO SERVICES – SEEING A DENTIST

LIBERTY Dental Plan contracts with Primary Care Providers and Specialists to provide services covered by Your Plan. Contact us toll-free at **1-888-700-5273** or via our website, **www.LIBERTYdentalplan.com**, to find a dentist in your area. All services and Benefits described in this publication are covered only if provided by a contracted Primary Care Provider or Specialist. The only time You may receive care outside the network is for Emergency Dental Services as described herein under "Emergency Dental Care" or "Urgent Care".

A. FACILITIES

LIBERTY makes available Primary Care Providers (General Dentist) and specialty care dental facilities throughout the state of California within a reasonable distance from Your home or workplace. Contact LIBERTY toll-free at 1-888-700-5243 or via website at www.LIBERTYdentalplan.com to find a dentist in Your area.

Our goal is to provide You with appropriate dental Benefits, delivered by highly qualified dental professionals in a comfortable setting. All of LIBERTY Dental Plan's contracted dentists have undergone strict credentialing procedures, background checks and office evaluations. In addition, each participating dentist must adhere to strict contractual guidelines. All dentists are pre-screened and reviewed on a regular basis. We conduct a quality assessment program which includes ongoing contract management to assure compliance with continuing education, accessibility for Members, appropriate diagnosis and treatment planning.

Your Primary Care Provider will provide for all of Your dental care needs including referring You to a Specialist, should it be necessary. Most Enrollees should have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a Primary Care Dental Office.

B. DENTAL HEALTH EDUCATION

For further information on using Your Dental Benefits, please see the website at www.LIBERTYdentalplan.com. The website contains other helpful information on dental and oral health information to assist You in assessing Your risk of future dental disease, home care measures You can take to keeping Your teeth and mouth healthy. Further, the condition of Your teeth, gums and mouth can have profound effect on Your total overall health. Information on how Your oral health can affect Your overall health conditions such as cardiovascular conditions, diabetes, obesity, pregnancy and pre- and peri-natal health as well as other health conditions can be found on the website.

C. CHOICE OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHAT PROVIDER DENTAL SERVICES MAY BE OBTAINED

1. **General Dentistry/Primary Care Dentistry:** When You join LIBERTY Dental Plan, You must choose a Primary Care Provider to whom You will be assigned. Your assigned Primary Care Provider is responsible for coordinating any specialty care dental services You might need. You must obtain general dental services from Your assigned Primary Care Provider. Your assigned primary care facility will share information with any Specialist to coordinate Your overall care.

   If You do not select a Primary Care Provider, one will be chosen for You by LIBERTY upon your enrollment and You will be notified of this assignment.

2. **Changing Primary Care Providers:** You may contact LIBERTY at any time to change Your Primary Care Provider. Contact our Member Services Department toll-free at 1-888-700-5243 (during regular business hours) or submit a change request in writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your requested change to a Primary Care Provider will be in effect on the first (1st) day of the following month if the change is received by LIBERTY Dental Plan prior to the twentieth (20th) of the current month. Your request to change dentists will not be processed if You have an outstanding balance with Your current dentist.

3. **Care from a Dental Specialist:** You may only obtain care from a dental Specialist only after Your referral to a Specialist has been submitted by Your assigned Primary Care Provider to LIBERTY for approval. You may only receive services from a dental Specialist that have been pre-approved for You. Your Specialist will submit a Pre-Authorization for services to LIBERTY for pre-approval.

   All services and Benefits described in this publication are covered only if provided by a contracted LIBERTY Dental Plan participating Primary Care Dentist or Specialist. The only time You may receive care outside the network is for Emergency Dental Services as described herein under "Emergency Dental Care".

D. URGENT CARE

Urgent care is care You need within 24 to 72 hours, and are services needed to prevent the serious deterioration of Your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate severe pain or bleeding or if an Enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death. Contact Your assigned Primary Care Provider for Your urgent needs during business hours or after hours. If You are out of the area, You may contact LIBERTY for referral to another contracted dentist that can treat Your urgent condition. For after-hours Urgent Care outside the Service Area, You may proceed to find a dentist who can assist You. LIBERTY will reimburse You for covered dental expenses up to a maximum of seventy-five dollars ($75), less applicable Co-payments per calendar year. You should notify LIBERTY as soon as possible after receipt of Urgent Care services, preferably within 48 hours. If it is determined that Your treatment was not due to a dental emergency, the services of any non-contracted dentist will not be covered.

E. EMERGENCY DENTAL CARE

All affiliated LIBERTY Dental Plan Primary Care Providers provide availability of emergency dental care twenty-four (24) hours per day, seven (7) days per week. The Plan provides coverage for Emergency Dental Services if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. You may also wish to consider contacting the "911" emergency response system. The use of such system should be done so responsibly.

In the event You require Emergency Dental Care, contact Your Primary Care Provider to schedule an immediate appointment. For urgent or unexpected dental conditions that occur after-hours or on weekends, contact Your Primary Care Provider for instructions on how to proceed.

If Your Primary Care Provider is not available, or if You are out of the area and cannot contact LIBERTY to redirect You to another contracted Dental Office, contact any licensed dentist to receive Emergency Care. LIBERTY will reimburse You for covered dental expenses up to a maximum of seventy-five dollars ($75), less applicable Co-payments per calendar year. You should notify LIBERTY as soon as possible after receipt of emergency services, preferably within 48 hours. If it is determined that Your treatment was not due to a dental emergency, the services of any non-contracted dentist will not be covered.

Emergency Dental Service *(covered by your LIBERTY Dental Plan*) is defined in the California Health & Safety Code, to include a dental screening, examination, evaluation by dentist or dental Specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a Dental Office.

Reimbursement for Emergency Dental Care: If the requirements in the section titled "Emergency Dental Care" are satisfied, LIBERTY will cover up to $75 of such services less applicable Co-payments per calendar year. If You pay a bill for covered Emergency Dental Care, submit a copy of the paid bill to LIBERTY Dental Plan, Claims Department, P.O. Box 26110, Santa Ana, CA, 92799-6110. Please include a copy of the claim from the Provider's office or a legible statement of services/invoice. Please forward to LIBERTY Dental Plan with the following information:

- Your membership information.
- Individual's name that received the emergency services.
- Name and address of the dentist providing the emergency service.
- A statement explaining the circumstances surrounding the emergency visit.

If additional information is needed, You will be notified in writing. If any part of Your claim is denied You will receive a written Explanation of Benefits (EOB) within 30 days of LIBERTY Dental Plan's receipt of the claim that includes:

- The reason for the denial.
- Reference to the pertinent Evidence of Coverage provisions on which the denial is based.

- Notice of Your right to request reconsideration of the denial, and an explanation of the Grievance procedures. You may also refer to the EOC section, GRIEVANCE PROCEDURES below.

F. SECOND OPINION

At no cost to You, You may request a second dental opinion diagnosis for services covered under Your plan when appropriate, by directly contacting Member Services either by calling the toll-free number 1-888-700-5243 or by writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your Primary Care Provider may also request a second dental opinion on Your behalf by submitting a Standard Specialty or Orthodontic Referral form with appropriate x-rays. All requests for a second dental opinion are processed by LIBERTY Dental Plan within five (5) business days of receipt of the request, or within 72 hours of receipt for cases involving an imminent and serious threat to your health including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Upon request, You may obtain a copy of LIBERTY Dental Plan's policy description for a second dental opinion.

G. REFERRAL TO A SPECIALIST

In the event that You need to be seen by a Specialist, LIBERTY Dental Plan requires prior benefit Authorization. Your Primary Care Provider is responsible for obtaining Authorization for You to receive specialty care.

The Pre-Authorization submission will be responded to within five (5) business days of receipt, unless urgent.

If Your specialty referral Pre-Authorization is denied or You are dissatisfied with the Pre-Authorization, You have the right to file a Grievance. See EOC section, "GRIEVANCE PROCEDURES" below.

If Your Primary Care Provider has difficulty locating a Specialist in Your area, contact LIBERTY Member Services for assistance in locating a Specialist.

H. AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES

No prior benefit Authorization is required in order to receive general dental services from Your Primary Care Provider. The Primary Care Provider has the authority to make most coverage determinations. The coverage determinations are achieved through comprehensive oral evaluations which are covered by Your plan. Your Primary Care Provider is responsible for communicating the results of the comprehensive oral evaluation and advising of available Benefits and associated cost.

Referral to a Specialist is the responsibility of Your assigned contracted Primary Care Provider (see Referral to a Specialist above).

Specialty services proposed by any Specialist to whom You are referred must be Pre-Authorized prior to rendering care, except for Emergency Dental Services (Emergency Dental Care and Urgent Care services described above).

You or Your Providers may call Member Services toll-free at 1-888-700-5243 for information on Pre-Authorization of services policies, procedures or the status of a particular referral or Pre-Authorization.

Specialty referral and Pre-Authorization of specialty services proposed by the Specialist is processed within 5 days of receipt of all information necessary to make the determination. When LIBERTY is unable to make the determination within the 5-day requirement, LIBERTY will notify Your Provider and You of the information needed to complete the review and the anticipated date when the determination will be made.

Any denial, delay or modification of services will contain a clear and concise description of the utilization review criteria, guideline, clinical reason or contractual section of the coverage documentation used to make such a determination. Such determinations will include the name and telephone number of the health care professional responsible for the determination and information on how You can

Determinations to deny, delay or modify treatment requested on Your behalf will contain information on how You may file a Grievance based on this determination.

Urgent requests: If You or Your Primary Care Provider encounter an urgent condition in which there is an imminent and serious threat to Your health including but not limited to, the potential loss of life, limb, or other major body function, or the normal timeframe for the decision making process as described above would be detrimental to Your life or health, the response to the request for referral should not exceed seventy-two (72) hours from the time of receipt of such information, based on the nature of the urgent or emergent condition.

The decision to approve, modify or deny will be communicated to the Primary Care Provider within twenty-four (24) hours of the decision. In cases where the review is retrospective (services already provided), the decision shall be communicated to the Enrollee within thirty (30) days of the receipt of the information.

I. CONTINUITY OF CARE

Current Members: Current Members may have the right to the benefit of completion of care with their terminated Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-700-5243 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your terminated Provider. We are not required to continue Your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with Your terminated Provider on the terms regarding Your care in accordance with California law.

New Members: A New Member may have the right to the qualified benefit of completion of care with their non-participating Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-700-5243 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your current Provider. We are not required to continue Your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with Your Provider on the terms regarding Your care in accordance with California law. This policy does not apply to new Members of an individual Subscriber contract.

J. LANGUAGE ASSISTANCE

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. To ask for language services call 1-888-700-5243.

Spanish (Español)

IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-888-700-5243.

IV. FEES AND CHARGES – WHAT YOU PAY

A. PREMIUMS AND PREPAYMENT FEES

Premiums are due to Your QHP prior to the month of coverage. In turn, LA Care must provide Premiums to LIBERTY to establish and continue Your coverage.

Your Premium and payment terms, including mailing address for payments, are defined by Your Qualified Health Plan.

Premiums must be paid for the period in which services are received.

B. CHANGES TO BENEFITS AND PREMIUMS

LA Care or LIBERTY may change the covered Benefits, Co-payments, and Premium rates annually. LA Care or LIBERTY will not decrease the covered Benefits or increase the Premium rates during the term of the agreement without giving notice to Your QHP at least sixty (60) days before the proposed change.

C. OTHER CHARGES

You are responsible only for Premiums and listed Co-payments for Covered Services. You may be responsible for other Charges for non-covered or optional services as described in this Evidence of Coverage document. You should discuss any Charges for non-covered or optional services directly with Your Provider. In order to be certain which services on Your treatment plan are covered Benefits of Your plan and which services, if any, are non-covered or optional services (for which You may be responsible for paying out-of-pocket), You may wish to obtain a written disclosure of all services proposed or received, whether covered or not.

If You receive services that require Pre-Authorization without the necessary Authorization (other than emergent or Urgent Care services as medically necessary), You will be responsible for full payment of the Provider's usual fee to the Provider for any such services.

You may be responsible for additional fees for returned or dishonored checks, cancelled credit card payments, broken or missed appointment Charges or other administrative Charges such as finance Charges to any third-party payment organizations as agreed upon mutually by You and Your Provider as per business arrangements and disclosures made by LIBERTY or the treating Provider.

Your plan has a yearly Out-of-Pocket Maximum. The yearly Out-of-Pocket Maximum is the most money You have to pay for Your Covered Services in a year. Out-of-Pocket costs include co-pays, coinsurance, or deductibles for all covered medical and dental services. Any payments for dental services accrue toward Your Health Plan's medical Out-of-Pocket maximum for the applicable metal level plan selected. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket maximums. To verify Your Out-of-Pocket Maximum, You can visit LA Care's website at www.lacarecovered.org or call LA Care's Member Services **1-855-270-2327 (toll-free)**. After You have reached the yearly Out-of-Pocket Maximum, LIBERTY will pay the rest of the cost of dental services for that year, as long as the service You receive is a covered benefit performed by Your assigned contracted dental Provider or authorized dental Provider.

D. LIABILITY FOR PAYMENT

You are responsible for payment of Premiums and listed Co-payments for any Covered Services subject to the limitations and Exclusions of Your plan.

You are responsible for the treating dentist's usual fee in the following situations:

- For non-Covered Services
- If You have services from a non-contracted dentist or facility
- If a Pre-Authorization was required and You did not have the treatment pre-authorized
- Services received out of area that are later deemed to not qualify as emergency or Urgent Care services, such as (but not limited to) routine treatment beyond the stabilization of the emergency situation

Emergency services may be available out-of-network or without Pre-Authorization in some situations (see Emergency Dental Care section above).

IMPORTANT: Prior to providing You with non-Covered Services, Your Contracted Dentist should provide You a treatment plan that includes each anticipated service and the estimated cost. If You would like more information about dental coverage options, You may contact our Member Services Department at 1-888-700-5243.

In no event are You ever responsible for any sums owed to a contracted Provider by LIBERTY. In the event that LIBERTY fails to pay a Non-contracting Provider, You may be liable to the Non-contracting Provider for the cost of services You received.

E. PROVIDER REIMBURSEMENT

LIBERTY pays for Covered Services to contracted dentists via a variety of arrangements including Capitation, fee-for-service and supplemental surpayments in addition to Capitation. Reimbursement varies by geographic area, General Dentist, specialty dentist and procedure code. For more information on reimbursement, You may address a request in writing to LIBERTY at the address shown above.

V. ELIGIBILITY AND ENROLLMENT

A. WHO IS ENTITLED TO BENEFITS

Your LIBERTY Dental Plan is provided by Your QHP and coordinated through LIBERTY. If LIBERTY receives Your completed enrollment form payment by the 20th day of the month, You are eligible to receive care on the first day of the following month. You may call Your selected dentist at any time after the effective date of Your coverage. Be sure to identify Yourself as a Member of LIBERTY Dental Plan when You call the dentist for an appointment. We also suggest that You keep this Evidence of Coverage or the Schedule of Benefits with applicable Limitations and Exclusions with You when You go to your appointment. You can then reference Benefits and applicable Co-payments which are the out-of-pocket costs associated with Your plan, as well as any non-covered treatment.

B. WHO IS ELIGIBLE TO ENROLL

For Essential Pediatric Dental Benefit plans: You must live in the plan Service Area. Enrollment is available for:

- Dependent children (including adopted) up to the nineteenth (19) birthday
- New Dependent children placed for adoption and stepchildren up to the nineteenth (19) birthday, and newborns.

VI. COVERED SERVICES

You are covered for the dental services and procedures listed below when necessary for Your dental health in accordance with professionally recognized standards of practice, subject to the limitations and Exclusions described for each category and for all services. Please see the Schedule of Benefits for a detailed listing of specific covered dental procedures and the Co-payments applicable to each, and a list of the Exclusions and limitations that are applicable to all dental services covered under Your LIBERTY Dental Plan.

Your Schedule of Benefits is provided to You at the inception of this agreement, or may be included herein as Appendix 1, when required. You may also receive a copy of Your Schedule of Benefits from LIBERTY or Your QHP.

A. Diagnostic Dental Services

Diagnostic dental services are those that are used to diagnose Your dental condition and evaluate necessary dental treatment when deemed necessary for Your dental health in accordance with professionally recognized standards of practice.

You are covered for the Diagnostic dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

B. Preventive Dental Services
Preventive dental services are those that are used to maintain good dental condition or to prevent deterioration of dental condition when deemed necessary for Your dental health in accordance with professionally recognized standards of practice.

You are covered for the Preventive dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

C. Restorative Dental Services
Restorative dental services are those that are used to repair and restore the natural teeth to healthy condition when deemed necessary for Your dental health in accordance with professionally recognized standards of practice.

You are covered for the Restorative dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

D. Endodontic Services
Endodontic dental services are procedures that involve treatment of the pulp, root canal and roots, when deemed necessary for Your dental health in accordance with professionally recognized standards of practice.

You are covered for the types of Endodontic dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

E. Periodontic Services
Periodontic dental services are those procedures that involve the treatment of the gum and bone supporting the teeth and the management of gingivitis (gum inflammation) and periodontitis (gum disease), when deemed necessary for Your dental health in accordance with professionally recognized standards of practice.

You are covered for the Periodontic dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

F. Prosthodontic Services
Removable prosthodontics is the replacement of lost teeth by a removable prosthesis and the maintenance of those appliances. Fixed prosthodontics is the replacement of lost teeth by a fixed prosthesis.

You are covered for the Prosthodontic dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

G. Oral Surgery Services
Oral surgery services are procedures that involve the extraction of teeth and other surgical procedures as listed in the Schedule of Benefits.

You are covered for the Oral Surgery dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

H. Adjunctive Dental Services
Adjunctive Dental Services are ancillary services such as anesthesia during dental services, bleaching, mouthguards, etc. You are covered for the Adjunctive dental services listed in Your Schedule of Benefits, together with related limitations and Exclusions.

I. Orthodontic Services
Orthodontic services are procedures that involve straightening teeth and treating discrepancies in the bite relationship of the teeth and jaws. See Your Schedule of Benefits, for a list of any covered orthodontic services provided in Your Benefit Plan, and any pertinent relevant limitations and Exclusions.

J. Urgent and Emergency Services
See information provided above in this Evidence of Coverage document for a description of coverage for Emergency Dental Services, including out of area urgent services, and how to access them.

K. Services Provided by a Specialist
See information provided above in this Evidence of Coverage document for a description of coverage for services available performed by a Specialist, including a list of the types of dental Specialists covered and how to access Specialist services.

VII. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

See Your Schedule of Benefits for limitations to covered procedures and Exclusions to Your dental Benefit Plan.

A. GENERAL EXCLUSIONS

LIBERTY will not cover:

- Care You get from a doctor who is not in the LIBERTY network, unless You have pre-approval from LIBERTY, or You need Urgent Care or Emergency Care and are outside the LIBERTY Service Area.
- Care that is not medically necessary
- Procedures that are not listed or included in the Schedule of Benefits.
- Exams that You need only to get work, go to school, play a sport, or get a license or professional certification.
- Services that are ordered for You by a court, unless they are medically necessary and covered by LIBERTY.
- The cost of copying Your medical records. (This cost is usually a small fee per page)
- Expenses for travel, such as taxis and bus fare, to see a doctor or get health care.
- Other Exclusions as well as particular benefit Limitations are listed in Your Schedule of Benefits.
- IMPORTANT: If You opt to receive dental services that are not covered services under this plan, a participating dental provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call member services at 1-888-700-5243 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this evidence of coverage document.

B. MISSED APPOINTMENTS

LIBERTY strongly recommends that if You need to cancel or reschedule an appointment with Your Provider that You notify the Dental Office as far in advance as possible. This will allow the LIBERTY and the Provider to accommodate another person in need of attention. Providers may charge a fee for missed or broken appointments with less than the recommended notice.

VIII. TERMINATION, RESCISSION AND CANCELLATION OF COVERAGE

A. TERMINATION OF BENEFITS

1. Termination Due to Loss of Eligibility

Your LIBERTY Plan may be terminated by Your Qualified Health Plan (QHP) coverage. If this happens, You will receive notice through Your QHP at least 30 days before the change takes effect.

Your LIBERTY Plan coverage may also end if You no longer live or work in the LIBERTY Service Area or if LIBERTY no longer offers Your dental plan.

This is an EPDB plan, and therefore You will be terminated upon reaching the limiting age for coverage stated in this EOC document.

2. Termination Due to Non-Payment of Premium

If Your Qualified Health Plan (QHP) does not pay the Premium, LIBERTY will send a notice to Your QHP saying that the Premium is overdue.

If Premiums are not paid according to the agreement, termination will be effective on midnight 30 days after the last day of the month for which Premiums were last received, subject to compliance with notice requirements accepted by LIBERTY Dental Plan. This is equivalent to a minimum of a 30-day grace period. Termination by LIBERTY will comply with Health and Safety Code, Section 1365(a) as amended and any associated guidance or regulation in force at that time.

If Premiums are not paid according to the Covered California agreement, terms and conditions, and You are a Covered California Member that receives an Advanced Premium Tax Credit (APTC) that pays for part of Your dental Premium, You will be provided with a three month grace period that begins on the first day of the month following the last day of the month for which Premiums were last received.

You may reinstate Your coverage by paying the entire outstanding amount of Premium due by the last day of the third month of the grace period. Your coverage will be suspended during the second and third months of the three-month grace period and Providers will not be obligated to provide Covered Services to You while Your coverage is suspended. You may receive services during the second and third month of the grace period but You will be financially responsible for the cost of those services unless Your coverage is reinstated on or before the end of the third month of the grace period. If You fail to pay the entire outstanding amount of Premium due, Your coverage will be terminated as of the first day of the second month of Your grace period.

3. Completion of Treatment In Progress After Termination

If You terminate from the Plan while the contract between You and LIBERTY Dental Plan is in effect, Your Primary Care Provider or Specialist must complete any procedure in progress that was started before Your termination, abiding by the terms and conditions of the Plan.

If You terminate coverage from the Plan after the start of orthodontic treatment, You will be responsible for any Charges on any remaining orthodontic treatment.

4. Termination Due to Fraud

Existing in-force coverage may be terminated by LIBERTY if LIBERTY can demonstrate that a Subscriber has performed and act of practice constituting fraud or made an intentional misrepresentation of material fact. Fraudulent practices or acts include, but are not limited to, permitting any other person to use their Member ID card to obtain services under this dental plan, or otherwise engages in fraud or deception in the provision of incomplete or incorrect "material" information to LIBERTY or to the Provider that would affect enrollment information, for use of the services or facilities of the plan or knowingly permits such fraud or deception by another. In such cases, Subscriber will receive a letter via certified mail at least 30 days prior to the effective date of the termination explaining the reason for the intended termination, and the notice of appeal rights. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such notice from LIBERTY Dental Plan.

5. Termination Due to Health Status

LIBERTY does not terminate based on any health status. If You believe that Your coverage is has been terminated, improperly canceled rescinded or not renewed based on Your health status or requirements for health care services, You may request a review to be performed by the Director of the Department of Managed Health Care. If the Director determines that a proper complaint exists under the provisions of this section, the Director shall notify the plan. Within 15 days after receipt of such notice, the plan shall either request a hearing or reinstate the Enrollee or Subscriber. A reinstatement shall be retroactive to time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the Subscriber or Enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement. You can contact the Department of Managed Health Care at (1-888-HMO-2219) or on a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet web site is http://www.hmohelp.ca.gov.

B. EFFECTIVE DATE OF TERMINATION

Coverage may be terminated, cancelled or non-renewed following 30 days since the date of notification of termination, except for fraud and intentional misrepresentation of material fact, which is effective immediately upon notification.

C. DISENROLLMENT

You may disenroll from the plan by contacting Your Qualified Health Plan by phone or in writing. Disenrollment is effective as of the end of the last day of the period for which Premium was paid.

D. RESCISSION

Rescission means that LIBERTY may cancel Your coverage as if no coverage ever existed. Rescission may be elected by LIBERTY only in the event of fraud or intentional misrepresentation of material fact such as, but not limited to, if You intentionally submitted incomplete or incorrect material information in Your enrollment application. You have the right to appeal any decision to rescind Your membership. Appeal procedures will be provided to You in the notice of rescission. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such notice from LIBERTY Dental Plan. Except as provided by law, LIBERTY may not rescind Your coverage after 24 months from the issuance of the coverage contract.

IX. RENEWAL AND REINSTATEMENT OF COVERAGE

Please refer to Your LA Care EOC for information regarding Renewal and Reinstatement of Coverage.

X. GRIEVANCE PROCEDURES

If You are dissatisfied with Your selected Primary Care Provider, personnel, facilities, specialty referral, Pre-Authorization, claim, or the dental care You receive, You have the right to complain to the dental plan. A Complaint is the same as a Grievance. Grievance Forms may be requested by contacting LIBERTY Dental Plan's Member Services Department at 1-888-700-5243. Grievance Forms are also available on our website, www.LIBERTYdentalplan.com, or by calling LIBERTY Member Services or by asking Your Provider. Grievance Forms are not necessary. LIBERTY will investigate a Grievance submitted in any format. Your complaint or Grievances may be:

- Sent in writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110, or
- Sent by facsimile to: LIBERTY Dental Plan's Member Services Department facsimile at (949) 223-0011, or
- Submitted verbally to: LIBERTY Dental Plan Member Services Representative at LIBERTY's toll-free number: 1-888-700-5243, or
- Submitted using our website online Grievance filing process by visiting www.LIBERTYdentalplan.com.

You may use a "patient advocate" to help You file a Grievance. For Grievances involving minors or incapacitated or incompetent individuals, the parent, guardian, conservator, relative or other designee of the Member, as appropriate may submit the Grievance to LIBERTY, or to the DMHC for urgent matters (see "Urgent Grievances" below)

If You have limited English proficiency, visual or other communication impairment, LIBERTY will assist You in filing a Grievance. Assistance may include translation of Grievance procedures, forms and LIBERTY's responses, and may also include access to interpreters, telephone relay systems to aid disabled individuals to communicate.

You will not be discriminated against in any way by LIBERTY or Your Provider for filing a Grievance.

You may file a Grievance for at least 180 calendar days following any incident or action that is the subject of Your dissatisfaction.

LIBERTY Dental Plan's representatives will review the problem with You and take appropriate steps for a quick resolution. You will receive acknowledgement of Your Grievance within five (5) calendar days of receipt. Grievances will be resolved within 30 days.

Grievances Exempt from Written Acknowledgement and Response: In some cases Grievances that are received by telephone, facsimile, e-mail or through a website that are not coverage disputes, or are not involving Dental Necessity and are resolved by the next business day do not require a written acknowledgement or response. In these cases You will be contacted by the same method by which You submitted the Grievance or otherwise discussed with You at the time You reported Your complaint.

The following information is required by the State of California pertaining to Your dental plan.

A. STATE OF CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC) COMPLAINT PROCEDURE

The DMHC has established a toll-free number for You as a Member to utilize should You have a complaint against a health care service plan, or requests for review of cancellations, rescissions and non-renewals under Health and Safety Code section 1365(b) and related guidance and rules. This number is **888-HMO-2219**. As a Member You may file a complaint against LIBERTY Dental Plan; however, You may only do so after contacting Your Plan directly to utilize its complaint resolution process.

A Member may immediately file a complaint with the California DMHC in the event of a dental emergency situation. In addition a Member may also file a complaint in the event that the Plan does not satisfactorily resolve the complaint (Grievance) within thirty (30) days of filing with Your health care service plan.

California Required Statement: The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Your Health Plan, You should first telephone Your Health Plan at **1-888-700-5243** and use Your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your Health Plan, or a grievance that remained unresolved for more than 30 days, You may call the Department for assistance. You may also be eligible for Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has

a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Grievance Resolutions and Responses: For Grievances related to requested services that were denied, delayed or modified based in whole or in part on a finding that the proposed health care service is not a covered benefit, the response will indicated the exact document, page and provision applicable to the Grievance response.

For Grievances related to requested health care services that were denied, delayed or modified in whole or in part based on a determination that the service is not medically (dentally) necessary, the response will indicate the criteria, clinical guideline or policy used in reaching the determination.

Urgent Grievances: For cases involving an imminent and serious threat to Your health including, but not limited to, sever pain, potential loss of life, limb, or major bodily function, LIBERTY will expedite the processing of Your Grievance upon notification of this urgent condition. LIBERTY will resolve to the urgent condition within 3 calendar days of receipt of the Grievance, or sooner, based on the condition. In the case of urgent Grievances, You are not required to await the determination by LIBERTY before accessing the DMHC as noted above.

If You are not satisfied with the resolution initially provided, You may contact the DMHC as noted above. You may also submit additional materials for additional consideration to LIBERTY Dental Plan's Quality Management Department. Your requests must be in writing with a detailed summary and should be directed to:

LIBERTY Dental Plan, Inc.
Quality Management Department
P.O. Box 26110
Santa Ana, CA 92799-6110

Any additional information will be processed as a new Grievance.

B. MEDIATION

You may also request voluntary mediation with LIBERTY before exercising Your right to submit a Grievance to the DMHC. The use of mediation does not preclude Your right to submit a Grievance to the DMHC upon completion of mediation. In order to initiate mediation, You or Your agent must voluntarily agree to the mediation process. Expenses for mediation will be borne equally by You and LIBERTY.

C. INDEPENDENT MEDICAL REVIEW (IMR)

In cases which result in the denial of the Pre-Authorization request for Covered Services by a LIBERTY Dental Plan Provider, and are considered the practice of medicine or are provided pursuant to a contract between LIBERTY and a health plan (that covers hospital, medical or surgical Benefits) may be eligible for the DMHC Independent Medical Review (IMR) program. Subscribers may request a form for the independent medical review of their case by contacting LIBERTY Dental Plan at 1-888-700-5243 or writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. You may also request the forms from the Department of Managed Health Care. The Department of Managed Health Care may be reached at 1-888-HMO-2219 or by visiting their website at: **http://www.hmohelp.ca.gov.** Independent Medical Review is only available for certain medical services.

D. ARBITRATION

If You or one of Your eligible Dependents is not satisfied with the results of LIBERTY Dental Plan's complaint resolution process, and all the complaint resolution procedures have been exhausted, the matter can be submitted to arbitration for resolution. If You, or one of Your eligible Dependents, believe that some conduct arising from or relating to Your participation as a LIBERTY Dental Plan Member, including contract or medical liability, the matter shall be settled by arbitration. The arbitration will be conducted according to the American Arbitration Association rules and regulations in force at the time of the occurrence of the Grievance (dispute or controversy) and subject to Section 1295 of the California code of Civil Procedure.

XI. MISCELLANEOUS PROVISIONS

A. COORDINATION OF BENEFITS

As a covered Member, You will always receive Your LIBERTY Benefits. LIBERTY does not consider Your Individual Plan secondary to any other coverage You might have. You are entitled to receive Benefits as listed in this EOC document despite any other coverage You might have in addition. However, any Covered California coverage that You have that is embedded into a full service health plan will act as the primary payor when You have a supplemental pediatric dental benefit through a family benefit plan.

B. THIRD PARTY LIABILITY

If services otherwise covered by virtue of this Individual Plan are deemed to be necessary due to a work-related injury or which are the liability of another third party, You agree to cooperate in LIBERTY's processes to be reimbursed for these services.

C. OPPORTUNITY TO PARTICIPATE IN LIBERTY'S PUBLIC POLICY COMMITTEE

If You wish to participate in LIBERTY's Public Policy Committee, which reviews plan performance and assists in establishing LIBERTY's public policies, please contact Member Services Department at 1-888-700-5243, or contact Quality Management Department at qm@libertydentalplan.com

D. REPORTING POSSIBLE FRAUD

LIBERTY has established a specific fraud hotline number: (888) 704-9833. The Fraud Hotline provides the opportunity to report reasonable and good faith fraud suspicions or concerns in an anonymous/confidential manner. This hotline is monitored by a designated Member of the LIBERTY Corporate Compliance Committee. All information reported on the anonymous hotline is then forwarded to LIBERTY Dental Plan's Quality Management team for full investigation.

The Chairman of the Committee and the Chief Compliance Officer, in conjunction with Legal Counsel, determine whether LIBERTY shall take any additional action, which may include, without limitation:

- The provision of information, for purposes of education, to the participating Provider describing the incident involving suspected fraudulent activity;
- Seek restitution from the participating Provider for any amounts paid by LIBERTY in connection with the incident involving suspected fraudulent activity;
- Termination of the Provider agreement in effect between LIBERTY and the participating Provider; and/or
- Referral of the matter to an appropriate governmental agency, including, without limitation, the State Board of Dental Examiners and Centers for Medicare and Medicaid Services.

E. NON DISCRIMINATION

Discrimination is against the law. LIBERTY complies with all applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently based on race, color, national origin, age, disability, or sex. LIBERTY provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

- Qualified interpreters, including sign language interpreters
- Written information in other languages and formats, including large print, audio, accessible electronic formats, etc.

If you need these services, please contact us at 1-888-700-5243. If you believe LIBERTY has failed to provide these services or has discriminated based on race, color, national origin, age, disability, or sex, you can file a grievance with LIBERTY's Civil Rights Coordinator:

- **Phone: (888) 704-9833**
- **TTY: (800) 735-2929**
- **Fax: (888) 273-2718**
- **Email: compliance@libertydentalplan.com**
- **Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx**

If you need help filing a grievance, LIBERTY's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)
Online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

F. FILING CLAIMS

As stated throughout this document, You are not required to file claims directly with LIBERTY. Your general dental services are arranged with the participating Primary Care Provider who submits claims or encounters on Your behalf. Your specialty care services are reported to LIBERTY via the Specialist. If You receive services out-of-network due to an emergency after-hours or out-of-area situation, consult the section above for submitting Your expenses to LIBERTY to receive reimbursement (see Reimbursement for Emergency Dental Services section above).

G. ORGAN DONATION

LIBERTY is required by DMHC to inform You that organ donation options are available to You. Organ donation has many Benefits to society, and You may wish to consider this option in the event of any health situation that may lead to the option to do so. You may find more information about organ donation at http://donatelife.net

H. LANGUAGE ASSISTANCE

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. See statements below:

IMPORTANT: Can You read this document? If not, we can have somebody help You read it.
You may also be able to get this letter written in Your language. For free help, please call
right away at 1-888-700-5243.

Spanish (Español)

IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además,
es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita,
llame ahora mismo al 1-888-700-5243.

I. LIBERTY DENTAL PLAN MEMBER SERVICES DEPARTMENT

LIBERTY Dental Plan Member Services provides toll-free customer service support Monday through Friday 8:00 a.m. to 5:00 p.m. on normal business days to assist Members with simple inquiries and resolution of dissatisfactions. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the department. Our toll-free number is 1-888-700-5243.

J. MEMBER RIGHTS

As a Member, You have the right to:

- Be treated with respect, dignity and recognition of Your need for privacy and confidentiality
- Express Grievances and be informed of the Grievance process
- Have access and availability to care
- Access Your Dental Records
- Participate in decision-making regarding your course of treatment
- Be provided information regarding a Provider
- Be provided information regarding the organization's services, Benefits and specialty referral process.
- A grace period of one month during which Benefits will be provided without the receipt of paid Premium
- A grace period of three months to reinstate coverage for any lapse in payment of Premium if You are a Covered California Member that receives an APTC that pays for part of Your dental Premium

LIBERTY Dental Plan Policies and Procedures for preserving the confidentiality of medical records are available and will be furnished to You upon request.

K. MEMBER RESPONSIBILITIES

As a Member, You have the responsibility to:

- Identify Yourself to Your selected Dental Office as a LIBERTY Dental Plan Member
- Treat the Primary Care Provider, office staff and LIBERTY Dental Plan staff with respect and courtesy
- Keep scheduled appointments or contact the Dental Office twenty-four (24) hours in advance to cancel an appointment
- Cooperate with the Primary Care Provider in following a prescribed course of treatment
- Make Co-payments at the time of service
- Notify LIBERTY Dental Plan of changes in family status
- Be aware of and follow the organization's guidelines in seeking dental care

L. FISCAL SEPARATION OF DECISION MAKING

It is LIBERTY's policy that all clinical review decisions made by staff and or contractors are based solely on appropriateness of care and services and the existence of coverage. LIBERTY does not reward or incentivize reviewers for issuing denials for coverage or care, nor provide incentives that would encourage decisions that result in underutilization. LIBERTY's Utilization Management staff annually signs an attestation that review decisions were made based solely on appropriateness of care and services and existence of coverage.

LIBERTY Dental Plan of California, Inc.

P.O. Box 26110

Santa Ana, CA 92799-6110

1-888-700-5243

Appendix 1:
SCHEDULE OF BENEFITS

Schedule of Benefits are provided as a separate document with your dental ID Card.

Appendix 2:

PREMIUM, PRE-PAYMENT FEES AND CHARGES

Premiums and Fees are established by the Qualified Health Plan

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