L.A. Care HEALTH PLAN

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

Coverage Period: 2017 – 2018
Plan Type: HMO

Summary of Benefits and Coverage: What This Plan Covers and What It Costs | **Coverage for Group**

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** or by calling **1.844.854.7272**.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the chart (starting on page 2) for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart (starting on page 2) for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, $1,000 co-payment per individual.	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 services this Plan does not 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 (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 participating providers, see lacare.org**	If you use a contracted 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, contracted, preferred, or participating for providers in their network. See the chart (starting on page 2) for how this plan pays different 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. To access behavioral health providers (mental health or substance use disorder), you do not need a referral from your PCP.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call **1.844.854.7272** or visit us at **lacare.org**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **cciio.cms.gov** or call **1.800.750.4776** to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $5) 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.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) In some cases, a non-plan provider may provide covered services at an in-network facility where you have been authorized to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-network facilities where we have authorized you to receive care.
- This plan requires you to use in-network **providers** unless authorized by the plan.

Common Medical Event	Services You May Need	Your Cost If You Use In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 co-pay/visit	Not covered	---none---
	Specialist visit	$2	Not covered	Referral from primary care physician required. Member will pay for services if not referred.
	Other practitioner office visit	Not covered	Not covered	---none---
	Preventive care/screening/immunization	$5	Not covered	---none---
If you have a test	Diagnostic test (X-rays, blood work)	0	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	0	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations and Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.lacare.org**	Generic drugs on Formulary	$5 per prescription	Not covered	Covers up to 30-day supply. 90-day supply for maintenance drugs. Exclusions apply, see your policy or plan document for additional information about **excluded services**.
	Brand named drugs on Formulary	$5	Not covered	Covers up to 30-day supply. Exclusions apply, see your policy or plan document for additional information about **excluded services**.
	Non-Formulary drugs	$5	Not covered	Covered if authorized. Exclusions apply, see your policy or plan document for additional information about **excluded services**.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	Not covered	Exclusions apply, see your policy or plan document for additional information about **excluded services**.
	Physician/surgeon fees	$0	Not covered	Exclusions apply, see your policy or plan document for additional information about **excluded services**.

Common Medical Event	Services You May Need	Your Cost If You Use In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations and Exceptions
If you need immediate medical attention	Emergency room services	$35	Not covered	Waived if admitted to hospital.
	Emergency medical transportation	$0	Not covered	Excludes coverage for transportation by airplane, passenger car, taxi or other form of public transportation.
	Urgent care	$5 per visit	Not covered	---none---
If you need help recovering or have other special health needs	Home health care	$0	Not covered	Custodial care not included
	Rehabilitation services	$5	Not covered	Includes outpatient physical, occupational, speech, and respiratory therapy.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	$0	Not covered	Benefit is limited to a maximum of 100 days per benefit year.
	Durable medical equipment	$0	Not covered	Equipment for home used as *medically necessary*.
	Hospice service	$0	Not covered	Limited to individuals who are diagnosed with a terminal illness with a life expectancy of 12 months or less.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental checkup	Not covered	Not covered	Not covered

Excluded Services and 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.)

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

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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.)

Your Rights to Continue Coverages:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at **1.888.839.9909**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1.866.444.3272** or **dol.gov/ebsa** or the U.S. department of Health and Human Services at **1.877.267.2323 x61565** or **cciio.cms.gov**

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 call, write, or visit the plan or go to the plan's website:

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

844.854.7272
TDD/TTY Service: **711**
lacare.org

Additionally, a consumer assistance program can help you file your appeal. Contact:

California Department of Managed Health Care
California Help Center
9 980th St, Suite 500#
Sacramento, CA 95814

888.466.2219
healthhelp.ca.gov
helpline@dmhc.ca.gov

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 **1.800.750.4776**. 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 interprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un interprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al **1.800.750.4776**. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al **1.888.466.2219**. (Spanish)

هام: يمكنك الحصول على خدمات مترجم مجانا للتحدث إلى طبيبك أو الخطة الصحية. للحصول على مترجم أو للسؤال عن معلومات مكتوبة باللغة العربية. أولا اتصل برقم الهاتف 1-800-750-4776 الخاص بالخطة الصحية وسيساعدك شخص يتحدث باللغة العربية وإذا كنت بحاجة إلى مزيد من المساعدة فاتصل بمركز المساعدة HMO على الرقم **1-888-466-2219** (Arabic)

مهم: میتوانید خدمات مترجم شفاهی را برای صحبت کردن با پزشک یا برنامه درمانی خود بطور رایگان دریافت کنید. برای دریافت مترجم شفاهی یا درخواست درمورد اطلاعات کتبی به فارسی، ابتدا با برنامه درمانی خود به شماره تلفن **1-800-750-4776** تماس بگیرید. شخصی که به فارسی تکلم میکند میتواند به شما کمک کند. اگر به کمک بیشتری نیاز دارید، با مرکز کمک HMO به شماره **1-888-466-2219** تماس بگیرید. (Farsi)

BANCHO: Вы можете бесплатно воспользоваться услугами переводчика во время обращения к врачу или в страховой план. Чтобы запросить переводчика или спросить о наличии печатных материалов на русском языке, позвоните в свой страховой план по телефону **1.800.750.4776**. Вам окажет помощь русскоговорящий сотрудник. Если вам нужна помощь в других вопросах, позвоните в справочный центр Организации медицинского обеспечения (HMO) по телефону **1.888.466.2219**. (Russian)

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 **1.800.750.4776**. 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**. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể nhận được dịch vụ thông dịch miễn phí khi khám tại bác sĩ hoặc khi liên hệ với chương trình bảo hiểm sức khỏe của quý vị. Để nhận được dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt, trước tiên hãy gọi số điện thoại chương trình bảo hiểm sức khỏe của quý vị theo số **1.800.750.4776**. Sẽ có người nói được tiếng Việt để giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, hãy gọi Trung tâm Hỗ trợ HMO theo số **1.888.466.2219**. (Vietnamese)

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** $7,540
- **Patient pays** $0

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 care	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,400
- **Patient pays** $0

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 care	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

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 pre-existing 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**. If the patient had received care from out-of-network **providers**, costs would have been higher.

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.