L.A. Care HEALTH PLAN®

L.A. Care Covered *Direct*™

A Helpful Guide to Your Health Care Benefits

2025

January 1, 2025 - December 31, 2025

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **1-855-270-2327** or visit us at **lacare.org**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **healthcare.gov/sbc-glossary** or call **1-855-270-2327** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$9,200 individual / $18,400 family.** Per calendar year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	**Yes.** Family, physician, and specialist office visits, preventive care, and other services not subject to deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$9,200 individual / $18,400 family.**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limits
Will you pay less if you use a network provider?	**Yes**. See lacare.lacare.org or call 1-855-270-2327 (TTY 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a participating provider in the plan's network. You will pay the most if you use an non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**Yes**.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	Subject to deductible after 1st 3 non-preventive visits *
	Specialist visit	0% coinsurance	Not covered	Subject to deductible Referral required. *
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Subject to deductible *
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	Prior Authorization is Required Subject to deductible *
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.lacare.org/members/getting-care/pharmacy-services	Tier 1 - Most Generics	0% coinsurance	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy Subject to deductible *
	Tier 2 -Preferred brand drugs	0% coinsurance	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy Subject to deductible *
	Tier 3 - Non-preferred brand drugs	0% coinsurance	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy Prior Authorization required. Subject to deductible *

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 - Specialty drugs	0% coinsurance	Not covered	Prior Authorization is required. Not available through Mail Service. Subject to deductible *
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible *
	Physician / surgeon fees	0% coinsurance	Not covered	Subject to deductible *
	Outpatient visit	0% coinsurance	Not covered	Subject to deductible *
If you need immediate medical attention	Emergency room care	0% coinsurance Physician fee – no charge	0% coinsurance Physician fee – no charge	Subject to deductible *
	Emergency medical transportation	0% coinsurance	0% coinsurance	Subject to deductible *
	Urgent care	0% coinsurance	Not covered	Subject to deductible * after 1st 3 non-preventive visits *
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible *
	Physician/surgeon fees	0% coinsurance	Not covered	Subject to deductible *
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not covered	Deductible does not apply to Outpatient office visit. For Outpatient Other Services the deductible applies after the 1st 3 non-preventive visits. Prior Authorization is Required for Psychological Testing. *
	Inpatient services	0% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible *
If you are pregnant	Office visits	No charge	Not covered	For prenatal care and preconception visits
	Childbirth/delivery professional services	0% coinsurance	Not covered	Subject to deductible *
	Childbirth/delivery facility services	0% coinsurance	Not covered	Subject to deductible *
If you need help recovering or have	Home health care	0% coinsurance	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs				providers. Prior Authorization is Required. Subject to deductible *
	Rehabilitation services	0% coinsurance	Not covered	Outpatient services Prior Authorization is Required. Subject to deductible *
	Habilitation services	0% coinsurance	Not covered	Outpatient services Prior Authorization is Required. * Subject to deductible *
	Skilled nursing care	0% coinsurance	Not covered	Up to a maximum of 100 days per Calendar Year per Member. Prior Authorization is Required. Subject to deductible *
	Durable medical equipment	0% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible *
	Hospice services	0% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible *
If your child needs dental or eye care	Children's Eye exam	No charge	Not covered	1 visit per calendar year
	Children's Glasses	0% coinsurance	Not covered	1 pair of glasses per year (or contact lenses in lieu of glasses). Subject to deductible
	Children's Dental check-up	No Charge	Not covered	Oral exam and preventive cleaning limited to 1 every 6 months. See your plan document for additional information about services.

Excluded Services & Other Covered Services:

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

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

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery	• Medical necessary routine foot care	• Services related to Abortion

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care at **1 (888) HMO-2219 (1-888-466-2219)** or hmohelp.ca.gov; U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or www.cciio.cms.gov; Covered California at **1 (800) 300-1506** or coveredca.com; or contact L.A. Care Health Plan at **1- 855-270-2327**. We are available 24 hours a day, 7 days a week, including holidays. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about contact your rights, this notice, or assistance, contact L.A. Care Customer Service at **1- 855-270-2327**. We are available 24 hours a day, 7 days a week, including holidays. Additionally, you can contact the California DMHC at **1-888-466-2219** or visit **dmhc.ca.gov.**

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1- 855-270-2327**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1- 855-270-2327**

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **1- 855-270-2327**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1- 855-270-2327**

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

About these Coverage Examples:

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

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

The plan's overall deductible	$9,200
Specialist *[cost sharing]*	0%
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$9,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$9,260**

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

The plan's overall deductible	$9,200
Specialist *[cost sharing]*	0%
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,220**

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

The plan's overall deductible	$9,200
Specialist *[cost sharing]*	0%
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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

Language Assistance

English Tagline
ATTENTION: If you need help in your language call **1-855-270-2327** (TTY: **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-855-270-2327** (TTY: **711**). These services are free of charge.

الشعار بالعربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1-855-270-2327** (TTY: **711**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1-855-270-2327** (TTY: **711**). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-855-270-2327** (TTY: **711**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-855-270-2327** (TTY: **711**): Այդ ծառայություններն անվճար են:

ប្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1-855-270-2327** (TTY: **711**)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1-855-270-2327** (TTY: **711**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **1-855-270-2327** (TTY: **711**)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1-855-270-2327** (TTY: **711**)。这些服务都是免费的。

فارسی زبان به مطلب (Farsi)
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-855-270-2327** (TTY: **711**) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-855-270-2327** (TTY: **711**) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-855-270-2327** (TTY: **711**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-855-270-2327** (TTY: **711**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-855-270-2327** (TTY: **711**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-855-270-2327** (TTY: **711**). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は **1-855-270-2327** (TTY: **711**) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。**1-855-270-2327** (TTY: **711**) へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-855-270-2327** (TTY: **711**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-855-270-2327** (TTY: **711**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1-855-270-2327** (TTY: **711**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1-855-270-2327** (TTY: **711**). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-855-270-2327** (TTY: **711**). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-855-270-2327** (TTY: **711**). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-855-270-2327** (TTY: **711**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-855-270-2327** (TTY: **711**). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-855-270-2327** (TTY: **711**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-855-270-2327** (TTY: **711**). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-855-270-2327** (TTY: **711**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-855-270-2327** (TTY: **711**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-855-270-2327** (TTY: **711**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-855-270-2327** (TTY: **711**). Các dịch vụ này đều miễn phí.

L.A. Care Covered Direct

Summary of Benefits[43]

Individual and Family Plan
HMO Plan

Minimum Coverage HMO

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 (EOC) carefully for a complete description of provisions, benefits, exclusions, prior authorization and other important information pertaining to this benefit plan.

Medical Provider Network:	**L.A. Care Network**
Vision Network:	**VSP**
Behavioral Health Network:	**Carelon**
Pediatric Dental Network:	**Liberty Dental**
Pharmacy Network:	**Navitus**
Drug Formulary:	**Standard Formulary**

Calendar Year Deductibles [2.11]

A Calendar Year Deductible is the amount a Member pays each Calendar Year before L.A. Care pays for Covered Services under the Plan.

		When using a Participating Provider[3,11]
Calendar Year Deductible	*Individual coverage*	$9,200
	Family coverage	$9,200: individual $18,400: F

Calendar Year Out-of-Pocket Maximum[4,14]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

When using a Participating Provider[3,11]	
Individual coverage	$9,200
Family coverage	$9,200: individual $18,400: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount L.A. Care will pay for Covered Services.

LA5995 11/24

Benefits[5]	Your Payment[15] When using a Participating Provider[3,11]	Deductible[2] applies
Preventive Health Services[6]		
Preventive Health Services	0%	No
Routine Physical Exam	0%	
Well Child Preventative Exam (up to age 23 months)	0%	
Physician services[22]		
Primary care office visit (1st 3 non-preventive care visits available at $0, then subject to deductible)	0% After Deductible	Yes
Specialist care office visit[36]	0% After Deductible	
Physician or surgeon services in an Outpatient Facility	0% After Deductible	
Physician or surgeon services in an Inpatient Facility	0% After Deductible	
Other professional services		
Other practitioner office visit[35]	0% After Deductible	Yes
Includes nurse practitioners, physician assistants, and therapists. (1st 3 non-preventive care visits available at $0, then subject to deductible)		
Acupuncture services (1st 3 non-preventive care visits available at $0, then subject to deductible)	0% After Deductible	
Family planning	0% After Deductible	
Allergy Testing and Treatment	0%	
Allergy serum purchased separately for treatment	0% After Deductible	
Office visits (includes visits for allergy serum injections)	0% After Deductible	
Podiatric services (1st 3 non-preventive care visits available at $0, then subject to deductible)	0% After Deductible	
Pregnancy and maternity care		
Physician office visits: prenatal and initial postnatal: including prenatal diagnosis of genetic disorders in cases of high-risk pregnancy	0%	Yes
Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	0% After Deductible	
Routine newborn circumcision[7]	0% After Deductible	
Termination of pregnancy-related services	0%	
Emergency Services		
Emergency room services *(copay waived if admitted)*	0% After Deductible	Yes
Emergency room Physician services	0%	
Urgent care center services (1st 3 non-preventive care visits available at $0, then subject to deductible)	0% After Deductible	Yes
Ambulance services[16] *This payment is for emergency or authorized non-emergency transport.*	0% After Deductible	Yes

	When using a Participating Provider[3,11]	Deductible[2] applies
Outpatient facility services		
Ambulatory Surgery Center	0% After Deductible	
Outpatient Department of a Hospital: surgery	0% After Deductible	Yes
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies[21]	0% After Deductible	
Inpatient facility services[19,20]		
Hospital services and stay (Including gender affirming care, bariatric surgery, Temporomandibular Joint Disorder (TMJ), and reconstructive surgery)	0% After Deductible	Yes
Diagnostic x-ray, imaging, pathology, and laboratory services		
• Outpatient Laboratory and Pathology	0% After Deductible	
• *Diagnostic Laboratory services are covered per service or per test when provided to diagnose illness and injury*		
• Outpatient diagnostic X-ray and imaging	0% After Deductible	
• *Including mammography and ultrasounds performed in Outpatient Radiology Center or Outpatient Hospital*		Yes
• Medical Imaging Services	0% After Deductible	
• *Including CT, PET scans, MRIs, and Nuclear Medicine Imaging performed in the Outpatient department of a Hospital or free-standing outpatient center. Prior authorization is required.*		
Rehabilitative and habilitative services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location (1st 3 non-preventive care visits available at $0, then subject to deductible)	0% After Deductible	Yes
Outpatient Department of a Hospital	0% After Deductible	
Rehabilitation unit of a Hospital for Medically Necessary days	0% After Deductible	
In an Inpatient facility, this Co-payment is billed as part of Inpatient Hospital Services		
Durable medical equipment (DME)		
DME *(Includes but not limited to Prosthetics, Orthotics, insulin pumps, etc.)*	0% After Deductible	Yes
Breast pump	0%	

	When using a Participating Provider[3,11]	Deductible[2] applies

Home health care services
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 and associated medical supplies)
  • 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.)
  • Medical supplies associated with infusion/injectable therapy
  • Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit and standard member copayments apply
	0% After Deductible	Yes

Skilled Nursing Facility (SNF) services[19] *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 start counting toward the maximum when the services are first provided even if the Calendar Year Medical Deductible has not been met.*	0% After Deductible	Yes
Hospice program services[18] *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* *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, Palliative care, and inpatient respite care.*	0% After Deductible	Yes
Other services and supplies Diabetes care services • Devices, equipment, and supplies • Self-management training[17] • Medical nutrition therapy[17]	0% After Deductible 0% 0%	Yes

Mental Health and Substance Use Disorder Benefits	Your Payment[15]	
Mental health and substance use disorder Benefits are provided through Carelon.	**When using a Carelon Participating Provider[3,11]**	**Deductible[2] applies**
Outpatient services		
Office visit, including Physician office visit (1st 3 non-preventive care visits available at 0%, then subject to deductible)	0% After Deductible	Yes
Other outpatient services[44], including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment[26] for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	0% After Deductible	Yes
Partial Hospitalization Program[25]	0% After Deductible	
Psychological Testing	0%	No
Inpatient services		
Physician inpatient services	0% After Deductible	Yes
Hospital services	0% After Deductible	
Residential care[24]	0% After Deductible	

Prescription Drug Benefits[7,8,27,28,29,30,31,32,33]	Your Payment[15]	
	When using a Participating Pharmacy[3,11]	**Deductible[2] applies**
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply. Note: If the retail price for a covered prescription drug, supply, or supplement is less than the co-payment, you will pay the lesser amount. The amount you pay will be applied to your out-of-pocket maximum limit.		
Contraceptive Drugs and devices[34]	0%	
Tier 1 Drugs (Most Generics)	0% After Deductible	
Tier 2 Drugs (Preferred Brand)	0% After Deductible	
Tier 3 Drugs (Non-preferred Brand)	0% After Deductible	Yes
Tier 4 Drugs (Specialty Drugs—Prior Authorization is required)	0% After Deductible	
Tier four shall consist of drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply.		
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices[34]	0%	
Tier 1 Drugs (Most Generics)	0% After Deductible	Yes
Tier 2 Drugs (Preferred Brand)	0% After Deductible	
Tier 3 Drugs (Non-Preferred Brand)	0% After Deductible	

Pediatric Benefits	Your Payment[15]	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3,11]**	**Deductible[2] applies**
Pediatric dental[9,39,40]		
Diagnostic and preventive services		
• Oral exam	0%	
• Preventive – cleaning	0%	
• Preventive – x-ray	0%	
• Sealants per tooth	0%	
• Topical fluoride application	0%	
• Space maintainers - fixed	0%	
Basic services		
• Restorative procedures	0% After Deductible	Yes
• Periodontal maintenance		
• Adjunctive general services		
Major services		
• Oral surgery		
• Endodontics		
• Periodontics (other than maintenance)	0% After Deductible	
• Crowns and casts		
• Prosthodontics		
Orthodontics (Medically Necessary)[41]	0% After Deductible	
Pediatric vision[10,38]		
Comprehensive eye examination *One exam per Calendar Year.*		
• Ophthalmologic visit	0%	
• Optometric visit	0% After Deductible	
Prescription Glasses *Includes frames and lenses (one pair per year)*	0% After Deductible	Yes
Contact Lenses *Including medically necessary contact lenses for the treatment of keratoconus pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism)*	0% After Deductible	

Definitions

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (Deductible):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before L.A. Care pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a "Yes" in the Benefits chart above.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, L.A. Care will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowed Charges, and charges for services above any Benefit maximum.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year. Any amount you have paid toward the individual OOPM will be applied to both the individual OOPM and the Family OOPM.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

7 Routine newborn circumcision

Routine newborn circumcision performed in the office, ASC or outpatient hospital Facility copayment applies when services are performed in an outpatient surgical facility.

8 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to L.A. Care for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

Request for Medical Necessity Review. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Oral Anticancer Drugs. You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

9 Pediatric Dental Coverage:

Pediatric dental Benefits are provided through L.A. Care's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Medically Necessary orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

This plan is compliant with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

10 Pediatric Vision Coverage:

Pediatric vision Benefits are provided through L.A. Care's Vision Plan Administrator (VPA).

Coverage for frames. If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider's charge.

"Collection frames" are covered with no Member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as "collection," but a comparable selection of frames is maintained.

"Non-collection frames" are covered up to an Allowable Amount of $150; however, if the Participating Provider uses:

- wholesale pricing, then the Allowable Amount will be up to $99.06.
- warehouse pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

Plans may be modified to ensure compliance with State and Federal requirements.

End Notes

11 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.

12 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.

13 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.

14 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.

15 Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.

16 Coverage for transportation by airplane, passenger car, taxi or other form of public transportation is not covered.

17 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.

18 The cost sharing for hospice services applies regardless of the place of service.

19 In the Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

20 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. For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.

21 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.

22 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.

23 Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).

24 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.

25 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.

26 Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.

27 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.

28 Drug tiers are defined as follows:

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

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

29 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.

30 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.

31 Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script up to 30 days per state law (Health and Safety Code §1367.656 Insurance Code §10123.206).

32 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 to pay their applicable copay for the Brand Name drug equivalent.

33 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.

34 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 to pay their applicable copay for the Brand Name contraceptive drug equivalent. In addition, select contraceptives may require prior authorization to be covered without a co-payment or Coinsurance.

35 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, Podiatrists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

36 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. 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.

37 This includes pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints.

38 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 glasses 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.

39 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.

40 A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2025 Dental Copay Schedule.

41 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.

42 For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.

43 Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Design.

44 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.

45 The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2025 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.

46 Where indicated, the deductible is waived for the first three non-preventive visits, which may include primary care visits, other practitioner office visits, specialist visits, urgent care visits or outpatient Mental Health/Substance Use Disorder visits.

47 These Endnotes do not limit an issuer's obligation to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirement of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.

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 and equity of care, safety and services for our members. These programs support you in staying healthy. They also help L.A. Care make sure our members are getting the care that they need.
- **Care Management Programs** for members who have difficult medical problems
- **Programs to better manage diseases**, like diabetes and/or asthma

How Decisions Are Made About Your Care

- How our doctors and staff make decisions about your care based only on need and benefits. We do not encourage doctors to provide less care than you need and doctors are not paid to deny care.
- How to reach us if you want to know more about how decisions are made about your care
- How to appeal a decision about your care, including external independent review
- 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**.

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

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**) if you are deaf or hard of hearing, 24 hours a day, 7 days a week and holidays.

L.A. Care Covered *Direct*™ Member Handbook

Subscriber Agreement & Combined Evidence of Coverage and Disclosure Form

L.A. Care Covered™ Direct

Table of Contents

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, this *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, 2025 (or your membership effective date, if later), through December 31, 2025 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, 2025. 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 member) 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 Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing).**

Note: This *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 *Direct*™ benefit plans and services. Our information is listed below:

L.A. Care Health Plan
1200 W. 7th Street,
Los Angeles, CA 90017
1.855.270.2327 (TTY 711)

By enrolling in and accepting health services under L.A. Care Covered *Direct*™, Members 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
- Another health plan
- Your doctor or providers of health care services
- Your application for 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

Confidentiality of Medical Information

In accordance with California law, L.A. Care protects the confidentiality of individual members' medical information. L.A. Care maintains medical information to provide access to individuals or healthcare providers for managing information or for diagnosis and treatment is considered a healthcare provider under this part. This designation applies only to this part and not to any other laws. Medical information includes reproductive or sexual health application information pursuant to Civil Code §§ 56.05 and 56.06.

The steps we take for this include:

- We do not require a protected individual* to obtain the primary subscriber or other member's authorization to receive sensitive services.**
- We will direct communications*** regarding a protected individual's receipt of sensitive services:
  - Directly to the protected individual's designated alternate mailing address, email address, or telephone number, or,

- In the absence of a designated alternate address or phone number, we will direct the communications to the telephone number on file in the name of the protected individual.

- We will not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any other plan member without expressed authorization of the protected individual.
- We will not disclose medical information relating to a child receiving gender affirming health care or mental health care in response to a civil action against a person or entity based on another state's law that authorizes an individual to bring a civil action against a person or entity that allows a child to receive gender-affirming health care or gender-affirming mental health care.
- We will not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care. Civil Code Section 56.109.

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

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

***Communications include:

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

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

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

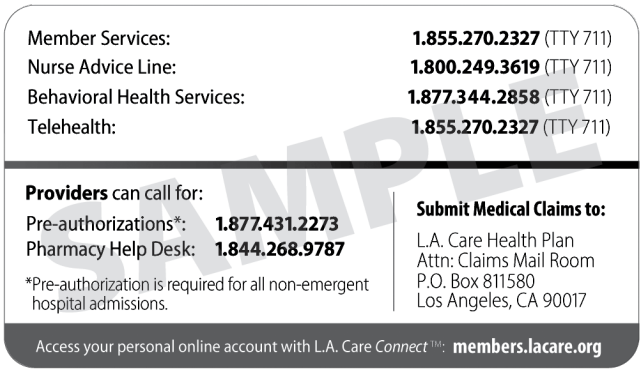
The request must include the member's information and the alternate contact information. Any request will be implemented within 7 days of receipt of a telephone request or 14 days of receipt of a first class mail request. The accommodation will remain in effect until the individual revokes the request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

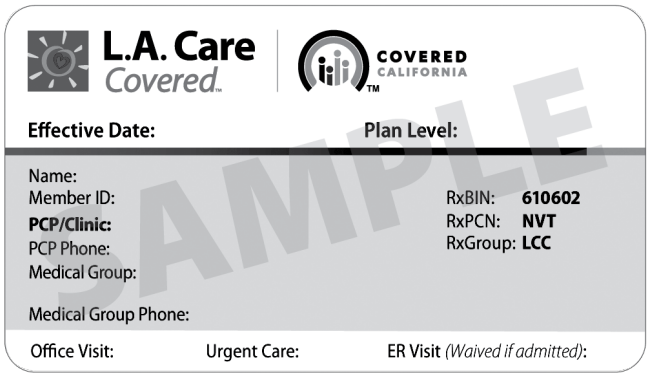
A STATEMENT DESCRIBING L.A. CARE HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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) if you are deaf or hard of hearing.

Member 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. Your member ID card contains information healthcare professionals need to make sure your care is covered. Not providing your member ID card when you seek care may result in inaccurate billing.





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

To better understand the information on your member 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, accessibility, and other provider characteristics. You can also request a provider directory by calling L.A. Care Member Services at **1.855.270.2327** (TTY 711 if you are deaf or hard of hearing). 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 female sterilization 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 Member Services at **1.855.270.2327** (TTY 711 if you are deaf or hard of hearing), to ensure that you can obtain the health care services that you need.

L.A. Care
Covered℠ Direct

Language Assistance 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. L.A. Care does not give your information to unauthorized users.

Written information in your language and format

English: Free language assistance services are available. You can request interpreting or translation services, information in your language or in another format, or auxiliary aids and services. Call L.A. Care at **1.855.270.2327** (TTY 711 if you are deaf or hard of hearing), 24 hours a day, 7 days a week, including holidays. The call is free.

Spanish: Los servicios de asistencia de idiomas están disponibles de forma gratuita. Puede solicitar servicios de traducción e interpretación, información en su idioma o en otro formato, o servicios o dispositivos auxiliares. Llame a L.A. Care al **1.855.270.2327** (TTY **711**), las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.

Chinese:提供免費語言協助服務 。 您可申請口譯或翻譯服務,您使用之語言版本或其他 格式的資訊, 或輔助援助和服務。請致電 L.A. Care 電話 **1.855.270.2327** (TTY **711**) , 服務時間為每週 7 天, 每天 24 小時(包含假日)。上述電話均為免費。

Vietnamese: Có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Quý vị có thể yêu cầu dịch vụ biên dịch hoặc phiên dịch, thông tin bằng ngôn ngữ của quý vị hoặc bằng các định dạng khác, hay các dịch vụ và thiết bị hỗ trợ ngôn ngữ. Xin vui lòng gọi L.A. Care tại **1.855.270.2327** (TTY **711**), 24 giờ một ngày, 7 ngày một tuần, kể cả ngày lễ. Cuộc gọi này miễn phí.

Tagalog: Available ang mga libreng serbisyo ng tulong sa wika. Maaari kang humiling ng mga serbisyo ng pag-interpret o pagsasaling-wika, impormasyon na nasa iyong wika o nasa ibang format, o mga karagdagang tulong at serbisyo. Tawagan ang L.A. Care sa **1.855.270.2327** (TTY **711**), 24 na oras sa isang araw, 7 araw sa isang linggo, kabilang ang mga holiday. Libre ang tawag.

Korean: 무료 언어 지원 서비스를 이용하실 수 있습니다. 귀하는 통역 또는 번역 서비스, 귀하가 사용하는 언어 또는 기타 다른 형식으로 된 정보 또는 보조 지원 및 서비스 등을 요청하실 수 있습니다. 공휴일을 포함해 주 7일, 하루 24시간 동안 L.A. Care, **1.855.270.2327** (TTY **711**)번으로 문의하십시오. 이 전화는 무료로 이용하실 수 있습니다.

:Arabic

خدمات المساعدة اللغوية متاحة مجانًا. يمكنك طلب خدمات الترجمة الفورية أو الترجمة التحريرية أو معلومات بلغتك أو بتنسيق آخر أو مساعدات وخدمات إضافية. اتصل بـL.A. Care على الرقم **1.855.270.2327** (TTY **711**) على مدار الساعة وطوال أيام الأسبوع، بما في ذلك أيام العطلات. المكالمة مجانية.

Panjabi: ਪੰਜਾਬੀ: ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ।ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ, ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਜਾਂ ਕਸਿੇ ਹੋਰ ਫੋਰਮੈਟ ਵਿੱਚ, ਜਾਂ ਸਹਾਇਕ ਉਪਕਰਣਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। L.A. Care ਨੂੰ **1.855.270.2327** (TTY **711**) ਨੰਬਰ ਉੱਤੇ ਕਾਲ ਕਰੋ, ਇੱਕ ਦਨਿ ਵਿੱਚ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੱਚ 7 ਦਨਿ, ਛੁੱਟੀਆਂ ਸਮੇਤ। ਕਾਲ ਮੁਫ਼ਤ ਹੈ।

Khmer: សេវាជំនួយខាងភាសា គឺមានដោយឥតគិតថ្លៃ។ អ្នកអាចស្នើសុំសេវាបកប្រែផ្ទាល់មាត់ ឬការបកប្រែ ស្នើសុំព័ត៌មាន ជាភាសាខ្មែរ ឬជាទំរង់មួយទៀត ឬជំនួយជ្រោមជ្រែង និងសេវា។ ទូរស័ព្ទទៅ L.A. Care តាមលេខ **1.855.270.2327** (TTY **711**) បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផងៗ។ ការហៅនេះគឺឥតគិតថ្លៃឡើយ។

Armenian: Տրամադրելի են լեզվական օգնության անվճար ծառայություններ: Կարող եք խնդրել բանավոր թարգմանչական կամ թարգմանչական ծառայություններ, Ձեր լեզվով կամ տարբեր ձևաչափով տեղեկություն, կամ օժանդակ օգնություններ և ծառայություններ: Զանգահարեք L.A. Care **1.855.270.2327** համարով (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոնական օրերը: Այս հեռախոսազանգն անվճար է:

Hmong: Muaj kev pab txhais lus pub dawb rau koj. Koj tuaj yeem thov kom muab cov ntaub ntawv txhais ua lus lossis txhais ua ntawv rau koj lossis muab txhais ua lwm yam lossis muab khoom pab thiab lwm yam kev pab cuam. Hu rau L.A. Care ntawm tus xov tooj **1.855.270.2327** (TTY **711**), tuaj yeem

Farsi:
خدمات رایگان امداد زبانی موجود می باشد. می توانید برای خدمات ترجمه شفاهی یا کتبی، اطلاعات به زبان خودتان یا فرمت دیگر، یا امدادها و خدمات اضافی درخواست کنید. با L.A. Care به شماره **1.855.270.2327** (TTY **711**) در 24 ساعت شبانروز و 7 روز هفته شامل روزهای تعطیل تماس بگیرید. این تماس رایگان است.

Russian: Мы предоставляем бесплатные услуги перевода. У Вас есть возможность подать запрос о предоставлении устных и письменных услуг перевода, информации на Вашем языке или в другом формате, а также вспомогательных средств и услуг. Звоните в L.A. Care по телефону **1.855.270.2327** (TTY **711**) 24 часа в сутки, 7 дней в неделю, включая праздничные дни. Этот звонок является бесплатным.

Hindi: मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। आप दुभाषिया या अनुवाद सेवाओं, आपकी भाषा या किसी अन्य प्रारूप में जानकारी, या सहायक उपकरणों और सेवाओं के लिए अनुरोध कर सकते हैं। आप L.A. Care को **1.855.270.2327** (TTY **711**) नंबर पर फ़ोन करें, दिन में 24 घंटे, सप्ताह में 7 दिन, छुट्टियों सहित। कॉल मुफ्त है।

Thai: มีบริการช่วยเหลือภาษาฟรี คุณสามารถขอรับบริการการแปลหรือล่าม ข้อมูลในภาษาของคุณหรือในรูปแบบอื่น หรือความช่วยเหลือและบริการเสริมต่าง ๆ ได้ โทร L.A. Care ที่ **1.855.270.2327** (TTY **711**) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์รวมทั้งวันหยุด โทรฟรี

Lao: ພາສາອັງກິດ ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍຮັບບໍລິການນາຍພາສາ ຫຼື ແປພາສາ ໄດ້, ສໍາລັບຂໍ້ມູນໃນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນ, ຫຼື ເຄື່ອງມືຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມ. ໃຫ້ໂທຫາ L.A. Care ໄດ້ ທີ່ **1.855.270.2327** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ, ລວມເຖິງວັນພັກຕ່າງໆ. ການໂທແມ່ນບໍ່ເສຍຄ່າ.

Japanese: 言語支援サービスを無料でご利用いただけます。通訳・翻訳サービス、日本語や他の形式での情報、補助具・サービスをリクエストすることができます。L.A. Careまでフリーダイヤル**1.855.270.2327** (TTY **711**) にてご連絡ください。祝休日を含め毎日24時間、年中無休で受け付けています。

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 Member Services at **1.855.270.2327** (TTY 711 if you are deaf or hard of hearing) 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 Member Services at **1.855.270.2327** (TTY **711** if you are deaf or hard of hearing) at least ten business days before your appointment with the following information:

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

If the appointment with your doctor is changed or canceled, call L.A. Care Member Services at **1.855.270.2327** (TTY **711** if you are deaf or hard of hearing) 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 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 are deaf or hard of hearing) if you cannot get the services you need or if services you need are difficult to get.

Complaints
You have the right to 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 or format
- Your cultural needs are not met

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

Service Area

The Service Area for L.A. Care Covered *Direct*™ 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 *Direct*™ will terminate.

If you travel outside of Los Angeles County
As a member of L.A. Care Covered *Direct*™, 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) including when traveling outside of California or the United States. 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 you are 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 to 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 *Direct*™ at the phone number located on your ID Card. If L.A. Care Covered *Direct*™ is not able to resolve your problem, contact the DMHC Help Center at **www.HealthHelp.ca.gov** or **1.888.466.2219**.

Appointment Wait Times

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

Urgent Appointments	**Wait Time**
For services that do not require prior approval	48 hours
For services that do require prior approval	96 hours
Routine Appointments	**Wait Time**
Primary care appointment	10 business days
Specialist appointment, including specialist physician for Mental Health and Substance Use Disorder services (MH/SUD).	15 business days
Appointment with a mental health or substance use disorder care provider (who is not a physician)	10 business days*
Appointment for other services to diagnose or treat a health condition	15 business days

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

Mental Health and Substance Use Disorder Services

If you are unable to attend the appointment offered by the L.A. Care, we will continue to arrange and schedule a new appointment to ensure the delivery of medically necessary MH/SUD services.

If an appointment or admission to a provider is not available within 90 calendar days of initially submitting a request, the member may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 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 L.A. Care Member Services at **1.855.270.2327** (TTY **711** if you are deaf or hard of hearing) 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 at lacare.org on the Internet

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. If you receive emergency care outside of the United States, you have a right to be reimbursed for the cost of emergency services at the maximum allowable amount.

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 checkups 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 a Member/Enrollee and an Enrolled Dependent?

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

Why point out the difference? Because Members/Enrollees often have special responsibilities, including sharing benefit updates with any Enrolled Dependent(s). Members/Enrollees also have special responsibilities that are noted throughout this publication. If you're a Member/Enrollee henceforth refer to member (Dependents henceforth referred to as enrolled dependents), 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 staff 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 their hours or you may check our online Provider Directory, which is available on **lacare.org**.

If you need medical advice during clinic/doctor office hours, you may call your PCP and speak to them 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. You can also seek urgent care through MinuteClinic™ retails clinics located in select CVS pharmacies in L.A. County and through Teladoc™ telehealth services (For more information refer to page 20 "Retail Clinics" and "Telehealth Services").

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 *Direct*™ may select a different PCP. Upon enrollment, you should contact L.A. Care Member Services at **1.855.270.2327** (TTY 711 if you are deaf or hard of hearing) 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 Member Services at **1.855.270.2327** (TTY 711 if you are deaf or hard of hearing) 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, the change may not be effective until the first day of the following month.
- 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 if you are deaf or hard of hearing).** 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 *Direct*™, 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 *Direct*™ 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 L.A. Care Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing).**

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 an L.A. Care Covered *Direct*™ 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 Member 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 prior authorization:

- Emergency services (go to "*Emergency Care Services*" section for more information)
- Preventive health services (including immunizations)

- Obstetrician and gynecological services in-network
- Sexual and reproductive health care services in network

If the services that you need are not available from a provider within the L.A. Care provider network, you may be referred to a provider outside of the L.A. Care Provider Network. All services from an approved referral to an out of network provider will be covered at the same cost sharing as they would be if they were provided by an in-network provider. Such referrals will be made in a timely manner, consistent with the standards defined above.

All health care services are reviewed, approved, or denied according to medical necessity. Call L.A. Care Member Services 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 if you are deaf or hard of hearing).**

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. Behavioral health services include treatment for pre and post-partum maternal mental health. You or your PCP can call Carelon Behavioral Health, L.A. Care's Behavioral Health vendor at **1.877.344.2858/1.800.735.2929** TTY/TDD (if you are deaf or hard of hearing) to get an appointment. Someone is available to help you connect to services 24 hours a day, 7 days a week, including holidays.

The benefits covered include but are not limited to intermediate services, including the full range of levels of care (as specified by California Code of Regulations Title 28 1300.74.72.01), including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment. L.A. Care will not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment. These benefits are as follows:

L.A. Care will provide coverage of health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary for the member, in accordance with current generally accepted standards of mental health and substance use disorder care, including but not limited to, the following:

(1) Basic health care services, including the following:

(A) Emergency health care services as defined by Health and Safety Code section 1317.1 rendered both inside and outside the service area of the applicable network consistent with the Knox-Keene Act.

(B) Urgent care services rendered inside and outside the service area of the applicable network consistent with the Knox-Keene Act.

(C) Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility.

(D) Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals.

(E) Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy.

(F) Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.

(G) Home health care service.

(H) Preventive health care services, regardless of whether a member has been diagnosed with a mental health condition or substance use disorder.

(I) Hospice care that is, at a minimum, equivalent to hospice care provided by the federal Medicare Program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.), (December 2022), and implementing regulations adopted for hospice care under Title XVIII of the Social Security Act in Part 418 of Chapter IV of Title 42 of the Code of Federal Regulations (December 2022), except Subparts A, B, G, and H.

(2) Behavioral health treatment for pervasive developmental disorder or autism spectrum disorder pursuant to Health and Safety Code section 1374.73.

(3) Coordinated specialty care for the treatment of first episode psychosis.

(4) Day treatment.

(5) Drug testing, both presumptive and definitive, including for initial and ongoing patient assessment during substance use disorder treatment.

(6) Electroconvulsive therapy.

(7) For gender dysphoria, all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health.

(8) Inpatient services, including but not limited to all the following:

(A) American Society of Addiction Medication (ASAM) inpatient levels of care (3rd edition) for substance use disorder rehabilitation and withdrawal management, or as described in the most recent version of the ASAM Criteria.

(i) 3.7, medically monitored intensive (adults) or high-intensity (adolescents) inpatient services.

(ii) 4, medically managed intensive inpatient services.

(B) High intensity acute medically managed residential programs Level of Care Utilization System and Child and Adolescent Level of Care/Service Intensity Utilization System (LOCUS and CALOCUS-CASII level 6A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(C) Medically managed extended care residential programs (LOCUS and CALOCUS-CASII level 6B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(9) Intensive community-based treatment, including assertive community treatment and intensive case management.

(10) Intensive home-based treatment.

(11) Intensive outpatient treatment.

(12) Medication management.

(13) Narcotic (opioid) treatment programs.

(14) Outpatient prescription drugs, if coverage for outpatient prescription drugs is provided. Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment.

(15) Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling.

(16) Partial hospitalization.

(17) Polysomnography.

(18) Psychiatric health facility services, including structured outpatient services as described in Health and Safety Code section 1250.2.

(19) Psychological and neuropsychological testing.

(20) Reconstructive surgery pursuant to Health and Safety Code section 1374.72. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

(21) Residential treatment facility services, including all the following:

(A) Intensive short-term residential services (LOCUS and CALOCUS-CASII level 5A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(B) Moderate intensity intermediate stay residential treatment programs (LOCUS and CALOCUS-CASII level 5B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(C) Moderate intensity long-term residential treatment programs (LOCUS and CALOCUS-CASII level 5C (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(D)ASAM residential levels of care (3rd edition), or as described in the most recent version of The ASAM Criteria:

(i) 3.1, clinically managed low intensity residential services.

(ii) 3.3, clinically managed population-specific high intensity residential services.

(iii) 3.5, clinically managed high intensity (adults) or medium intensity (adolescents) residential services.

(22) School site services for a mental health condition or substance use disorder that are delivered to the member at a school site pursuant to Health and Safety Code section 1374.722.

(23) Transcranial magnetic stimulation.

(24) Withdrawal management services, including all the following ASAM levels (3rd edition), or as described in the most recent version of The ASAM Criteria:

(A) 1-WM, ambulatory withdrawal management without extended on-site monitoring.

(B) 2-WM, ambulatory withdrawal management with extended on-site monitoring.

(C) 3.2-WM, clinically managed residential withdrawal management.

(D) 3.7-WM, medically monitored inpatient withdrawal management.

(E) 4-WM, medically managed intensive inpatient withdrawal management.

Home health care services.

L.A. Care will cover home health care services if all the following conditions are satisfied:

- The member is confined to the home except for infrequent or relatively short duration absences, or when absences are attributable to the need to receive medical treatment, due to a mental health condition or substance use disorder.
- Skilled nursing care on an intermittent basis, physical therapy, occupational therapy, or speech-language pathology services are medically necessary for the evaluation or treatment of a member's mental health condition or substance use disorder or its symptoms. These services (refer to above) shall be reasonable and necessary to improve the member's current condition, maintain the member's current condition, or prevent or slow further deterioration of the member's condition.
- The member's physician, physician assistant, nurse practitioner, or clinical nurse specialist attests that the coverage conditions outlined above are met, and establishes, and periodically reviews no less frequently than once every 60 days, a plan of care that includes the services specified below and defines the frequency and duration of visits.

L.A. Care will cover all the following home health care services as specified in the plan of care prepared by the member's physician, physician assistant, nurse practitioner, or clinical nurse specialist:

- Part-time skilled nursing care, including by a registered nurse, licensed practical nurse under the supervision of a registered nurse, or psychiatrically trained nurse.
- Part-time home health aide services for personal care.
- Physical therapy.
- Speech-language pathology.
- Occupational therapy.
- Medical social services.
- Medical supplies provided by a home health agency while the member is under a home health plan of care.
- Durable medical equipment while a member is under a home health plan of care to the extent the member's health plan contract includes coverage for durable medical equipment.

L.A. Care will cover both part-time skilled nursing services and part-time home health aide services furnished any number of days per week, provided that the skilled nursing services and home health aide services, combined, are furnished less than eight hours per day and 35 hours per week.

L.A. Care will cover preventive health care services, including the following:

(1) Screening, brief intervention and referral to treatment, primary care-based interventions, and specialty services for persons with hazardous, at-risk, or harmful substance use who do not meet the diagnostic criteria for a substance use disorder, or persons for whom there is not yet sufficient information to document a substance use or addictive disorder, as described in ASAM level of care 0.5 (3rd edition), or the most recent version of The ASAM Criteria.

(2) Basic services for prevention and health maintenance, including: screening for mental health and developmental disorders and adverse childhood experiences; multidisciplinary assessments; expert evaluations; referrals; consultations and counseling by mental health clinicians; emergency evaluation, brief intervention and disposition; crisis intervention and stabilization; community outreach prevention and intervention programs; mental health first aid for victims of trauma or disaster; and health maintenance and violence prevention education, as described in LOCUS and CALOCUS-CASII level of care zero (version 2020), or the most recent versions of LOCUS and CALOCUS-CASII.

(3) Preventive health care services for a mental health condition or substance use disorder that are required under Health and Safety Code section 1367.002.

L.A. Care will cover the following for a mental health condition or substance use disorder:

(1) A health care benefit that is medically necessary according to the requirements noted on pages 30 - 35, and California Code of Regulations Section 1300.74.72, and 1300.74.721, and is furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law.

(2) Emergency health care services that are furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law, including by or at a licensed or certified health care provider or facility owned or operated by, employed by, or contracted with, a political subdivision to provide emergency health care services or behavioral health crisis services, regardless of whether the health plan is contracted with the health care provider, facility, or political subdivision to furnish emergency health care services or behavioral health crisis services to its members.

Behavioral Health services that do not require a prior authorization:

- Initial Behavioral Health Assessment
- Preventive Health Care Services, regardless of whether a member has been diagnosed with a mental health condition or substance use disorder.
- Medically necessary treatment of Mental Health or Substance Use Disorder provided by a 988 center, mobile crisis team or other provider of behavioral health crisis services
- Emergency Room Services
- Individual Therapy
- Group Therapy
- Diagnostic Evaluation
- Outpatient Medication Management
- Narcotic (opioid) treatment
- Outpatient Mental Health and Substance Use Services
- Crisis Intervention
- Services, other than prescription drugs, received under the Community Assistance, Recovery, and Empowerment (CARE) court agreement or CARE plan.
- Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility.

Behavioral Health services that may require prior authorization include, but are not limited to:

- Crisis Residential Services
- Inpatient Mental Health and Services
- Inpatient Substance Use Disorder Services
- Inpatient services, including but not limited to all the following:
  - American Society of Addiction Medication (ASAM) inpatient levels of care (3rd edition) for substance use disorder rehabilitation and withdrawal management, or as described in the most recent version of the ASAM Criteria:
    - 3.7, medically monitored intensive (adults) or high-intensity (adolescents) inpatient services.
    - 4, medically managed intensive inpatient services. Clinically managed low intensity residential services
  - High intensity acute medically managed residential programs Level of Care Utilization System and Child and Adolescent Level of Care/Service Intensity Utilization System (LOCUS and CALOCUS-CASII level 6A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).
  - Medically managed extended care residential programs (LOCUS and CALOCUS-CASII level 6B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).
- Inpatient non-Medical Transitional Residential Recovery Services for Mental Health and Substance Use
- Intensive community -based treatment, including assertive community treatment and intensive case management.
- 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
- Withdrawal management services, including all the following ASAM levels (3rd edition), or as described in the most recent version of The ASAM Criteria:
  - 1-WM, ambulatory withdrawal management without extended on-site monitoring.
  - 2-WM, ambulatory withdrawal management with extended on-site monitoring.
  - 3.2-WM, clinically managed residential withdrawal management.
  - 3.7-WM, medically monitored inpatient withdrawal management.
  - 4-WM, medically managed intensive inpatient withdrawal management.
- Applied Behavior Analysis (ABA) Services
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)
- Residential treatment facility services, including all the following:
  - Intensive short-term residential services (LOCUS and CALOCUS-CASII level 5A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).
  - Moderate intensity intermediate stay residential treatment programs (LOCUS and CALOCUS-CASII level 5B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).
  - Moderate intensity long-term residential treatment programs (LOCUS and CALOCUS-CASII level 5C (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).
  - ASAM residential levels of care (3rd edition), or as described in the most recent version of The ASAM Criteria:
    - 3.1, clinically managed low intensity residential services.
    - 3.3, clinically managed population-specific high intensity residential services.
    - 3.5, clinically managed high intensity (adults) or medium intensity (adolescents) residential services.

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

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

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

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

Before L.A. Care can transition the member to an in-network provider, L.A. Care shall provide the member, the member's representative (if any), and the provider(s) treating the member with at least 90 calendar days' notice. The notice shall inform the member of the name and contact information of the in-network provider to which the plan intends to transition the member and information about how the member may file a complaint with the plan if the member, the member's representative, or member's provider believes transitioning the member to an in-network provider will harm the member or is not within the standard of care. If the member or the member's representative expresses dissatisfaction to the transition to an in-network provider, L.A. Care will treat that objection as a grievance pursuant to Health and Safety Code section 1368.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call L.A. Care at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at **1.888.466.2219; or 3**) contact the California Department of Managed Health Care through its website at **www.healthhelp.ca.gov** to request assistance in obtaining MH/SUD services.

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 they think you should see a specialist.

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 their 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 them 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. Please refer to the section *Grievance and Appeals* 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

L.A. Care network 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.

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 is one examples of such specialty medications, which are identified in the Formulary with a special code SP – (Specialty Pharmacy Availability), MSP (Mandatory Specialty Pharmacy), LMSP (Mandatory Lumicera 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**
- **Resources: L.A. Care Covered *Direct*™ Formulary**

You may also call Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing).** Some medications require special handling and require that they be processed and mailed to you by an L.A. Care contracted specialty pharmacy.

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 fora long-term health condition, such as high blood pressure or diabetes. For more information on how to set up a mail-order account or to order refill(s) for an unexpired prescription, call Member Services at **1.855.270.2327** (TTY 711 if you are deaf or hard of hearing) or visiting L.A. Care's website, **lacare.org**. Click on each of the following:

- **For Members**
- **Pharmacy Services**
- **Mail Order Pharmacy Form**

If the medication(s) has (have) no refill(s) remaining, you will need to obtain a new prescription from your doctor or other prescriber. Mail order is an optional and free service if you choose to use it.

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 each of the following:

- **For Members**
- **Pharmacy Services**
- **L.A. Care Covered *Direct*™ Formulary**

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

If there is a generic equivalent to a brand name drug, L.A. Care will ensure that the member is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. See CCR Section 1372.73(a)(7).

For details regarding prescription drug cost sharing or prior authorization requirements you can access real time information via L.A. Care's online formulary available through our member portal, L.A. Care Connect. You can also call L.A. Care Member Services at **1.855.270.2327 (**if you are deaf or hard of hearing) 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.

Log onto your member account at **members.lacare.org** to check if you are eligible for a prescription drug and for information on your prescription drug, such as:

- Drug formulary status and if there are restrictions or special rules
- Co-pay information
- Pharmacy information

You can find the most current formulary on the **www.lacare.org** website.

The L.A. Care Formulary includes:

- Approved prescription drugs
- Diabetic supplies: Insulin, insulin syringes, glucose test strips, lancets, continuous glucose monitors and associated supplies.
- 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 if you are deaf or hard of hearing)**.

- 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.
- The State of California passed the Pharmacy Law AB 1048, Arambula. Health care: pain management and Schedule II drug prescriptions. Beginning July 1, 2018, the law authorizes a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescriber. The law would require the pharmacy to retain the original prescription, with a notation of how much of the prescription has been filled, the date and amount of each partial fill, and the initials of the pharmacist dispensing each partial fill until the prescription has been fully dispensed. The bill would authorize a pharmacist to charge a professional dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription.

When filling a prescription you may obtain a partial fill. You may only be charged one full co-payment for the completed prescription. If you have been charged twice (once for the partial fill and again for the complete fill) contact L.A. Care Member Services at **1.855.270.2327 (if you are deaf or hard of hearing)** to receive information regarding obtaining reimbursement for the excess co-payment.

- You may be required to provide copies of pharmacy receipts showing payment of multiple co-payments for the prescription.

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 section *Grievance and Appeals* 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, or is inconsistent with good professional practice for the provision of medically necessary covered services then an exception to the step therapy rule can be requested.

- **Exceptions to Coverage:** Requests to make an exception to a quantity limits or step therapy rule or for coverage of a non-formulary drug, can be submitted to L.A. Care Health Plan by your doctor or other prescriber in the form of a prior authorization with justification and clinical documentation supporting the provider's determination. A decision for approval or denial of the exception request can be made within 24 hours if the request is urgent or within 72 hours if the request is not urgent. If you are not satisfied with the exception-to-coverage decision, you have the right to appeal the decision with L.A. Care Health Plan or file a grievance with 3 different reviewers:
  1. L.A. Care,
  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.

L.A. Care will not prohibit or supersede a step therapy exception request as described in California Code of Regulations Section 1367.206(b).

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. Common conditions that may fall under urgent care are:

- Cold/flu
- Vomiting/Diarrhea
- Rashes
- Urinary Tract Infections
- Earache/headache
- Back pain
- Sprains/Strains
- Skin/eye infections
- Wheezing or cough
- Abdominal pain

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.

Retail Clinics
L.A. Care has partnered with MinuteClinic™ to provide alternative access to urgent care through their retail clinic locations. MinuteClinic™ has locations

in select CVS pharmacies around L.A. County. MinuteClinic™ locations are staffed by nurse practitioners and/or physician assistants. To find a retail clinic near you:

- Visit **https://www.lacare.org/health-plans/ la-care-covered/find-provider**
- Visit **www.cvs.com/minuteclinic** and enter your ZIP code

Telehealth Services
L.A. Care has partnered with Teladoc™ Health, Inc. to provide telehealth services for our members as another alternative for urgent care. Teladoc™ delivers care wherever you are by phone or video conferencing. If you use Teladoc™ services, you have the right to access your resulting medical records, and those records will be shared with your primary care provider, unless you object.To access care through Teladoc™:

- Visit **www.teladoc.com** – click "Log in/Register"
- Call Teladoc™ at **1.800.835.2362**
- Contact L.A. Care Member Services at **1.855.270.2327 (if you are deaf or hard of hearing)**

Your cost for accessing telehealth services will not exceed what your cost would be if you received the same services in person from a doctor, nurse practitioner, or physician assistant. This applies regardless of if you receive telehealth services through Teladoc™ or through independent or private telehealth services offered through your participating provider group or primary care provider. If you use Teladoc™ services, you have the right to access your resulting medical records, and those records will be shared with your primary care provider, unless you object.

Emergency services
Emergency services are covered 24-hours a day, 7 days a week, anywhere in the world. 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. If you are outside of the United States you will have to pay out of pocket for the emergency services you have received. L.A. Care will reimburse you the maximum allowable amount.

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 if you are deaf or hard of hearing).

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

Continuity of Care by a Terminated Provider Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the L.A. Care *Covered*™ or L.A. Care Covered *Direct*™ provider network. Contact L.A. Care Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)** to receive information regarding eligibility criteria and assistance with requesting continuity of care from a terminated provider. You may be required to make a copayment, have a deductible or other cost-sharing fees during the period of completion of care with a provider who is no longer contracted with L.A. Care *Covered*™ or L.A. Care Covered *Direct*™.

Continuity of Care for New Members by Non-Contracting Providers

Newly covered Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment or if prior coverage was terminated by a plan under certain circumstances or if any prior coverage was withdrawn from the market can request completion of care in certain situations with a non-contracting provider who was providing services to the Member at the time the Member's L.A. Care Covered *Direct*™ coverage became effective. Contact L.A. Care Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)** to receive information regarding eligibility criteria and assistance with requesting continuity of care from a non-contracting provider. You may be required to make a copayment, have a deductible or other cost-sharing fees during the period of completion of care with a provider who is not contracted with L.A. Care Covered *Direct*™.

Continuity of Care when being treated for Maternal Mental Health Conditions

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

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

L.A. Care Covered Direct

Grievance & Appeals

L.A. Care Grievance and Appeals

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, please let us know. Many issues or concerns can be promptly resolved by our Member Services Department. If you have not already done so, you may want to first contact L.A. Care Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)**. However, you may file a grievance with L.A. Care at any time and do not have to contact L.A. Care Member Services before filing a grievance with L.A. Care.

What is a grievance?

A grievance is an expression of dissatisfaction, or a complaint by 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 **www.lacare.org/members/ member-support/file-grievance**.
- 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 (such as large print or audio).

  L.A. Care Health Plan
  Member Services Department
  1200 W. 7th Street,
  Los Angeles, CA 90017
  1.855.270.2327
  TTY: **711**
  www.lacare.org/members/member-support/file-grievance/grievance-appeal-form
- 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 **1.888.466.2219**.

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
- You have filed a grievance with L.A Care and the health care is still denied, changed, delayed or the grievance remains unresolved after 30 days.

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 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 (1.855.250.2327) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 1.888.466.2219and a TDD line (1.877.688.9891) for the hearing and speech impaired. The department's Internet Web site http://www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

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

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

L.A. Care Covered™ Direct

Eligibility & Enrollment

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

- Live or reside in Los Angeles County

Open Enrollment Period

Per California law, the open enrollment period for our L.A. Care Covered *Direct*™ Members begins November 1st each year and continues through January 31st of the following year. For enrollments received from November 1st through December 15th coverage will begin on January 1st. For enrollments received from December 16th through January 31st, coverage will begin on February 1st. During the open enrollment period, our existing Members may add eligible dependents, report demographic changes, change carriers, or change Benefit Plans by updating their application, or contacting the L.A. Care Covered *Direct*™ Enrollment Support Services at **1.855.222.4239 (TTY 711 if you are deaf or hard of hearing)**. 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 their 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 L.A. Care Covered *Direct*™ 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 during the open enrollment period or 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, in accordance as applicable through Federal law (Title 45 Code of Federal Regulations Section § 155.420(c)(2) and State law (10 California Code of Regulations Section 6504), rules and regulations.

These qualifying life events are:

- Lost my health insurance including Medi-Cal
- Permanently moved to/within California
- Had a baby
- Adopted a child
- Got married
- Lost status as a dependent
- Entered into domestic partnership
- Returned from active duty military service
- Released from incarceration

- Gained citizenship/lawful presence
- Domestic abuse or spousal abandonment
- Other qualifying life events, as defined by law.

Please contact our L.A. Care Covered *Direct*™ Enrollment Support Services at **1.855.222.4239 (TTY 711 if you are deaf or hard of hearing)** 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 *Direct*™, individuals may visit the L.A. Care website at lacare.org and download an electronic application, or contact L.A. Care, to request an application or they can apply over the phone with an enrollment specialist.

Starting Date of Coverage

L.A. Care will review and process your complete application upon receipt. Please wait for your monthly invoice to make your initial premium payment. 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 Health Plan 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. You will need to complete an L.A. Care Covered *Direct*™ application to add new dependents to your existing coverage. All dependents must meet eligibility criteria and must be approved by L.A. Care. Please contact our Member Services Department at 1.855.270.2327 **(TTY 711 if you are deaf or hard of hearing)** if you need additional information.

L.A. Care Covered™ Direct

Payment Responsibilities

What are Premiums (Prepayment Fees)?

Premiums are monthly fees a member pays to cover the basic costs of the health care package for themselves and any Enrolled Dependent(s). You must pay the health plan premiums directly to L.A. Care when due.

Monthly Premiums

Your monthly premium is based on the following factors: 1) the benefit plan you selected (Platinum, Gold, etc.) and; 2) your age and where you reside. Once you are enrolled in L.A. Care Covered *Direct*™, you will receive a monthly premium bill in the mail. Please visit **lacare.org** to learn more about how to make your premium payments. You have 60 days from your effective date to submit your first payment. 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 *Subscriber Agreement & Member Handbook.*

L.A. Care offers a variety of options and methods by which you may pay your monthly premium:

Pay Online
Register or log onto your member account at **members.lacare.org.** You can either make a one-time payment, or set up recurring payments. Auto-Pay payments will be automatically deducted from your account on the day premiums become due, or the day before the coverage month begins.

Pay by Mail
Send a personal check, business check, money order, or cashier's check payable to L.A. Care Health Plan.

Please mail your payment to:

L.A. Care Health Plan
L.A. Care Covered *Direct*™
PO Box 512547
Los Angeles, CA 90051-9865

Pay by Phone (Self-Service)
If you would like to make a phone payment using our self-service option, please call 1-855-270-2327, listen to the greeting, and select option 3.

Have your L.A. Care Member Id Number located on the back of your ID card, or the Account Number located on your invoice available.

Pay by Phone is available 24 hours a day, 7 days a week including holidays.

L.A. Care will not increase your premium during the calendar year unless change plans and/or report a demographic change which may affect your eligibility and premium amount. Important: If your address changes, please reach out to our Member Services Department at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)**.

Proof of Coverage

Show your member ID card to the doctor, pharmacy, hospital, or other health care provider when you seek care. Your member ID card contains information healthcare professionals need to make sure your care is covered. Not providing your member ID card when you seek care may result in inaccurate billing.

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. You must always be prepared to pay the co-payment during a visit to your 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:

- Childhood Immunizations at your physician's office.
- Adult Immunizations at your physician's office or at an L.A. Care Network pharmacy.
- Well-child visits

Please see the Preventive Care Services 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 if you are deaf or hard of hearing)**.

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, during your diagnostic exam your provider confirms an exception 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.
- If 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 (OOPM)

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 *Direct*™ 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 including amounts for charges applied towards your deductible 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.

Tracking Your Deductible and Out-of-Pocket Maximum

L.A. Care will keep track of charges that are counted toward your deductible and out of pocket maximum (OOPM). We will provide you with the balance for each for every month in which you have used benefits until the annual balance equals the full deductible amount or the full OOPM. You may also request your accrual balances for

the deductible and OOPM from L.A. Care at any time. L.A. Care will mail you these updates unless you have opted out of mailed notices. To request accrual balance information at any time or opt out of the mailed updates, please contact L.A. Care Member Services at **1.855.270.2327 or access your L.A. Care Connect member portal account at lacare.org. You can opt back into paper notifications at any time.** You may also access your Explanation of Benefits (EOB) and threshold certificate via the member portal. L.A. Care will make every effort to ensure accurate and timely information, but there may be delays in reporting of visits and payments from your provider which may impact the net accrual information. Please request and save all receipts for payments you make to your health care providers for covered services for your records.

Termination of Benefits
You will be disenrolled from L.A. Care Covered *Direct*™ for the following reasons:

- The member fails to pay premiums upon due date
- The member moves out of Los Angeles County
- The member requests transfer to another QHP
- The death of the member

Request to Terminate Upon Written Notice

L.A. Care may terminate your coverage 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 member. Under no circumstances will a memberbe terminated due to health status or the need for health care services. Any member who believes their enrollment has been terminated due to the member'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 if you are deaf or hard of hearing).**

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 member pursuant to this section, it shall be dated, sent to the last-known address of the member and state:

a. The cause of termination or non-renewal with specific reference to the section of this *Subscriber Agreement & Member Handbook* giving rise to the right of termination or non-renewal;

b. That the cause for termination or non-renewal was not the member's health status or requirements for health care services;

c. The effective date and time of termination or non-renewal; and

d. That notwithstanding the Member Appeals (Grievance) procedure set forth in this *Subscriber Agreement & Member Handbook*, if you believe that their Health Plan membership has been terminated because of their

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 a membere is terminated by L.A. Care, notice to the member is sufficient if sent to members' last known address.*

Termination by L.A. Care for Nonpayment of Premiums

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 L.A. Care Covered *Direct*™ Confirmation of Disenrollment 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.

Reinstatement of Coverage

If you are terminated for non-payment, you may call L.A. Care at 1-855-270-2327 (TTY: 711) to request reinstatement of your cancelled policy, provided that such request is made within one month from the end of the grace period. Otherwise, you will not be eligible to re-enroll for health insurance coverage until the next open enrollment period, unless you have a defined life event that allows you to enroll under a Special Enrollment Period.

Disenrollment and Cancellation

If you would like to be disenrolled from L.A. Care Covered *Direct* ™, please contact L.A. Care Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing).** L.A. Care Health Plan will calculate any overpayments and refund you, but to facilitate the reimbursement process, please contact Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)** to request a refund.

Plan Benefits

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

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 presurgical 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.

Behavioral Health Services

Behavioral Health Services includes treatment for Mental Health and Substance Use Disorder conditions. L.A. Care provides coverage for medically necessary treatment of behavioral health conditions. L.A Care also covers court ordered health care services required or recommended under a Community Assistance Recovery and Empowerment (CARE) plan. These services as specified by the CARE plan are provided at no cost sharing with the exception of required prescription drugs. This is regardless of whether the services are provided by an in-network or out-of-network provider.

NOTICE: You, your representative, and/or your provider may request our utilization review determination criteria and education program materials. We must provide this information at no cost.

For more information, please call Carelon Behavioral Health, L.A. Care's vendor for Behavioral Health services, at **1.877.344.2858/1.800.735.2929** TTY/TDD to make an appointment. Someone is available to help you connect to services 24 hours a day, 7 days a week, including holidays.

Inpatient Mental Health Services

Psychiatric emergencies are life-threatening events that require immediate attention. During a psychiatric emergency, services are available by contacting 911 or going to the nearest hospital without prior authorization. L.A. Care covers the following inpatient mental health services:

- Inpatient Psychiatric hospitalization
- Coordinated specialty care for the treatment of first episode psychosis.
- Inpatient non-medical transitional residential care for Mental Health Disorders
- 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, psychotropic medications, and services provided by licensed physicians and other health care professionals.

Outpatient Mental Health Services

L.A. Care covers the following outpatient mental health services:

- Mental Health evaluation, treatment and care
- Individual, group and family therapy
- Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy.
- Psychological and neuropsychological testing.
- Medication Management
- Partial hospitalization
- Psychiatric Observation for an acute psychiatric crisis
- Mental Health Intensive Outpatient Treatment
- Outpatient Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)
- Day-treatment
- Intensive outpatient treatment
- Polysomnography (sleep study)
- Psychiatric health facility services, including structured outpatient services as described in Health and Safety Code section 1250.2.
- School site services for a mental health condition or substance use disorder that are delivered to the member at a school site pursuant to Health and Safety Code section 1374.722.
- Outpatient prescription drugs, if coverage for outpatient prescription drugs is provided. Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment.
- Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling.

Please refer to the section about *Specialists Care* (Page 27) in this document for more information regarding a full list of behavioral health outpatient services that do not require a prior authorization.

Crisis Services

L.A. Care covers behavioral health crisis services that are provided by a 988 center, mobile crisis team, or other providers of behavioral health crisis services for medically necessary treatment of a mental health or substance use disorder. These services can include, but are not limited to, confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. These services do not require prior authorization and are covered regardless of whether the service is provided by an in-network or out-of-network provider or facility.

For the medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed through the 988 system, these services may or may not require prior authorization depending on the level of care required (see page 27 to determine which Behavioral Health services do and do not require prior authorization). When L.A. Care is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, L.A. Care shall within 30 minutes of the time the provider makes the initial telephone call requesting information, either authorize post-stabilization care or inform the provider that L.A. Care will arrange for the prompt transfer of the member's care to another provider.

A 988 center, mobile crisis team, or other provider of behavioral health crisis service shall not bill a patient who is a member of L.A. Care for post-stabilization care, except for the in-network cost-sharing amount. Violations of this may be reported to L.A. Care and the DMHC. If the member receives services and care from an out-of-network provider, the L.A. Care member shall pay no more than the same cost sharing that the member would pay for the same services received from an in-network-provider, which shall be referred to as the "in-network cost-sharing amount." An out-of-network provider shall not bill or collect an amount from the member for 988 services except for the in-network cost-sharing amount.

Behavioral Health Treatment (including Applied Behavioral Analysis)
L.A. Care covers Behavioral Health Treatment, Including Applied Behavioral Analysis for members under 21 years of age with a recommendation from a licensed physician, surgeon or psychologist that evidence-based Behavioral Health Treatment services are medically necessary. L.A. Care also covers behavioral health treatment for pervasive developmental disorder or autism spectrum disorder pursuant to Health and Safety Code section 1374.73.
A diagnosis of Autism Spectrum Disorder is no longer required for authorization of these services.

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

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

Please refer to the section titled *Continuity of Care* (Page 34) in this document for information regarding continuation of care with an existing provider.

Inpatient detoxification
L.A. Care covers 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
L.A. Care covers the following services for treatment of Substance Use Disorder:

- Day-treatment
- Intensive outpatient treatment
- Individual and group Substance Use Disorder evaluation, counseling, and treatment
- Medical treatment for withdrawal symptoms
- Medical treatment for withdrawal symptoms
- Partial hospitalization
- Polysomnography (sleep study)
- School site services for a substance use disorder that are delivered at a school site pursuant to Health and Safety Code section 1374.722
- Medication management

- Outpatient prescription drugs, if coverage for outpatient prescription drugs is provided. Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment.
- Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling.

Additional Specialty Group Substance Use Disorder
L.A. Care covers opioid replacement therapy treatment for all members when medically necessary at a licensed treatment center approved by the medical group.

Transitional Residential Recovery Services
L.A. Care covers 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
- 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

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

Clinical criteria developed by nonprofit professional associations, or a successor organization thereto, are used by L.A. Care's behavioral health vendor to make utilization review determinations that are within the scope of the criteria. For a full list of nonprofit professional associations please contact L.A. Care at **1.844.858.9940**.

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 Members ages 9 through 45
  - L.A. Care will not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for the HPV vaccine.
- Mammography for breast cancer screening
- Prostate cancer screening
- Diethylstilbestrol services
- Colorectal cancer screening, including Fecal Immunochemical Test (FIT), Fecal Occult Blood Test (FOBT), Multitarget Stool DNA Test, and colonoscopy.

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.

Clinical Trials

If you have a life-threatening disease, including cancer, you may be able to be part of a clinical trial. A clinical trial is a research study relating to the prevention, detection, or treatment of life-threatening diseases to find out if a treatment or drug is safe and treats a member's disease. 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 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 members 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 Independent Medical Review (IMR) on the denial. You can learn more about this in the "*What should I do if I am unhappy?*" section.

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 for adults age 19 or older 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
- Medically necessary diabetic foot care.
- 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:
L.A. Care provides coverage for medically necessary biomarker testing, as prescribed, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions, as prescribed.

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

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, continuous 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)

Exclusions:

- 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 (including ambulance and air ambulance), provided by non- participating providers. The amount you pay will not exceed the cost sharing amount you would pay for the same covered services from a participating provider.

Emergency Services Out of the Service Area

If an emergency occurs while out of the service area or outside of the United States, 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. If you are outside of the United States, you will have to pay for the emergency services that you receive. L.A. Care will reimburse for the covered emergency services up to the maximum allowable amount. When you submit your claim, you must submit the medical records, a doctor billing statement, and proof of payment for review.

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 if you are deaf or hard of hearing).**

Family Planning

Family planning services are provided to members of childbearing 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

Beginning January 1, 2024, FDA approved contraceptive drugs, devices and products that are available over the counter without a prescription are covered at no charge ($0 copayment). Family planning services also include counseling, patient education on contraception, female sterilization, surgical procedures for the termination of pregnancy (called an abortion), and vasectomies. All of these services are covered at no charge and do not require prior authorization. Please call L.A. Care's Member Services Department at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)** if you need more information about the centers that perform these services.

Health Education Services

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is a year-long program for people who have pre-diabetes or are at risk for type 2 diabetes. The DPP will help you make small changes to your food choices and activity levels to prevent the onset of type 2 diabetes. You may qualify for this program if you:

- Are 18 years of age or older
- Have a BMI > 25 (or > 23 if self-identified as Asian)
- Within the last 12 months have
  - HbA1C test with a value between 5.7 and 6.4

    or
- Fasting plasma glucose of 100-125 mg/dL ***or***
  - 2-hour post-glucose challenge of 140-199 mg/dL
- Have no previous diagnosis of type 1 or type 2 diabetes
- Excludes gestational diabetes
- Do not have End Stage Renal Disease

My Health In Motion™

L.A. Care Health Plan offers its members an online health and wellness platform, called My *Health In Motion*™ (My HIM) at no cost. L.A. Care Health Plan's (L.A. Care) Health Education unit has contracted with vendor MediKeeper, Inc to offer this platform.

My HIM promotes healthy living and provides L.A. Care members with tools and resources to make positive lifestyle changes. Through My HIM, members are able to complete a Health Assessment, view a personalized report of their health risks and strengths, utilize custom tools and workshops based on their risks, communicate with Certified Health Coaches and dietitians, and browse a comprehensive library of health resources. Members must be 18 years of age or older to use My HIM.

My HIM is offered through a targeted online site for L.A. Care *Covered*™ Direct (LACCD) members. Members can only access the specific site for their Line of Business (LOB). You can access the My *Health In Motion* (MyHIM) Wellness Portal) through the L.A. Care Connect Member portal at **members.lacare.org**.

The commercial site members only are offered an incentive program, where they can earn up to $215 in rewards (gift cards) every calendar year just for participating in the My *Health In Motion*™ Rewards Program. The points can be electronically redeemed for gift cards to over 100 retail stores. The points earned in one calendar year do not roll over. The program has several ways to earn points to redeem for gift cards.

The incentive structure for Plan Year 2025 is as follows:

- Completing a Health Assessment -$40
- Completing a 3-month Health Coaching program -$30
- Completing **any two** of the following workshops:
  - Quitting Tobacco and Nicotine (LivingFree) -$30
  - Getting Active (LivingFit)-$30
  - Managing Diabetes (LivingWell)-$30
  - Nutrition or Eating Health (LivingLean)-$30
  - Controlling Alcohol (LivingSmart)-$30
- Annual Preventive Exam- $25 (validation form required)
- Diabetes Management - $30 (validation/evidence required)
- Controlling Blood Pressure - $30 (validation/evidence required)
- Information about My HIM is available through various avenues including, but not limited to, the member handbook, L.A. Care welcome packet, L.A. Care website, member newsletters, and targeted mailings.

The My HIM program offers an opportunity for members to complete a Health Assessment at initial registration that meets NCQA specifications and requirements. Based on the risk score and findings of the health assessment, members are linked to health resources that address identified health areas requiring attention such as:

- Healthy weight (BMI) maintenance;
- Smoking and tobacco use cessation;
- Encouraging physical activity;
- Healthy eating;
- Managing stress;
- Avoiding at-risk drinking;
- Identifying depressive symptoms

- And more!

Additionally, members have the option to schedule coaching appointments with Certified Health Coach and dietitians that are L.A. Care staff.

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 if you are deaf or hard of hearing)** to request a list of testing sites.

Home Health Care

L.A. Care will cover home health care services if all the following conditions are satisfied:

- The member is confined to the home except for infrequent or relatively short duration absences, or when absences are attributable to the need to receive medical treatment, due to a mental health condition or substance use disorder.
- Skilled nursing care on an intermittent basis, physical therapy, occupational therapy, or speech-language pathology services are medically necessary for the evaluation or treatment of a member's mental health condition or substance use disorder or its symptoms. These services (refer to above) shall be reasonable and necessary to improve the member's current condition, maintain the member's current condition, or prevent or slow further deterioration of the member's condition.
- The member's physician, physician assistant, nurse practitioner, or clinical nurse specialist attests that the coverage conditions outlined above, and establishes, and periodically reviews no less frequently than once every 60 days, a plan of care that includes the services specified below and defines the frequency and duration of visits.
- L.A. Care will cover all the following home health care services as specified in the plan of care prepared by the member's physician, physician assistant, nurse practitioner, or clinical nurse specialist:
- Part-time skilled nursing care, including by a registered nurse, licensed practical nurse under the supervision of a registered nurse, or psychiatrically trained nurse.
- Part-time home health aide services for personal care.
- Physical therapy.
- Speech-language pathology.
- Occupational therapy.
- Medical social services.
- Medical supplies provided by a home health agency while the member is under a home health plan of care.
- Durable medical equipment while the member is under a home health plan of care to the extent the member's health plan contract includes coverage for durable medical equipment.

L.A. Care will cover both skilled nursing services and home health aide services furnished any number of days per week, provided that the skilled nursing services and home health aide services, combined, are furnished less than eight hours per day and 35 hours per week.

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 (palliative care), 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
- Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals.

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.

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): including pre-natal diagnosis of genetic disorders in cases of high-risk pregnancy.
  - 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 member returns to the plan's service area.

If you are pregnant, call L.A. Care Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)** 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 Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)** if you have any questions.

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

- Cryopreservation of eggs or sperm
- Radiation shielding

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

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

Medical Nutrition Therapy (MNT)

MNT is a nutrition-based treatment provided by a registered dietitian nutritionist. It consists of consultations to determine a nutrition diagnosis and course of action to help manage certain health conditions such as diabetes, chronic kidney disease and obesity. A treating physician referral required. Physician referral required. Some members may not qualify.

Medical Transportation

Emergency transportation services
L.A. Care covers ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life.

In accordance with California Code of Regulations Sections 1371.56(a)(2) and 1371.56(b), costs for noncontracting ground ambulance providers will not exceed the in-network cost-sharing amount for services subject to this section. L.A. Care will inform the member and the noncontracting provider of the in-network cost-sharing amount owed by the member and will disclose whether or not the member's coverage is regulated by the department.

The in-network cost-sharing amount paid by the member pursuant to this section will count toward the limit on annual out-of-pocket expenses established under Section 1367.006. Cost sharing arising pursuant to this section will count toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

The in-network cost-sharing amount paid by the member pursuant to this section shall satisfy the member's obligation to pay cost sharing for the health service.

Non-emergency transportation services
This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, and psychiatric transport van services.

The forms of transportation are authorized when:

- Your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, and
- Transportation is required for the purpose of transferring from facility to facility or from a facility to your home.

Limits of Emergency and Non-emergency transportation services
This emergency transportation benefit allows for transportation to emergency medical services by ambulance or psychiatric transport van, including medically necessary air ambulance services.

Non-emergency transportation services are limited to transport between facilities or from a facility to your home, if medically necessary. The non-emergency transportation benefit does not cover transportation by airplane, passenger car, taxi or other form of public transportation.

Outpatient Hospital Services 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.

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.

Exclusions:

- Comfort, convenience, or luxury equipment or features are not covered.

Pain Management

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. In addition, behavioral health, instrument-based therapy, immersive therapeutics and medical devices are covered for pain management to help prevent overuse of opioids.

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 through the end of the month the member turns 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, if you are deaf or hard of hearing)**.

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 through the end of the month the member turns 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 **1.800.877.195**, and a customer service representative will help you find another provider. Covered benefits include the following:

- Eye exam, includes dilation if indicated and refraction (covered in full once per calendar year)
- 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. L.A. Care Covered covers aphakia without age limits as required by Section 1367.005, subdivision (a)(2).
- Low vision services, including exam and associated devise

Podiatric Services (Foot Care)

Podiatric (foot care) services are covered including diagnosis and treatment of conditions affecting the foot, ankle and structures of the leg.

Medically necessary routine foot care is covered. Routine foot care is considered medically necessary when the individual suffers from a metabolic, neurologic or peripheral vascular condition which causes severe circulatory impairment or areas of reduced sensation in the individual's legs or feet.

- Routine foot care that is not medically necessary is not covered.

Prenatal Care

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

- Prenatal supplements
- Diagnostic and genetic testing

Prescription Drugs, Supplies, and Supplements (Outpatient)

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 accordance 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:
- Dentists if the drug is for dental care
- 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
- 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

You 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 co-payment):

- 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 including Orally Administered Anticancer Medications
For Members in the Platinum 90 HMO, Gold 80 HMO, and Bronze HMO plans, the cost share for a 30-day prescription drug supply may not exceed $250 per script.

(1) Notwithstanding any deductible, the total amount of copayments and coinsurance the member is required to pay shall not exceed $250 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the contract.

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

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 the retail price for a covered prescription drug, supply, or supplement is less than the defined co-payment, you will pay the lesser amount. The amount you pay will be applied to your out-of-pocket maximum limit and your deductible (if applicable).

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 *Direct*™ 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 coinsurance 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 prescription drugs, supplies, and supplements exclusions*" section).

Diabetes urine-testing supplies and insulin-administration devices
We cover at no charge ($0 co-payment):

- Ketone test strips
- Acetone test tablets

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

It's important to see your doctor at least once a year, even if you are not sick. We cover a variety of Preventive Care Services. In accordance with 42 U.S.C.A Section 300gg -13(a). Section 1367.002, Preventive Care Services, prenatal care or pre-conception visits are covered at no charge. Periodic health exams include all routine diagnostic testing and laboratory services. These include, but are not limited to:

- Periodic health maintenance exams, including annual physical 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). Coverage is also included for COVID-19 immunization at no charge.
  - COVID-19 testing
- Sexually Transmitted Disease (STD) tests, including home test kits when ordered by your in-network provider.
- Cytology exams on a reasonable periodic basis
- Other age appropriate immunizations
- Acquired Immune Deficiency Syndrome (AIDS) vaccine
- HIV Pre-Exposure Prophylaxis (PrEP) and HIV Post-Exposure Prophylaxis (PEP) and associated necessary services, including those for initial care and follow-up care.
- Osteoporosis Services
- Eye examinations:
  - Routine exam
- Health education
- All generally medically accepted cancer screening tests including, but not limited to:
  - Breast Cancer Screening

  - Prostate Cancer Screening
  - Colorectal cancer screening, including Fecal Immunochemical Test (FIT), Fecal Occult Blood Test (FOBT), Multitarget Stool DNA Testing and colonoscopy.*
  - General Cancer Screening
  - Mammography Services
  - Cervical Cancer Screening
  - Diethylstilbestrol Services
  - Adverse Childhood Experience (ACEs) screening
- 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).
- In addition, L.A. Care also covers COVID-19 therapeutics (such as anti-virals like Paxlovid™) at no charge.
- Preventive health care services, including the following:
  - Screening, brief intervention and referral to treatment, primary care-based interventions, and specialty services for persons with hazardous, at-risk, or harmful substance use who do not meet the diagnostic criteria for a substance use disorder, or persons for whom there is not yet sufficient information to document a substance use or addictive disorder, as described in ASAM level of care 0.5 (3rd edition), or the most recent version of The ASAM Criteria.
  - Basic services for prevention and health maintenance, including: screening for mental health and developmental disorders and adverse childhood experiences; multidisciplinary assessments; expert evaluations; referrals; consultations and counseling by mental health clinicians; emergency evaluation, brief intervention and disposition; crisis intervention and stabilization; community outreach prevention and intervention programs; mental health first aid for victims of trauma or disaster; and health maintenance and violence prevention education, as described in LOCUS and CALOCUS-CASII level of care zero (version 2020), or the most recent versions of LOCUS and CALOCUS-CASII.
- Preventive health care services for a mental health condition or substance use disorder that are required under Health and Safety Code section 1367.002.

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

For tests performed for diagnostic purposes following a finding from a test performed for preventive purposes, the standard co-payment for the diagnostic test will apply.

Exclusions

- Members will only receive exams related to their medical needs. For example, a parent's desire for physical exam will not be covered.
- Immunizations required for travel.
- Tests prescribed by a provider who is not part of the L.A. Care provider network.

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 their 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, breast implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this section.

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

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, disease.
- Reconstructive surgery pursuant to Health and Safety Code section 1374.72. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.
- 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)

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

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

- Outpatient Imaging & Laboratory

Substance Use Disorder Services

We provide coverage for medically necessary treatment of substance use disorders. Please refer to definition of Medically Necessary Treatment of a Mental Health or Substance Use Disorder. For more information, please refer to the Behavioral Health Services section of the EOC.

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.

Transgender Services

For gender dysphoria, L.A. Care covers all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health.

These services are provided when medically necessary and may include:

- Psychological assessments to determine readiness for surgery and/or procedures
- Hormone Replacement Therapy (HRT)
- Laboratory testing to monitor hormone therapy
- Gender affirming surgeries and procedures

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 *Direct*™ Member continues to stay enrolled in the QHP product. They 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).

The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit **www.dhcs.ca.gov/HACCP**.

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.
- Cosmetics provided when medically necessary for Mental Health / Substance Use Disorder treatment.

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) unless medically necessary for Mental Health / Substance use disorder treatment. 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 unless medically necessary for Mental Health/ Substance Use Disorder treatment. 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, with the exception of treatment for medically necessary fertility preservation services related to iatrogenic infertility (i.e. infertility caused by medical treatment, such as surgery, chemotherapy, or radiation).

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 unless medically necessary for Mental Health/ Substance use disorder treatment.

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 members 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 Mental Health/ Substance Use Disorder services provided by an unlicensed individual who meets the definition of a psychological assistant, an associate clinical social worker, a registered psychologist, a psychological intern, trainee or other unlicensed individual qualified per state law to provide the services.

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 at the addresses set forth below:

If to L.A. Care:

L.A. Care Health Plan
Attention: Director of Customer Solution Center 1200 W. 7th Street,
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 States Postal Service or courier.

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 Member Services **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing).**

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 for covered services.

Reimbursement Provisions – If You Receive a Bill

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

L.A. Care Health Plan
Attn: Member Reimbursement Request
P.O. Box 811610
Los Angeles, CA 90081

You can call L.A. Care Member Services at **1.855.270.2327 (TTY 711 if you are deaf or hard of hearing)**. This call is free.

Independent Contractors

L.A. Care physicians, PPGs, hospitals, and other health care providers are not agents or employees of L.A. Care. Instead, they are independent contractors. Although L.A. Care regularly credentials the doctors who provide services to members, L.A. Care does not, itself, provide these services. As such, L.A. Care is not responsible for the actions or omissions of any person who does provide these services to members. This includes any doctor, hospital, or other provider or their employees.

Review by the Department of Managed Health Care (DMHC)

A member may ask for a review by the DMHC if L.A. Care cancels or refuses to renew a member's enrollment, and the member feels that it was due to reasons of health or use of benefits. The member can call the DMHC toll-free at **1.888.466.2219.**

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 a public entity, operating managed health care plans, including L.A. Care Covered *Direct*™, and 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

Member 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 their 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 the member 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 member 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 & 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, if you are deaf or hard of hearing).**

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 *Direct*™ on their own behalf. An applicant is also a person who applies on behalf of a child for whom they are 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.

Autism Spectrum Disorder (ASD) is a behavioral disorder characterized by

- Persistent deficits in social communication and social interaction across multiple contexts,
- Restricted, repetitive patterns of behavior, interests, or activities.
- Symptoms present in the early developmental period
- Symptoms that cause clinically significant impairment in social, occupational, or other areas of current functioning
- Disturbances that are not better explained by intellectual disability or global developmental delay.

Please see full definition of ASD in Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Behavioral Health Services include is an all-inclusive term referring to mental health and substance use disorder treatment pursuant to 1374.72, including but not limited to behavioral health crisis services that are provided to a member by a 988 center, mobile crisis team, or other provider of behavioral health crisis services.

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, if you are deaf or hard of hearing).

Clinical Trial is a research study relating to the prevention, detection, or treatment of a life-threatening disease or condition including a clinical trial funded by, among others, a qualified nongovernmental research entity.

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.

Continuous Glucose Monitor is a device used for monitoring blood glucose on a continual basis using an electrode implanted under the skin and held in place by an adhesive. A transmitter attached to the electrode sends data to a separate receiver.

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.

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 *Direct*™

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 condition 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 your 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.

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

Essential Health Benefits (EHB) are health care service categories that must be covered by certain plans and all Medicaid state plans as of 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.

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 or the health plan's denial of the service and/or treatment you requested. 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.

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.

Iatrogenic Infertility is infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

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 public entity, operating managed health care plans, including L.A. Care Covered *Direct* TM, and run by a Board of Governors.

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 them.

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.

Medically Necessary Treatment of Mental Health or Substance Use Disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) n accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

(Please see section 1374.72(a)(3)(A) of the California Health and Safety Code).

Member is a person who is enrolled and effectuated in L.A. Care *Direct*™.

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

Mental Health Disorders are mental health conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or

that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

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 people with disabilities.

Open Enrollment Period is a designated period of time each year from November 1st through January 31st of the following year 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 coinsurance 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 *Direct*™.

Premium is monthly fee that a 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 Care Professional is a PCP, specialist, or other licensed health care provider who is acting within their 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 *Direct*™.

Severe Mental Illnesses (SMI) is a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include, but are not limited to schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.

Skilled Nursing Facility is a facility licensed by the California Department of Health Care Services (DHCS) 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, replace 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 Autism Spectrum Disorder.

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.

Substance Use Disorders (SUD) are substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

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/TDD is a communication device for the deaf and hard of hearing, 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.

L.A. Care
Covered™ Direct

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

Services for People

American Disabilities Act Information 1-800-514-0301
Hearing Impaired users/California Relay Service TTY/TDD 1-800-735-2929
Hearing Impaired users/California Relay Services TTY/TDD 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 711
Authorizations 1-877-431-2273
Carelon Behavioral Health Hotline 1-877-344-2858
Carelon Behavioral Health Hotline TTY/TDD 1-800-735-2929
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) 1-888-466-2219
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

CALIFORNIA INDIVIDUAL ESSENTIAL PEDIATRIC DENTAL BENEFIT PLAN COMBINED EVIDENCE OF COVERAGE (EOC) AND DISCLOSURE FORM

LA Care Covered and LA Care Covered Direct Children's Dental HMO Benefit (EPDB) Plan
L.A. Care Covered Direct is your Qualified Health Plan (QHP).
L.A. Care Covered Direct arranges for your **Essential Pediatric Dental Benefit** coverage provided by LIBERTY Dental Plan of California.

Availability of Language Assistance: Interpretation and translation services is available for members with limited English proficiency, including translation of documents into certain threshold languages at no cost to you. To ask for language services call 1-888-703-6999/TTY: 1-877-855-8039. Make sure to notify your primary care dentist or specialty dentist of your personal language needs upon your initial dental visit.

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 sin ningún costo a usted. Para obtener ayuda gratuita, llame ahora mismo al 1-888-703-6999/TTY: 1-877-855-8039.

Hereinafter in this document, LIBERTY Dental Plan of California, Inc. will be referred to as "LIBERTY" or "the Plan." L.A. Care Health Plan may be referred to as "LACCD".

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 copy of the dental plan contract is available upon request.

A STATEMENT DESCRIBING LIBERTY'S POLICIES AND PROCEDURES FOR MAINTAINING THE CONFIDENTIALITY OF MEDICAL AND DENTAL RECORDS IS AVAILABLE AND WILL BE PROVIDED TO YOU UPON REQUEST AT NO COST.

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 plan benefits.

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

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Confidential communications

California law states that you can ask for confidential communications regarding the receipt of sensitive services. These types of services can include:

- Bills and attempts to collect payment
- A Notice of Adverse Benefit Determination(s)
- An Explanation of Benefit notice(s)
- A Plan's request for additional information regarding a claim
- A notice of a contested claim
- The name and address of a provider, description of services received, and other information related to a visit.
- Any verbal, written or electronic communications from the Plan that contain protected health information.

To request confidential communications from LIBERTY for any of the services listed above, please call Member Services or you can submit a request in writing by mail or fax to any of the following:

- Online: LIBERTY's website by visiting www.libertydentalplan.com
- By mail to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA 92799-6110
- By fax to: (877) 831-6019
- By telephone to: LIBERTY's Member Services at 888-703-6999
- By TDD/TTY: 877-855-8039

I. GENERAL INFORMATION

THIS BENEFITS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS COMBINED EOC AND DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE REVIEWED FOR A DETAILED DESCRIPTION OF DENTAL BENEFITS, LIMITATIONS, AND EXCLUSIONS.

Liberty Dental Plan Children's Dental HMO Benefit Matrix	
Copayment Plan	
(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.
(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 - $300.00 Endodontic Services……..No Cost - $300.00 Periodontic Services……..No Cost - $350.00 Prosthodontic Services……..……No Cost - $350.00

	Implant Services.....……..……No Cost - $350.00 Oral and Maxillofacial Surgery …….No Cost - $350.00 Orthodontic Services……..…..No Cost - $1,000.00
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	The member may receive a maximum benefit of up to $75 per year 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 dental category and procedure listed above, that is covered under the program, has a specific co-payment, which is shown in the Schedule of Benefits (Appendix I) of this combined Evidence of Coverage.

A copy of your combined Evidence of Coverage (EOC) will be made available yearly or upon request and will include any changes about your dental benefits or LIBERTY's enrollee public policies.

The Schedule of Benefits is attached as Appendix 1.

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 services LIBERTY covers and does not cover. Also read your Schedule of Benefits, which lists dental services, co-payments and other fees. This EOC represents the Children's Dental HMO benefits covered as part of your Health Plan as arranged by L.A, Care Covered. To be eligible for this coverage, you must meet the eligibility requirements as stated in this document.

B. HOW TO CONTACT LIBERTY

We are here to help you. Please contact us by going online, mailing, or calling us. You can also download our LIBERTY Dental mobile app on your smartphone.

LIBERTY's 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 can use the California Relay Service's toll-free telephone number 711 to contact the Department of Managed Health Care.

LIBERTY Important Contact Information			
Hours:	**Website:**	**Mailing Address:**	**Member Services:**
Monday - Friday 8:00 a.m. to 5:00 p.m.	www.libertydentalplan.com	LIBERTY Dental Plan, P.O. Box 26110 Santa Ana, CA 92799-6110	888-703-6999 TTY: 877-855-8039

C. LIBERTY'S SERVICE AREA

LIBERTY has a service area, which is the state of California. This is the area in which LIBERTY provides dental coverage. You must live, work, and receive all dental services in California, unless you need Emergency or Urgent Care. If you move out of California, you must tell LIBERTY. **L.A. Care Covered Direct Dental Benefit Plan's Service Area is Covered California Region Region 15 and 16, Los Angeles County.**

D. LIBERTY'S NETWORK

Our network includes general dentists and specialty dentists that LIBERTY has contracts with to provide covered services to our members. To use your benefits, covered services must be performed by your Primary Care Dentist (PCD) or other network providers.

To get a copy of your LIBERTY Provider Directory, go to our website at www.libertydentalplan.com, or you can download and use our mobile app on your smartphone, or call Member Services.

If you to go an out-of-network provider, you will have to pay all the cost, unless you received pre-approval from LIBERTY or you require Emergency/Urgent Care. If you are new to LIBERTY, or your PCD's contract ends, you may be able to continue to see your current dentist. This is called *continuity of care)*.

E. YOUR PRIMARY CARE DENTIST (PCD)

When You join LIBERTY, you do not need to choose a Primary Care Dentist (PCD). A PCD is usually a general dentist who provides your basic care and coordinates the care you need from other dental specialty Providers. You may access services from any contracted general dentist in the network.

F. LANGUAGE AND COMMUNICATION ASSISTANCE

Interpretation and translation services are available for members that speak limited English, including translation of documents into other languages. If English is not your first language, LIBERTY provides interpretation services and translation of some written materials in your preferred language at no cost to you. To ask for language services call 888-703-6999/TTY: 1-877-855-8039.

If you have a preferred language, please tell us of your personal language needs by completing an online survey at https://www.libertydentalplan.com/Members/Member-Language-Survey.aspx or calling 888-703-6999/TTY: 1-877-855-8039.

Make sure to let your PCD or specialty dentist know of your preferred language needs at your first dental visit. LIBERTY provides language assistance services for all your dental appointment(s). If your PCD, specialty dentist, or dental office staff, cannot talk with you in your preferred language, LIBERTY can give you interpretation services, at no cost to you.

LIBERTY makes certified interpretation services available to you at no cost and does not recommend using family members, minors or friends to assist you. Please call our Member Services to arrange for an in-person interpreter as far in advance of your appointment time as possible, but no less than seventy-two (72) hours from the time of your appointment. If you have an Emergency/Urgent Care appointment, LIBERTY can provide you with interpretation services over the phone, to help you talk to the office staff in your preferred language.

G. HOW TO GET DENTAL CARE WHEN YOU NEED IT

Call your PCD first for all your dental care unless you are having a medical emergency. If you are having a medical emergency call your primary care physician, 911, or go to the closest emergency room.

You usually need a referral and pre-approval to get care from a specialty dentist other than your PCD. The care must be medically necessary for your health. Your dentist and LIBERTY follow guidelines, criteria, and policies to decide if care is medically necessary for your health. If you disagree with LIBERTY that a service is medically necessary for your health, you can request reconsideration (an appeal), file a grievance, or in some cases, you can request an Independent Medical Review (IMR).

Covered dental services are also called benefits, and must be a service that LIBERTY covers. Your Schedule of Benefits will show you what services LIBERTY covers under your dental plan. Your Schedule of Benefits is provided with this document, at the start of your plan, and is available anytime on the LIBERTY website at www.libertydentalplan.com, through our mobile app for your smartphone, or upon request from our Member Services.

H. SCHEDULING APPOINTMENTS

California law states that you have the right to schedule an appointment within a reasonable time based on your oral needs. The table below shows you the wait time for each type of appointment to treat your oral condition. If for any reason you are unable to schedule an appointment within these timeframes, please call our Member Services at 888-703-6999/TTY: 1-877-855-8039 for assistance.

Type of Appointment	Condition/Type of Services	Appointment Wait Time
Emergency Care	Severe pain, swelling, bleeding	24 hours a day, 7 days a week
Urgent Care	Broken filling/lost crown	72 hours
Initial	Exam, x-rays	36 business days
Routine Care (Non-Emergency)	Restorative care (fillings/crowns)	36 business days
Preventive Care	Cleanings	40 business days
Specialty Dentist	Oral Surgeon, Endodontist, etc.	30 calendar days
In-Office Wait Time	Scheduled appointments only	Not to exceed 30 minutes
Telephone Wait Time	To answer incoming calls	Within 30 seconds
Return Call Wait Time	Returning calls from voicemails	Within 30 minutes

I. SPECIALTY REFERRALS AND PRE-ESTIMATES

Your PCD must submit a request for a specialty referral to LIBERTY for pre-approval if you need services from a specialty dentist. Pre-approval is also called pre-estimate. Make sure your PCD submits a specialty referral to LIBERTY, and you get a pre-approval. Once you receive the approval for consultation to the needed specialty dentist, the specialty dentist will submit a pre-estimate for any services they feel are needed. If you do not have an approved specialty referral from LIBERTY before you see a specialty dentist, you will have to pay for all of the costs of any services you receive.

IMPORTANT: You do **not** need a specialty referral and pre-approval to see your PCD, or to get emergency care or urgent care.

J. EMERGENCY CARE

A condition is considered an emergency if you have severe pain, swelling, or bleeding. A condition is also considered an emergency, if you reasonably think that your condition, without treatment, could cause your health or body to be in serious danger or lead to death.

Emergency care is a covered 24 hours a day, 7 days a week, anywhere in the world. If you require Emergency care, contact your PCD, including unexpected dental conditions that take place after normal business hours or on weekends.

Medical emergencies are not covered by LIBERTY if the services are rendered in a hospital setting which are covered by a medical plan, or if LIBERTY determines the services were not dental in nature. If you are having a medical emergency call your primary care physician, 911, or go to the nearest emergency room.

K. URGENT CARE

Urgent Care is care needed to prevent an oral condition from getting worse due to an unexpected illness or injury, and care cannot be delayed.

Urgent Care is covered, anywhere in the world and appointment should be scheduled within 72 hours. If you require Urgent care, contact your PCD, including unexpected dental conditions that take place after normal business hours or on weekends.

L. CARE WHEN YOU ARE OUT OF THE LIBERTY SERVICE AREA

Only emergency and urgent care is covered outside of the LIBERTY service area.

M. COSTS

- A Premium is what you pay to your Qualified Health Plan (QHP) to keep coverage. Premiums are paid to L.A Care covered.
- A co-payment is the amount that you must pay to your PCD or a specialty dentist for a covered dental procedure. 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-payments, or coinsurance 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 can be other costs incurred for optional, non-covered, and upgraded material services that do not apply to out-of-pocket maximums.
- To verify your out-of-pocket maximum, please visit our website at www.libertydentalplan.com, download our mobile app on your smart phone, or call LIBERTY's Member Services, toll-free at 888-703-6999/TTY: 1-877-855-8039.

N. IF YOU HAVE A GRIEVANCE ABOUT YOUR LIBERTY DENTAL PLAN

LIBERTY provides a grievance resolution process. You can file a grievance (also called complaint or appeal) with LIBERTY for any dissatisfaction you have with the Plan, your dental benefits, a claim determination, pre-estimate determination, your PCD, specialty dentist, or any part of your dental plan benefits.

If you disagree with LIBERTY's decision about your grievance, you can get help from the California Department of Managed Health Care Help Center. In some cases, the Department of Managed Health Care 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 dental plan.

II. DEFINITIONS OF USEFUL TERMS FOUND IN THIS DOCUMENT

The following words used in this document are important for you to know:

- **Appeal:** A request made to LIBERTY by a member, a provider acting on behalf of a member, or other authorized designee to review an action by the Plan to delay, modify or deny a pre-estimate or claim for dental services.
- **Applicable:** To have an effect on someone or something
- **Authorization:** A LIBERTY written notice of approval that you can proceed with treatment requested.
- **Benefits:** Medically necessary dental services covered by LIBERTY that are available through this dental plan. Also known as dental plan benefits.

- **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.
- **Capitation:** Pre-paid payments made by LIBERTY to a network general dentist to provide services to assigned members.
- **Charges:** The fees requested for proposed or completed dental services.
- **Consultation**: A meeting with a specialty dentist to determine care and a treatment plan, as needed.
- **Contracted Dental Group, Dental Office, or Provider:** A dental facility, general dentist, specialty dentist, and dental office staff that are under a signed contract with LIBERTY to provide services to our members in accordance with the Plan's clinical guidelines and criteria. Also knowns as in-network.
- **Co-payment:** The amount listed on the Schedule of Benefits that is charged to a member at the time of service for covered dental plan benefits.
- **Covered Services:** The set of dental procedures that are benefits of your LIBERTY dental plan.
- **Dental Records:** Refers to diagnostic aids, intra-oral and extra-oral x-ray(s), written treatment records, 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 actively enrolled in LIBERTY. Also known as a enrollee, member or subscriber.
- **Disputed Dental Service:** Any service that is the subject of a dispute filed by either member, a provider acting on behalf of a member, or other authorized designee. Also knowns as a grievance or appeal.
- **Domestic Partner:** Any person whose domestic partnership is currently registered with a governmental body pursuant to state or local law. This includes both same-sex and opposite-sex couples.
- **Emergency Care:** A dental screening, examination, or evaluation by a LIBERTY provider to determine if an emergency dental condition exists, and to provide care to treat any emergency symptoms within the capability of the facility within professionally recognized standards of care.
- **Emergency Dental Condition:** A dental condition that if not treated immediately could reasonably be expected to result in placing the persona's health in jeopardy, causing severe pain or impairing function.
- **Endodontist:** A specialty dentist who specifically treats disease and injuries to the pulp and root of the tooth. Also known as a root canal specialist.
- **Enrollee:** LIBERTY considers an enrollee to mean the same as a member, dependent or subscriber who are actively enrolled in the Plan.

- **Essential Health Benefit (EHB)**: A set of 10 categories of services health and dental insurance plans must cover under the Affordable Care Act. Plans must include dental coverage for children. Dental benefits for adults are optional. Specific services can vary based on state requirements.
- **Essential Pediatric Dental Benefit (EPDB):** Refers to plans mandated by the Affordable Care Act to provide essential pediatric dental benefits to children.
- **Exclusion:** Refers to any dental procedure or service that is not available under your LIBERTY dental plan.
- **Explanation of Benefits (EOB):** A written statement from LIBERTY about a claim, showing what was covered under your dental plan, what was paid for by the Plan, and what you must pay for.
- **General Dentist:** A licensed dentist who provides general dental services and who does not identify as a specialty dentist. Also known as your Primary Care Dentist.
- **Grievance:** Any expression of dissatisfaction; also known as a complaint. See Grievance section of this EOC for the rules, regulations, and processes.
- **Group Plan:** A dental benefit plan through an employer or group providing dental benefit coverage through LIBERTY.
- **Independent Medical Review (IMR):** A California program where certain denied services can be subject to an external review. IMR is only available for certain medical services.
- **In-Network Benefits:** Dental benefits available to you when you receive services from a LIBERTY contracted general dentist or specialty dentist.
- **Limitations:** Refers to the number of services allowed, type of services allowed, and/or the most affordable dentally appropriate service.
- **Medical Necessity or Medically Necessary:** Covered services which are necessary and appropriate for the treatment of the teeth, gums, and supporting structures and that are (a) provided according to professionally recognized standards or practice; (b) determined to be consistent with the dental condition, and (c) are the most appropriate type, supply and level of service considering the potential risks, benefits, and covered services which are alternatives.
- **Member:** LIBERTY considers a member to mean that same as an enrollee, subscriber, or dependent who are actively enrolled with LIBERTY.
- **Network General Dentist:** A dentist who has signed a contract with LIBERTY to provide services to our members in accordance with LIBERTY's guidelines and criteria.
- **Non-Contracted Provider:** A general dentist or specialty dentist that is not in contract with LIBERTY to provide service to members. Also knowns as out-of-network provider.
- **Non-Covered Service:** A dental procedure or service that is not covered under your dental plan.
- **Open Enrollment Period:** A period of time where enrollment in a dental plan can be started or changed.

- **Oral Surgeon:** A specialty dentist who treats diseases, injuries, deformities, and appearance of the mouth, jaws, and face.
- **Orthodontist:** A specialty dentist who treats problems in the way the upper and lower teeth fit together in biting or chewing.
- **Out-of-Area Coverage:** Benefits provided when you are out of the LIBERTY's service area, or away from your PCD. Also known as out-of-network coverage.
- **Out-of-Area Urgent Care:** Urgent services that are needed while you are located out of the service area or away from your PCD. Also known as out-of-network urgent care.
- **Out-of-Pocket Maximum**: Refers to the maximum amount you will spend for covered services each year.
- **Pediatric Dentist:** A specialty dentist who treats children from birth to adolescence, providing primary and full range of preventive care treatment.
- **Periodontist**: A specialty dentist who treats diseases of the gums and tissue around the teeth.
- **Plan:** LIBERTY Dental Plan of California, Inc., also knowns as "LIBERTY".
- **Pre-Estimate:** A request made by a LIBERTY provider to approve services before they are performed. Also known as a pre-approval.
- **Premium:** The amount of money that you or your employer/group must pay monthly to LIBERTY for dental coverage.
- **Primary Care Dentist (PCD):** A contracted general dentist who provided services to LIBERTY members. The primary care dentist is responsible for providing or arranging specialty care for needed dental services.
- **Professional Services:** Dental services or procedures provided by a licensed dentist or approved assistants.
- **Provider:** A contracted primary care dentist, dental group, dental clinic, or specialty dentist who provides dental plan benefits and services to LIBERTY members.
- **Referral:** A request from your primary care dentist to direct you to a specialty dentist for evaluation and services as needed.
- **Service Area:** The counties in California where LIBERTY provides coverage.
- **Schedule of Benefits**: A document that outlines the type of dental procedures covered by your LIBERTY dental plan, including any copayments, deductibles, out-of-pocket maximums, exclusions, and limitations.
- **Specialty Dentist:** A dentist that has received advanced training in one of the dental specialties approved by the American Dental Association, and practices as a specialist. Dental specialties include Endodontists, Oral Surgeon, Periodontists and Pediatric Dentists.
- **Subscriber:** LIBERTY considers a subscriber to mean that same as an enrollee, member, or dependent who are actively enrolled with LIBERTY.

- **Surcharge:** An amount charged in addition to a listed co-payment for a requested service or treatment.
- **Terminated Provider:** A provider that is no longer contracted with LIBERTY to provide services to members of the Plan.
- **Urgent Care:** Dental care that you need soon to prevent a serious health problem.
- **Usual Fee:** A provider's usual charge for a service, not covered under your dental plan benefits.

III. ACCESS TO SERVICES – SEEING A DENTIST OR SPECIALTY DENTIST

LIBERTY contracts with general dentists and specialty dentists to provide services covered by your plan. To find a dentist in your arear, you can go to our website at www.libertydentalplan.com, download the LIBERTY mobile app on your smart phone, or call us toll-free at 888-703-6999/TTY: 1-877-855-8039.

All services and benefits described in this Evidence of Coverage (EOC) are covered only if provided by a contracted Primary Care Dentist (PCD) or specialty dentist. The only time you can receive care out-of-network is for emergency dental services as defined under "**Emergency Dental Care**" or "**Urgent Care**".

A. DENTAL OFFICES

LIBERTY makes available PCDs and specialty dentists throughout the state of California within a reasonable distance from your home or workplace.
You can find a dentist in your area by going to our website, **www.libertydentalplan.com**, downloading our mobile app on your smart phone, or calling us toll-free at **888-703-6999/TTY: 1-877-855-8039.**

Our goal is to provide you with appropriate dental benefits, delivered by highly qualified dental professionals in a comfortable setting. All of LIBERTY's contracted private practice dentists must meet LIBERTY's credentialing criteria, prior to joining our network. In addition, each participating dentist must adhere to strict contractual guidelines. All dentists are pre-screened and reviewed on a regular basis.

LIBERTY conducts a quality assessment program, which includes ongoing contract management to confirm compliance with continuing education, appointment availability for members, appropriate diagnosis, and treatment planning. Your PCD will provide all your dental care needs including referring you to a specialty dentist, if necessary. All members will have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a PCD office.

B. DENTAL HEALTH EDUCATION

For more information on using your dental benefits, please go to our website at www.libertydentalplan.com. The website contains other helpful information on dental and oral health information to assist you including home care measures you can take to keeping your teeth and mouth healthy. It is important to know the condition of your teeth, gums and mouth can affect 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 post pregnancy health as well as other health conditions can be found on our website.

C. CHOICE OF PROVIDERS

1. Primary Care Dentist (PCD): You do not have to choose an assigned PCD. You can access care from any in network PCD. Your PCD is responsible for coordinating any specialty care dental services you may need. You must obtain general dental services from your PCD. Your PCD will share information with any specialty dentist to coordinate your overall care.

You can locate a LIBERTY contracted provider by going online to our website at www.libertydentalplan.com, downloading our mobile app on your smartphone, or calling the Member Service. Once you have located a LIBERTY contracted provider, you can call the office to schedule an appointment. The PCD will contact LIBERTY to verify your eligibility.

2. Changing PCDs: You can request to change your PCD at any time. You can use our mobile dental app to find a dentist and request an office transfer, call our Member Services toll-free at (888) 703-6999/TTY: 1-877-855-8039, during regular business hours, or submit a change request in writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110.

If you request to change your PCD, your new dental office may be made effective as early as the first (1st) day of the current month. There are some dental offices that require offices changes to take place on the first (1st) day of the following month. You can reach out to the new PCD office to ask about their process or contact Member Services.

3. Care from a Specialty Dentist: You can obtain care from a specialty dentist after your PCD submits a referral to LIBERTY for approval. You can only receive services from a specialty dentist that has been pre-approved for you by LIBERTY. Your specialty dentist will submit a pre-estimate for services to LIBERTY for review and determination of benefits.

- All services and benefits described in this EOC are covered only if provided by a contracted LIBERTY PCD or specialty dentist. Services received by a non-contracted provider are not covered. The only time you can receive care out-of-network is for emergency or urgent dental services as described under "**Emergency Dental Care**" or **"Urgent Dental Care"**.

D. TELE-DENTISTRY

Tele-dentistry is a virtual dental service, available twenty-four (24) hours per day, seven (7) days per week, as an alternative solution to help you monitor your dental health, especially when you and your PCD cannot be in the same physical location. Providers are available by phone and computer from anywhere to address emergency and urgent dental needs. LIBERTY covers tele-dentistry services to help improve access and continuity of dental care for our members. There is no difference in your dental coverage for tele-dentistry. The same benefits are available with tele-dentistry as it would be for in-person visits.

Your provider can determine through a consultation whether you have an emergency dental problem and can provide instructions on how to treat conditions. If you have a cracked or chipped tooth, soft tissue lesion (bump on your gums), small cavity, jaw pain, or similar non-emergency condition, a tele-dentistry consultation through phone or video may work. If you need urgent treatment, it must be scheduled for an onsite visit.

You can set up an appointment with your dental office, by phone or online to discuss regular dental services, dental problems, and instructions on how to treat conditions. Contact your PCD if you are experiencing dental pain or a potential dental emergency. If your PCD is not available, contract LIBERTY toll-free for assistance with the tele-dentistry program. If an in-person visit is required, dental emergency visits are coordinated by LIBERTY's Member Services, at no cost to you.

If you are experiencing a life-threatening medical emergency, immediately contact 911.

E. URGENT CARE

Urgent Care is care you need within seventy-two (72) hours, to prevent the serious worsening of your dental health due to an unforeseen illness or injury for which treatment cannot be delayed.

LIBERTY provides coverage for urgent dental services only if the services are required to alleviate severe pain, bleeding, or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction, or death.

Contact your PCD for your urgent needs during business hours or after hours. If you are out of the LIBERTY service area, call the Plan for referral to another contracted dentist that can treat your urgent condition.

For after-hours urgent care outside the LIBERTY service area, you can find a provider who can assist you with your urgent condition. LIBERTY will reimburse you for covered dental expenses up to a maximum of seventy-five dollars ($75) per year.

You will still be responsible for your co-payments as determined by your dental plan design. You should notify LIBERTY as soon as possible after you receive of urgent care services, preferably within forty-eight (48) hours.

In the event that LIBERTY determines that your treatment was not due to a urgent dental condition, the services of any a non-contracted provider will not be covered, and you will not be eligible for reimbursement.

F. EMERGENCY DENTAL CARE

Emergency Dental Care is defined by California laws, to include a dental screening, examination, evaluation by general dentist or specialty dentist to determine if an emergency dental condition exists, and to provide care that would be considered within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a dental office/clinic setting and emergency room in a hospital.

Emergency dental care is an allowable benefit, based on your Schedule of Benefits. LIBERTY will provide benefits for emergency dental services and will ensure the availability of a provider in the event that an on-call network provider is unavailable in a dental setting or hospital. LIBERTY will not cover services that are determined were not dental in nature.

All LIBERTY contracted PCD offices provide availability of emergency dental services twenty-four (24) hours per day, seven (7) days per week. LIBERTY provides coverage for emergency dental services if, without treatment, your health may be in serious jeopardy, you may experience serious harm to bodily functions or serious dysfunction of any bodily organ or part.

Emergency care can include, but is not limited to, care for a bad injury, severe pain, or a sudden serious dental illness. If you are having a medical emergency call your primary care physician, 911, or go to the nearest emergency room.

In the event you require emergency dental care, contact your PCD to schedule an immediate appointment. For urgent or unexpected dental conditions that occur after-hours or on weekends, contact your PCD for instructions on how to proceed. If your PCD is not available, or if you are out of the LIBERTY service area and cannot contact the Plan for assistance in locating 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) per year. You will be responsible for your co-payments as determined by your dental plan benefits.

You should tell LIBERTY as soon as possible after receipt of emergency dental services, preferably within forty-eight (48) hours. If it is determined that your treatment was not due to a dental emergency, the services of any non-contracted provider will not be covered, and you will not be eligible for reimbursement.

If the requirements in the section titled **"Emergency Dental Care"** are satisfied, LIBERTY will cover up to seventy-five dollars ($75). 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 statement of services/invoice. You can also find a copy of the dental claim form on our website at the following:
https://www.libertydentalplan.com/Resources/Documents/ADA%20Claim%20Form.pdf

Please ensure the statement or invoices are clearly readable and forward to LIBERTY with the following information:

- The subscriber's full name and identification number
- The name and identified number of the person who received the emergency dental services
- Name, address, and telephone number of the dentist that provided the emergency dental services
- A statement explaining the circumstances surrounding the emergency dental service 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 thirty (30) calendar days of LIBERTY's receipt of the claim that includes:

- The reason for denied services
- Reference to the applicable EOC conditions, or LIBERTY clinical guidelines and criteria, on which the denial is based on.
- Information on how to request reconsideration of the denial or file a grievance, and an explanation of the grievance procedures. You can also refer to the EOC section, GRIEVANCE PROCEDURES.

G. SECOND OPINION

You can request a second dental opinion, at no cost to you, for services covered under your plan, by calling the Member Services toll-free number (888) 703-6999/TTY: 1-877-855-8039 or by writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110.

Your PCD can also request a second dental opinion on your behalf by submitting a standard specialty referral form with appropriate x-rays and documentation. All requests for a second dental opinion are processed by LIBERTY within five (5) business days of receipt of the request, or seventy-two (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 approval, LIBERTY will make the appropriate second dental opinion arrangements and advise the attending dentist of your concerns. You will then be advised of the arrangement so an appointment can be scheduled. Upon request, you can ask a copy of LIBERTY's policy for second dental opinions.

H. REFERRAL TO A SPECIALTY DENTIST

In the event that you need to be seen by a specialty dentist, LIBERTY requires your PCD to submit a specialty referral for approval. LIBERTY will process the request for a standard, non-emergency, specialty referral within five (5) business days of receipt.

1. EMERGENCY REQUESTS

If you or your PCD encounter an emergency condition in which the normal timeframe for the decision making process as described above would be detrimental to your life or health, including, but not limited to, the potential loss of life, limb, or other major body function, a request for emergency referral or pre-estimate can be requested.

LIBERTY's response to the emergency request will not take longer than seventy-two (72) hours from the time of receipt of all information needed to make a decision.

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

2. PENDED REQUESTS

There are times when LIBERTY requires additional information from your PCD to process the request for a specialty referral. When additional information is needed, LIBERTY will send you and your PCD a letter explaining why the request for the specialty referral was pended, the additional information that is needed, and when the additional information is needed to make a decision.

Specialty referrals can stay pended for up to fourteen (14) calendar days, if the necessary information is not received LIBERTY will make based on the documentation provided by the PCD, your dental plan benefits and the Plan's guidelines and criteria.

3. SPECIALTY DENIST VISITS

Once you complete the first visit with the specialty dentist, called a consultation, you will be provided a treatment plan that includes the procedures recommended to treatment your condition, if the services are covered or not covered, and the amount you will pay for the services.

- You specialty dentist is required to submit a pre-estimate to LIBERTY, to determine coverage, benefits, medical necessity and/or appropriateness, except for emergency dental services (see the **"Emergency Dental Care"** and **"Urgent Care Services"** described above).
- You will be financially responsible for the listed copayments and deductibles for covered services. If you chose to have any services completed that were denied by LIBERTY based on medical necessity, or any non-covered or elective services, you will be financially responsible for the specialty dentist's usual fee.

IMPORTANT NOTE: Specialty services and treatment plans that are pre-approved by LIBERTY, are only available with the specialty dentists who requested the services. Specialty services and treatment plans are not transferrable from one specialty dentist to another specialty dentist, unless both specialty dentists agree with the proposed treatment plan.

I. AUTHORIZATION OF SERVICES

A pre-approval is not required to receive dental services from your PCD. Your PCD has the ability to make most coverage determinations. Treatment plans to determine your dental benefits are completed through comprehensive oral exams, which are covered by your plan.

Your PCD is responsible for communicating the results of the comprehensive oral exam and providing you with a treatment plan that includes your available benefits and the associated costs.

Your specialty dentist must use the process outlined above in **"Referral to Specialty Dentist"**.

You, your PCD, or specialty dentist can call LIBERTY's Member Services toll-free at 1-888-703-6999/TTY: 1-877-855-8039 for information on the Plan's pre-approval of services policies or the status of a referral or pre-estimate.

If you are not satisfied with LIBERTY's decision to delay, modify, or deny services requested on a specialty referral and/or pre-estimate, you have the right to request reconsideration. Please reference the GRIEVANCE PROCEDURES section in this EOC for more information on how to request reconsideration.

J. CONTINUITY OF CARE

1. **Current Members:** Current LIBERTY members have the right to the completion of care for certain serious, recurring dental conditions with their provider that is no longer contracted with LIBERTY (terminated provider). Please call LIBERTY's Member Services at 1-888-703-6999/TTY: 1-877-855-8039 to see if you are eligible for this benefit.

   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. You can request a copy of the LIBERTY's Continuity of Care Policy, at no cost.

2. **New Members**: A new LIBERTY member has the right to the completion of care for certain specified serious, recurring dental conditions with their provider that is not contracted with LIBERTY (out-of-network provider). Please call LIBERTY's Member Services at 1-888-703-6999/TTY: 1-877-855-8039 to see if you are eligible for this benefit.

You must make a specific request to continue under the care of your current out-of-network 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. You can request a copy of the LIBERTY's Continuity of Care Policy, at no cost.

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, HEALTH PLAN must provide Premiums to LIBERTY to establish and continue your coverage. Premiums must be paid for the period in which services are received.

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

B. CHANGES TO BENEFITS AND PREMIUMS

L.A. Care Covered Direct or LIBERTY may change the covered benefits, co-payments, and premium rates L.A. Care Covered Direct or LIBERTY will not decrease the covered benefits or increase the premium rates during the term of the agreement without giving you notice at least sixty (60) days before the proposed change.

C. OTHER CHARGES

You are responsible for the premiums and listed co-payments for covered services. You will be responsible for other charges for non-covered or optional services as described in this EOC document.

You should discuss any charges for non-covered or optional services directly with your PCD or specialty dentist. To avoid any financial misunderstandings, make sure your PCD or specialty dentist gives you a written treatment pan of all services proposed or received, whether covered or not.

If you receive services without a require and approved pre-estimate from LIBERTY, other than emergency or urgent care services as medically necessary, you will be responsible for full payment of the PCD's or specialty dentist's usual fee.

IMPORTANT: You will be responsible for additional fees for returned or dishonored checks, cancelled credit card payments, broken, or missed appointments. Charges are as agreed upon mutually by you and your PCD or specialty dentist as per business

arrangements and disclosures made by the treating provider. LIBERTY does not have jurisdiction over internal office policies or business arrangements mutually agreed upon by you and your PCD or specialty dentist.

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-payments, 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 L.A. Care Covered Direct website at **lacare.org** or call L.A. Care Covered Direct 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 s contracted dental PCD, specialty dentist, or authorized dental provider.

D. RESPONSIBILITY 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 design.

You are responsible for the PCD's or specialty dentist's usual fee in the following situations:

- Non-covered and optional services
- Services completed with a non-contracted office, PCD or specialty dentist
- Services completed prior to or without a required approved pre-estimate from LIBERTY
- Services completed outside of LIBERTY's service area that are determined to not qualify as emergency or urgent care services. This can include routine treatment that was not completed to treat an emergency dental situation.

Emergency services are available out-of-network or without a pre-estimate in some situations, see **"Emergency Dental Care"** or "**Urgent Dental Care"** sections above.

IMPORTANT:

- Prior to providing you with non-covered services, your PCD or specialty dentist should provide you with a treatment plan that includes each recommended service and the estimated cost. If you would like more information about dental coverage options, call LIBERTY's Member Services at 888-703-6999/TTY: 1-877-855-8039 .
- If you elect to receive dental services that are not covered services under this plan, the PCD or specialty dentist can charge you the usual fee for those services. Prior to providing a member with dental services that are not a covered benefit, the PCD or specialty dentist should provide you with treatment plan that includes each recommended service and the estimated cost of each service. If you would like more information about dental coverage options, call LIBERTY's Member Services at 888-703-6999/TTY: 1-877-855-8039 or your benefits administrator to fully understand your coverage, you should carefully review this EOC document.
- In the event a child's legal parent or guardian is court ordered to enroll a child in this dental plan, LIBERTY will provide benefits outlined in this EOC within the applicable requirements of the court order. Any claims payable under this EOC will be paid, at LIBERTY's discretion, to the child's legal parent or guardian, for any expenses paid out of pocket.

E. PROVIDER REIMBURSEMENT

LIBERTY provides multiple ways to pay our contracted PCDs and specialty dentists for covered services. This includes capitation, fee-for-service, and supplemental sur-payments. Payments change by geographic area, general dentist, specialty dentist and procedure code. For more information on reimbursement, you can send a written request to LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110.

You will not be held financially responsible for any monies owed to a LIBERTY contracted PCD or specialty dentist. In the event that LIBERTY fails to pay a non-contracted provider, you will be responsible for the cost of services you received.

V. ELIGIBILITY AND ENROLLMENT

A. WHO CAN ENROLL

You and your enrolled eligible dependents must live or work in the LIBERTY's service area.

You can enroll:

- Dependent children up to their nineteenth (19) birthday.
- New dependent children placed with you for adoption, stepchildren, and newborns up until their nineteenth (19) birthday.

B. WHO IS ELIGIBLE FOR BENEFITS

Your dental plan is provided by your QHP and coordinated through LIBERTY. If LIBERTY receives your completed enrollment form payment by the twentieth (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 when you call the dentist for an appointment. We also suggest that you keep this EOC or the Schedule of Benefits (Appendix 1) with you when you go to your appointment. You can then reference benefits, co-payments, out-of-pocket costs, exclusions and limitations, as well as any non-covered treatment.

VI. COVERED SERVICES

You are covered for the following dental services and procedures when medically necessary for your dental health and in accordance with professional dental standards of practice. Covered services are subject to the limitations and exclusions described for each category and for all services.

Please see your Schedule of Benefits (Appendix 1) for a detailed listing of specific covered services and the co-payments applicable to each, and a list of the limitations and exclusions that are applicable to all dental services covered under your LIBERTY dental plan.

A. DIAGNOSTIC DENTAL SERVICES

Diagnostic dental services are those that are used to diagnose your dental condition and help determine what treatment is needed. Diagnostic dental services include oral exams and x-rays.

B. PREVENTIVE DENTAL SERVICES

Preventive dental services are those that are used to maintain good dental condition or to prevent your dental condition from getting worse. Preventive services include cleanings and some periodontal services.

C. RESTORATIVE DENTAL SERVICES

Restorative dental services are those that are used to repair and restore your teeth to a healthy condition. Restorative services include fillings and crowns.

D. ENDODONTIC SERVICES

Endodontic dental services involve treatment of the pulp, canals and roots. Endodontic services include root canal procedures.

E. PERIODONTAL SERVICES

Periodontal dental services involve the treatment and management of the gums and bone supporting the teeth. Periodontal services include periodontal scaling and root planing (deep cleaning).

F. PROSTHODONTIC SERVICES

Prosthodontics dental services involve the replacement of lost teeth by an appliance and the maintenance of those appliances. Prosthodontic services include removable partial and full dentures or fixed bridge.

G. ORAL SURGERY SERVICES

Oral Surgery involve surgical procedures on your teeth, mouth, gums or jaw. Oral surgery dental services include the removal of teeth and other surgical procedures.

H. ADJUNCTIVE DENTAL SERVICES

Adjunctive dental services usually mean any treatment or service that is provided as part of another covered service. Adjunctive dental services include anesthesia (deep sleep or numbing medicine) during approved dental services, mouthguards, and other procedures.

I. ORTHODONTIC SERVICES

Orthodontic dental services involve the straightening teeth and treating an improper bite of the teeth and jaws. Orthodontic dental services include braces and retainers. Orthodontic benefits are only available when medically necessary as outlined in your Schedule of Benefits.

VII. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

See your Schedule of Benefits (Appendix 1) for limitations to covered procedures and exclusions to your plan benefits. Other exclusions are listed in your comprehensive schedule of benefits provided with this document at the beginning of your dental plan, and available upon request, at no cost.

A. GENERAL EXCLUSIONS

LIBERTY will not cover:

- Services you get from a PCD or specialty dentist who is not contracted with LIBERTY, unless you have pre-approval from LIBERTY, or you need emergency or urgent care outside the LIBERTY service area.

- Any dental procedure or service that are not medically necessary, as determined by LIBERTY, in accordance with professionally recognized standards of dental practice.
- Any dental procedure or services that is not specifically listed as a covered benefit under your dental plan. See your Schedule of Benefits (Appendix 1) for a full list of exclusions.
- Any dental procedure or service for cosmetic purposes or for conditions that are a result of hereditary developmental defects.
- Any dental procedure, service, or appliances provided by a dentist who specializes in prosthodontic services.
- Services that are ordered for you by a court, unless they are medically necessary and covered by LIBERTY.
- The cost of copying your dental records with your PCD or specialty dentist
- Expenses for travel, such as taxis and bus fare, to see your PCD, specialty dentist or get dental care.
- Other exclusions are listed in your comprehensive schedule of benefits provided with this document at the beginning of your plan, also available separately, upon request.

- **IMPORTANT:** If you elect receive dental services that are not covered under this plan, a PCD or specialty dentist can charge you the usual fee for those services. Prior to completing any services that are not covered under this plan, the PCD or specialty dentist should provide you with a treatment plan that includes the recommended service to be completed and the estimated cost of each service. If you would like more information about dental coverage options, call LIBERTY's Member Services at (888) 703-6999/TTY: 1-877-855-8039 or speak with your benefits administrator. To fully understand your coverage, carefully review this EOC and your Schedule of Benefits.

B. MISSED APPOINTMENTS

LIBERTY strongly recommends that if you need to cancel or reschedule an appointment with your PCD or specialty dentist, that you notify the dental office as far in advance as possible, but no later than seventy-two (72) hours prior to your appointment. This will allow the PCD or specialty dentist to accommodate another person in need of attention. Dental offices can 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

This is an EPDB plan, and benefits will be terminated once the member(s) reach the age limit for coverage, nineteen (19) years old, as stated in this document.

Your LIBERTY dental plan coverage can be terminated by your Qualified Health Plan (QHP) coverage. If this happens, you will receive notice through your QHP at least thirty (30) calendar days before the change takes effect. Coverage for your dependents will also end, at the same time.

Your LIBERTY dental plan coverage, including coverage for your dependents, can also end if:

- You no longer live or work in the LIBERTY Service Area or if LIBERTY no longer offers Your dental plan.

2. Termination Due to Non-Payment of Premium

- If your 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 your QHP's agreement, your LIBERTY dental plan coverage will end on midnight of the last day of the thirty (30) calendar day grace period, subject to submission of the notice requirements required by LIBERTY. Members are given a grace period of at least thirty (30) consecutive days, beginning on the date specified in the "Notice of Start of Grace Period".

- Coverage will continue under the Plan contract during the grace period. If premiums are not paid, coverage will end after the completion of the grace period followed by a written notice of the cancellation to the subscriber. The written notice will state the reason for the cancellation and the time period when the cancellation became effective.

3. Completion of Treatment In Progress After Termination

- If your dental plan coverage ends while the contract between you and LIBERTY is in effect, your PCD or specialty dentist must complete any procedure in progress that was started before your termination, abiding by the terms and conditions of the Plan.
- If your dental plan coverage ends with LIBERTY after the start of orthodontic treatment, you will be responsible for any charges on any remaining orthodontic treatment.

4. Termination Due to Fraud

- Fraud is not allowed by federal law. Your dental plan coverage will immediately end with LIBERTY, if you plan, commit, or knowingly allow someone to commit fraud or deception.

- Examples of fraud:
  - You allow another person to use your identification card to complete services under this plan.
  - You misrepresent yourself, or your dependents, by providing incomplete or incorrect "material" information to LIBERTY, or your dental provider, that would affect enrollment or for use of dental plan benefits.
  - You intentionally deceive LIBERTY, or you misrepresent yourself or allow someone else to do so in order to get dental care services.

In cases of suspected fraud, you will receive a letter by certified mail at least thirty (30) days prior to the date of termination. The letter will include the reason for the planned termination, and your appeal rights. If you feel that enrollment will be incorrectly canceled, rescinded, or not renewed, a request for a review can be submitted to the Director of the Department of Managed Health Care. Once you have completed the appeal process, your coverage will be terminated immediately and you will receive written notice from LIBERTY.

5. Termination Due to Health Status

- LIBERTY does not terminate based on any health status. If you believe that your coverage has been terminated based on your health status or requirements for health care services, you can request a review from 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 will notify LIBERTY. Within fifteen (15) calendar days after receipt of such notice, LIBERTY will either request a hearing or reinstate the member coverage. The reinstatement will be retroactive to time of cancellation or failure to renew.

- LIBERTY will be responsible for the expenses incurred by the member for covered dental 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 1-888-466-2219 or TDD line at 1-877-688-9891 for the hearing and speech impaired. The Department of Managed Health Care's web site is www.dmhc.ca.gov.

B. EFFECTIVE DATE OF TERMINATION

Coverage can be ended, cancelled, or non-renewed within thirty (30) days following the date of notification of termination, except for fraud or deception as stated above, in which coverage is ended immediately upon notification.

C. DISENROLLMENT

You can disenroll at any time with at least a fourteen (14) calendar days advance notice, by contacting Covered California or Your Qualified Health Plan by phone or in writing.

Disenrollment is effective on the date specified or fourteen (14) calendar days after termination is requested, if reasonable notice is not provided.

D. RESCISSION

Rescission means that LIBERTY can cancel your coverage as if no coverage existed. LIBERTY can only rescind your coverage in the event of fraud or intentional misrepresentation of material facts. You have the right to appeal any decision to rescind your membership. Appeal procedures will be provided to you in the notice of rescission.

If you feel that enrollment will be incorrectly canceled, rescinded, or not renewed, a request for a review can be submitted to the Director of the Department of Managed Health Care. Once you have completed the appeal process, your coverage will be terminated immediately and you will receive written notice from LIBERTY. Except as provided by law, LIBERTY may not rescind your coverage after twenty-four (24) months from the date the dental coverage was issued.

IX. RENEWAL AND REINSTATEMENT OF COVERAGE

Please refer to your L.A Care Covered EOC for information regarding renewal and reinstatement of coverage.

YOUR RIGHT TO SUBMIT A GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NON-RENEWAL OF YOUR PLAN ENROLLEMENT

If you believe your dental plan coverage has been, or will be, incorrectly cancelled, rescinded, or not renewed, you have the right to file a grievance with L.A. Care covered Direct and/or the Department of Managed Health Care.

Option (1) - Submit a grievance to LIBERTY

You can submit a grievance to L.A. Care Covered Direct in any of the following ways:

- Go online to lacare.org and file electronically
- Fax your written grievance to 213.438.5748
- Call our Member Services at 855.270.2327, TTY Health Plan TTY 711
- Mail your written grievance to: LA Care, Member Services Department, 1200 W. 7th Street, Los Angeles, CA 90017.

You may want to submit your grievance to L.A. Care Covered Direct first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible after you receive the "Notice of Cancellation, Rescission, or Nonrenewal".

We will resolve your grievance or provide a pending status within three (3) calendar days of receipt. If you do not receive a response from L.A. Care Covered Direct within three (3) calendar days, or if you are not satisfied in any way with the L.A. Care response, you can submit a grievance to the Department of Managed Health Care as detailed under Option 2, below.

Option (2) - Submit a grievance to the Department of Managed Health Care.

You can submit a grievance directly to the Department of Managed Health Care without first submitting it to L.A. Care Covered Direct or after you have received our decision on your grievance.

- You can submit a grievance to the Department of Managed Health Care online at: www.dmhc.ca.gov
- You can submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, California 95814-2725
- You can contact the Department of Managed Health Care for more information on filing at grievance at:

  Phone: 1-888-466-2219
  TDD: 1-877-688-9891
  Fax: 1-916-255-5241

X. GRIEVANCE AN APPEALS PROCEDURES

If you are dissatisfied with your PCD, specialty dentist, dental office personnel or facilities, specialty referral, pre-estimate, claim, any part of your dental care, LIBERTY, or L.A. Care Covered Direct you have the right to submit a grievance. A grievance is the same as a complaint. You will not be discriminated against in any way by L.A Care Covered, LIBERTY, your PCD, or specialty dentist for filing a grievance.

A. FILING A GRIEVANCE

You can submit your grievance using a Liberty grievance form. Liberty does not require that you use a grievance form; we will investigate a grievance submitted in any format. Grievance forms are available at any of the following:

- From your PCD or specialty dentist office
- In this EOC document under Appendix 2 "FORMS"
- On our website at www.libertydentalplan.com
- Call our Member Services at (888) 703-6999 or TTY: (877) 855-8039

You can submit your grievance and additional materials for consideration to any of the following:

- Online: Liberty's website by visiting www.libertydentalplan.com
- Download our mobile app on your smartphone
- By mail to: Liberty Dental Plan, Grievances and Appeals, P.O. Box 26110, Santa Ana, CA, 92799-6110
- By fax to: Liberty's Grievances and Appeals at (833) 250-1814
- By telephone to: Liberty's Member Services at (888) 703-6999
- By TDD/TTY: (877) 855-8039

You can use a "patient advocate" to help you file a grievance. For grievances involving minors, dependents, or members with a disability who are incapacitated, parents, guardians, conservators, relatives, or other designees with the authority to act on behalf of the member, you can submit a grievance to Liberty. Liberty will request written proof of active guardianship, when necessary.

Urgent matters can be submitted to the Department of Managed Health Care, see "Urgent Grievances and Appeals" below.

If you speak limited English, have visual or other communication issues, Liberty will assist you in filing a grievance. Assistance includes translation of grievance procedures, forms and Liberty's responses. Liberty also provides access to interpreters, telephone relay systems to aid disabled individuals to communicate.

You have one-hundred-eighty (180) calendar days following any incident or action that is the subject of your dissatisfaction to file a grievance with Liberty. Liberty's representatives will review the problem with you and take appropriate steps for a quick resolution. You will receive acknowledgement letter confirming receipt of your grievance within five (5) calendar days. Standard grievances will be resolved within thirty (30) calendar days.

Grievances Exempt from Written Acknowledgement and Response: In some cases, Liberty's Member Services can help resolve grievances received over the telephone within twenty-four (24) hours of receipt, but no later than the close of the next business day.

Grievances resolved by Member Services, within the time frame mentioned above, do not require a written acknowledgement or response. The following categories cannot be resolved by Liberty's Member Services and must addressed through the standard grievance process: coverage disputes, appeals, experimental or investigational treatment, unsanitary office conditions or procedures, potential discrimination, and quality of completed treatment.

B. URGENT (EXPEDITED) GRIEVANCES AND APPEALS

You can request an urgent or expedited review of your grievance or appeal when you feel there could an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life or major bodily function. A Liberty licensed dentist will review your request to determine if you meet the expedited review criteria. Upon review and determination that your case does qualify for expedited review, Liberty will resolve your grievance or appeal within three (3) calendar days of receipt, or sooner, based on your condition.

If your situation meets the definition of urgent under the law, Liberty's review of your grievance or appeal will be conducted as quickly as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you can request an expedited external review by contacting Liberty's Member Services at (888) 703-6999/TTY: (877) 855-8039.

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 (**1-888-703-6999**) **/TTY: 1-877-855-8039** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

STATE OF CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DEPARTMENT) COMPLAINT PROCEDURE

The Department of Managed Health Care has established a toll-free number **(888-466-2219)** and a TDD line **(1-877-688-9891)** that you can utilize should you have a complaint against L.A. Care Health Plan, LIBERTY, or requests for review of cancellations, rescissions and non-renewals under California laws and related rules. Except in cases of emergency dental situations as described below, you must file your grievance with Liberty first; if you are not satisfied with the outcome of your grievance, or you do not receive a written response within thirty (30) calendar days, you can contact the Department of Managed Health Care to file a complaint against Liberty.

Please note: Department of Managed Health Care complaints can only be filed once you have exhausted your grievance rights with Liberty. However, you can immediately file a complaint with the Department of Managed Health Care without having to file a grievance to Liberty first in the event of an emergency dental situation.

C. YOUR RIGHT TO FILE AN APPEAL:

Appeal Resolutions and Responses: An appeal is a request by a member, a provider acting on behalf of a member, or other authorized individual, to review an action by Liberty that delayed, modified, or denied services, in whole or in part. The written appeal responses for services denied based on medical necessity, not a covered benefit, or another criteria, will include clear and easily understood language, the reason, criteria, and dental policies for our decision along with the applicable provision and page numbers from your EOC.

If you are not satisfied with Liberty's determination, you have up to one-hundred-eighty (180) calendar days from the date listed on the notice of determination to file an appeal. An appeal allows you to submit additional information that is relevant to your claim, or pre-estimate, and ask that Liberty review it.

You can include documents, records, or other written information with your appeal. You can also request, free of charge, copies of all documents, records and other information from Liberty that are relevant to your claim. Liberty will review the information that you submit and will reconsider your claim, or pre-estimate. As part of your appeal, you can request from Liberty, the name of any medical expert or other individual that Liberty sought advice from, while reconsidering your claim or pre-estimate.

You can submit your appeal and additional materials for consideration to any of the following:

- Online: Liberty's website by visiting www.libertydentalplan.com
- By mail to: Liberty Dental Plan, Grievances and Appeals, P.O. Box 26110, Santa Ana, CA, 92799-6110
- By fax to: Liberty's Grievances and Appeals at (833) 250-1814
- By telephone to: Liberty's Member Services at (888) 703-6999
- By TDD/TTY: (877) 855-8039

D. MEDIATION

You can also request voluntary mediation with Liberty before exercising your right to submit a grievance to the Department of Managed Health Care. The use of mediation does not preclude your right to submit a grievance to the Department of Managed Health Care 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 equally shared by you and Liberty.

E. INDEPENDENT MEDICAL REVIEW (IMR)

Cases denied by Liberty, for covered services that are found not to be medically necessary, experimental or investigational treatment, or payment disputes for emergency services, may be eligible for the Department of Managed Health Care Independent Medical Review (IMR) program.

IMR is only available for certain medical services. An IMR form will be included with your appeal resolution letter, if your appeal was denied due to medical necessity,

experimental or investigational treatment, or is a payment dispute for emergency services. You can also get a copy of the IMR form in any of the following ways:

- Online at www.libertydentalplan.com, under File a Grievance or Appeal
- In this EOC document under Appendix 2 "FORMS"
- By mail to: Liberty Dental Plan, Grievances and Appeals, P.O. Box 26110, Santa Ana, CA, 92799-6110
- By telephone to: Liberty's Member Services at (888) 703-6999
- By TDD/TTY: (877) 855-8039

You can also request the forms from the Department of Managed Health Care. The Department of Managed Health Care can be reached at 1-888-466-2219, TDD/TTY: 1-877-688-9891 or by visiting their website at: **www.dmhc.ca.gov.** You can read more on the IMR process, under the **California Required Statement** listed on the previous page.

F. ARBITRATION

If you or one of your eligible dependents is not satisfied with the results of Liberty's grievance resolution process, and all the grievance resolution procedures have been exhausted, the matter can be submitted to binding arbitration for resolution. You or one of your eligible dependents can submit a grievance to the Department of Managed Health Care for review and resolution prior to any arbitration.

As a condition of your membership in Liberty, disputes arising from or relating to your participation as a Liberty member, including contract or medical liability or malpractice (for example, whether any covered services rendered were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered) will be settled by binding arbitration.

Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

The arbitration will be conducted according to the commercial rules of the American Arbitration Association (AAA) in force at the time of the occurrence of the grievance (dispute or controversy) and subject California laws and related codes.

Arbitration will be conducted by a mutually acceptable arbitrator selected by the parties, or if the parties are unable to agree, by the arbitrator selection process established by AAA.

You can initiate arbitration by submitting a written request for arbitration to Liberty.

- Mail to:
    - Liberty Dental Plan
    - Attn: Arbitration Request
    - P.O. Box 26110
    - Santa Ana, CA 92799-6110

The written request must include a clear statement describing the nature of the dispute, attempts to resolve the dispute with Liberty, the relief or remedy sought, and the dollar amount involved. The arbitration will take place in California, unless some other location is mutually agreed upon by the parties.

The arbitrator is required to follow applicable state or federal law. The arbitrator can interpret the terms of this EOC but will not have the power to change, modify, or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. The arbitrator will have the power to grant all legal and equitable remedies and award compensatory damages provided by California law, except that punitive damages will not be awarded. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award, setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

You must pay your own attorney's fees, should you choose to have an attorney. Liberty will have to pay its own attorney's fees. If you cannot pay your part of the arbitrator's fees and expenses due to extreme hardship, you can ask Liberty in writing to assume all or a portion of your share of the fees. Upon such written notice, Liberty can send your request to an independent professional dispute resolution organization to make a determination as to whether Liberty should pay for some or all of your share of the arbitrator's fees and expenses. Such requests should be submitted to the address provided above.

Arbitration must be initiated within one (1) year of the earlier of the date the dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, it will be deemed waived and forever barred.

XI. MISCELLANEOUS PROVISIONS

A. COORDINATION OF BENEFITS

As a Liberty member, you will always receive your benefits. Liberty does not consider your plan secondary to any other coverage you may have. You have the right to receive

benefits as listed in this EOC document despite any additional coverage you may have. 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 group 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. PUBLIC POLICY COMMITTEE

LIBERTY has a group called the Public Policy Committee. This group is made up of members, support staff and our Dental Director. The group talks about Liberty policies and is responsible for:

- Recommending ways to better serve our members
- Reviewing quality metrics to ensure member satisfaction
- Suggesting improvements to Liberty's programs
- Reviewing Liberty's financial reports

Joining this group is voluntary and you will be paid for each meeting you attend. If you would like to take part in Liberty's Public Policy Committee, please call or emails us or you can complete the Public Policy Committee Application included in Appendix 2 "FORMS" and return it to Liberty, information listed below.

- Mail to:
  Liberty Dental Plan of California
  Public Policy Committee (QM Department)
  P.O. Box 26110
  Santa Ana, CA 92799-6110
- Call: (888) 703-6999 or TTY (888) 855-8039
- Fax to: (888) 334-6027
- Email to: QM@libertydentalplan.com

D. CONFIDENTAL COMMUNICATIONS

California law states that you can ask for confidential communications regarding the receipt of sensitive services. These types of services can include:

- Bills and attempts to collect payment

- A Notice of Adverse Benefit Determination(s)
- An Explanation of Benefit notice(s)
- A Plan's request for additional information regarding a claim
- A notice of a contested claim
- The name and address of a provider, description of services received, and other information related to a visit.
- Any verbal, written or electronic communications from the Plan that contain protected health information.

To request confidential communications from LIBERTY for any of the services listed about, please call Member Services or you can submit a request in writing by mail or fax to any of the following:

- Online: Liberty's website by visiting www.libertydentalplan.com
- Download our mobile app on your smartphone
- By mail to: LIberty Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110
- By fax to: (949) 270-0101
- By telephone to: Liberty's Member Services at (888) 703-6999
- By TDD/TTY: (877) 855-8039

E. NOTICE OF NON-DISCRIMINATION

- Discrimination is against the law. Liberty Dental Plan (Liberty) follows State and Federal civil rights laws. Liberty does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

LIBERTY provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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, please contact us between 8:00 a.m. to 5:00 p.m. (PST) by calling (888) 703-6999. Or, if you cannot hear or speak well, please call (877) 855-8039.

HOW TO FILE A GRIEVANCE

If you believe that Liberty has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Liberty's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Call Liberty's Civil Rights Coordinator, Monday through Friday, 8:00 a.m. to 5:00 p.m. (PST) by calling 888-704-9833. Or if you cannot hear or speak well, please call (877) 855-8039.
- In writing: Fill out a complaint form or write a letter and send it to:
- Liberty Dental Plan, Civil Rights Coordinator, P.O. Box 26110,Santa Ana, CA 92799-6110
- In person: Visit your doctor's office or Liberty and say you want to file a grievance.
- Electronically: Visit Liberty's website at https://www.libertydentalplan.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:
- **Michele Villados**
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
- **P.O. Box 997413, MS 0009**
- **Sacramento, CA 95899-7413**
- Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**
- If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**
- In writing: Fill out a complaint form or send a letter to:
- **U.S. Department of Health and Human Services**
- **200 Independence Avenue,**
- **S.W. Room 509F, HHH Building**
- **Washington, D.C. 20201**
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

F. MEMBER RIGHTS

As a member, you have the right to:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including covered services.
- To be able to choose a PCD within LIBERTY's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment.

- To voice grievances, either verbally or in writing, about LIBERTY, or any part of your care.
- To receive care coordination.
- To request an appeal of decisions to deny, delay, or modify services or benefits.
- To receive oral interpretation services in your primary spoken language.
- To formulate advance directives.
- To disenroll upon request.
- To access minor consent services.
- To receive written member-informing materials in alternative formats, upon request, (such as braille, large-size print and audio format) and in a timely fashion based on the format being requested and in accordance with California laws.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, in accordance with federal laws.
- Freedom to exercise these rights without adversely affecting how you are treated by LIBERTY, your providers, or the state.

G. MEMBER RESPONSIBILITIES

As a member, you have the responsibility to:

- Pay your coverage premium on time
- Identify yourself to your selected PCD as a LIBERTY member
- Treat the PCD, office staff, and LIBERTY staff with respect and courtesy
- Keep your scheduled appointments, or contact the dental office at least seventy-two (72) hours in advance to cancel an appointment
- Cooperate with the PCD in following a prescribed course of treatment
- Make your co-payments at the time of service
- Notify your PCD of your personal language needs
- Notify Liberty of changes in your family status
- Be aware of and follow the organization's guidelines in seeking dental care
- Have treatment completed with your assigned PCD
- Follow all of the dental office's rules about care and conduct
- Follow the referral process for specialty care
- Give your PCD, to the best of your knowledge, correct information about your physical and dental health
- Tell your PCD if you have any sudden changes to your physical and dental health

- Tell your PCD or specialty dentist that you understand the treatment plan and what is of you required of you
- Staying with the treatment plan, that you understood and agreed to, with your PCD or specialty dentist
- Your own actions, if you refuse treatment, or do not follow your PCD's or specialty dentist's treatment plan, instructions and advice
- Understanding your dental benefits, including what is and is not covered under your plan design.

H. 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 PCD who submits claims or encounters on your behalf.

Services provided by a specialty dentist are reported to LIBERTY by the specialty dentist. 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 ("**Reimbursement for Emergency Dental Services**").

I. ORGAN DONATION

Liberty is required by the Department of Managed Health Care 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 can lead to the option to do so. You can find more information about organ donation at http://donatelife.net/

J. 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. Services can only be denied for medical necessity, by an appropriately licensed and qualified dentist, working within LIBERTY's written clinical criteria and guidelines. Individual member needs, as well as the characteristics of the local delivery system, as taking into full consideration during the review process. LIBERTY does not reward our dental reviewers for issuing denials for coverage, care, or provide incentives that would encourage barriers to care/services or decisions that result in underutilization.

LIBERTY's Utilization Management Department staff annually signs an attestation that review decisions were made based solely on appropriateness of care and services and existence of coverage.

K. COMPLIANCE PLAN

A. COMPLIANCE PLAN OBJECTIVE

- LIBERTY is dedicated to ensuring that it complies with all applicable federal and state laws, rules, regulations and procedures, including Health Insurance Marketplace requirements, in a timely and effective manner. All LIBERTY board members, officers, employees, contractors, providers and members are expected to meet these various legal requirements.

  For these reasons, LIBERTY has developed and instituted a Corporate Compliance Plan. The Corporate Compliance Plan is designed to ensure LIBERTY fulfills all statutory and contractual obligations in a fair, accurate and consistent manner.

  The Corporate Compliance Plan not only addresses health care fraud, waste and abuse, but the requirements and obligations set forth by the Centers for Medicare and Medicaid (CMS), employment, whistleblower and insurance laws.

  LIBERTY's policies and procedures for preserving the confidentiality of medical and dental records are available upon request.

B. DEFINITIONS

- **Fraud** – includes, but is not limited to, "knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit." Fraud also includes fraud or misrepresentation by a member with respect to coverage of individuals and fraud or deception in the use of the services or facilities of LIBERTY or knowingly permitting such fraud or deception by another.
- **Waste** – means the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls. Waste does not normally lead to an allegation of "fraud", but it could.
- **Abuse** – means the excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use so to abuse one's position or authority. "Abuse" does not necessarily lead to an allegation of "fraud", but it could.

C. POLICY

It is the policy of LIBERTY to review and investigate all allegations of fraud, waste, and abuse, whether internal or external, to take corrective action for any supported allegation and to report confirmed misconduct to the appropriate parties both internal and external.

D. REPORTING POSSIBLE FRAUD

Liberty has established a specific fraud hotline number: (888) 704-9833/TTY: (877) 855-8039. 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's Quality Management team for full investigation.

- Liberty's Corporate Compliance Hotline: (888) 704-9833/TTY (877) 855-8039
- Liberty's Compliance Unit email: compliance@libertydentalplan.com
- Liberty's Special Investigations Unit Hotline: (888) 704-9833
- Liberty's Special Investigations Unit email: SIU@libertydentalplan.com

The Chairman of the Committee and the Chief Compliance Officer, in conjunction with Legal Counsel, determine whether Liberty will take any additional action, which can 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
- 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.

LIBERTY Dental Plan of California, Inc.
P.O. Box 26110
Santa Ana, CA 92799-6110
(888) 703-6999

Appendix 1:

SCHEDULE OF BENEFITS
COVERED SERVICES

Insert LIBERTY Dental Plan Family Dental HMO Schedule of Benefits

Your plan-specific Schedule of Benefits is provided in a separate document.

Appendix 2:
FORMS
G&A Form
IMR Form
Public Policy Form

Appendix 3:
PREMIUM, PRE-PAYMENT FEES
AND CHARGES

Your Group's Premium and various other Fees and Charges are provided to the Group sponsor

Appendix 4:
Insert NOTICE OF LANGUAGE ASSISTANCE SERVICES

LIBERTY Dental Plan of California, Inc.

Children's Dental HMO – L.A. Care Covered Direct Minimum Coverage

Individual Deductible: $9,200 per 2025 Calendar Year - Individual Out of Pocket Maximum: 9,200 per 2025 Calendar Year

Family Deductible: $18,400 per 2025 Calendar Year - Family Out of Pocket Maximum: $18,200 per 2025 Calendar Year

✓ Members must visit 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 medically 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 L.A. Care Covered Direct. 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.lacare.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 combinin g eligible expenses of two or more covered family Members.

✓ As part of your health plan benefit, this dental plan shares the Health Plan's Calendar Year Deductible. Dental benefits are covered at 100% by the plan after you meet the Calendar Year Deductible and Calendar Year Out-of-Pocket Ma

CDT Code	Description	Patient Responsibility	Limitation
	Diagnostic Services		
D0120	Periodic oral evaluation	covered at 100%	1 (D0120) every 6 months per provider
D0140	Limited oral evaluation	covered at 100%	1 (D0140) per patient per provider
D0145	Oral evaluation under age 3	covered at 100%	
D0150	Comprehensive oral evaluation	covered at 100%	1 (D0150) per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	covered at 100%	1 (D0160) per patient per provider
D0170	Re-evaluation, limited, problem focused	covered at 100%	up to 6 of (D0170, D0171) in a 3 month period, no more than 12 in 12 months
D0171	Re-evaluation, post operative office visit	covered at 100%	
D0180	Comprehensive periodontal evaluation	covered at 100%	only be billed as D0150
D0190	Screening of a patient	not covered	
D0191	Assessment of a patient	not covered	
D0210	Intraoral, comprehensive series of radiographic images	covered at 100%	1 of (D0210, D0709) every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	covered at 100%	20 of (D0220, D0230, D0707) 12 months, per provider
D0230	Intraoral, periapical, each add 'l radiographic image	covered at 100%	
D0240	Intraoral, occlusal radiographic image	covered at 100%	2 of (D0240, D0706) every 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	covered at 100%	1 (D0250) per date of service
D0251	Extra-oral posterior dental radiographic image	covered at 100%	1 of (D0251, D0705) per date of service
D0270	Bitewing, single radiographic image	covered at 100%	1 of (D0270, D0708) per date of service
D0272	Bitewings, two radiographic images	covered at 100%	1 (D0272) every 6 months per provider
D0273	Bitewings, three radiographic images	covered at 100%	downcode to D0270 and D0272
D0274	Bitewings, four radiographic images	covered at 100%	1 (D0274) every 6 months per provider, age 10 and over
D0277	Vertical bitewings, 7 to 8 radiographic images	covered at 100%	downcode to D0274
D0310	Sialography	covered at 100%	
D0320	TMJ arthrogram, including injection	covered at 100%	3 (D0320) per date of service
D0322	Tomographic survey	covered at 100%	2 (D0322) every 12 months per provider
D0330	Panoramic radiographic image	covered at 100%	1 of (D0330, D0701) every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	covered at 100%	2 of (D0340, D0702) every 12 months per provider
D0350	2D oral/facial photographic image, intra-orally/extra-orally	covered at 100%	4 of (D0350, D0703) per date of service
D0396	3D printing of a 3D dental surface scan	covered at 100%	
D0419	Assessment of salivary flow by measurement	not covered	
D0431	Adjunctive pre-diagnostic test	not covered	
D0460	Pulp vitality tests	covered at 100%	
D0470	Diagnostic casts	covered at 100%	1 (D0470) per provider, only a benefit with covered Orthodontic services, for permanent dentition
D0502	Other oral pathology procedures, by report	covered at 100%	
D0601	Caries risk assessment and documentation, low risk	covered at 100%	
D0602	Caries risk assessment and documentation, moderate risk	covered at 100%	
D0603	Caries risk assessment and documentation, high risk	covered at 100%	
D0701	Panoramic radiographic image, image capture only	covered at 100%	1 of (D0330, D0701) every 36 months per provider
D0702	2-D cephalometric radiographic image, image capture only	covered at 100%	2 of (D0340, D0702) every 12 months per provider
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	covered at 100%	4 of (D0350, D0703) per date of service
D0705	Extra-oral posterior dental radiographic image, image capture only	covered at 100%	1 of (D0251, D0705) per date of service
D0706	Intraoral, occlusal radiographic image, image capture only	covered at 100%	2 of (D0240, D0706) every 6 months per provider

D0707	Intraoral, periapical radiographic image, image capture only	covered at 100%	20 of (D0220, D0230, D0707) every 12 months, per provider
D0708	Intraoral, bitewing radiographic image, image capture only	covered at 100%	1 of (D0270, D0708) per date of service

LIBERTY Dental Plan of California, Inc.
Children's Dental HMO – L.A. Care Covered Direct Minimum Coverage

CDT Code	Description	Patient Responsibility	Limitation
	Diagnostic Services (continued)		
D0709	Intraoral, comprehensive series of radiographic images, image capture only	covered at 100%	1 of (D0210, D0709) every 36 months per provider
D0801	3D dental surface scan, direct	covered at 100%	
D0802	3D dental surface scan, indirect	covered at 100%	
D0803	3D facial surface scan, direct	covered at 100%	
D0804	3D facial surface scan, indirect	covered at 100%	
D0999	Unspecified diagnostic procedure, by report	covered at 100%	
	Preventive Services		
D1110	Prophylaxis, adult	covered at 100%	1 of (D1110, D1120, D4346) every 6 months
D1120	Prophylaxis, child	covered at 100%	
D1206	Topical application of fluoride varnish	covered at 100%	1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	covered at 100%	
D1310	Nutritional counseling for control of dental disease	covered at 100%	
D1320	Tobacco counseling, control/prevention oral disease	covered at 100%	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	covered at 100%	
D1330	Oral hygiene instruction	covered at 100%	
D1351	Sealant, per tooth	covered at 100%	1 of (D1351,D1352) every 36 months 1st, 2nd, 3rd molars
D1352	Preventive resin restoration, permanent tooth	covered at 100%	
D1353	Sealant repair, per tooth	covered at 100%	1 (D1353) every 36 months 1st, 2nd, 3rd molars
D1354	Application of caries arresting medicament application, per tooth	covered at 100%	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first treatment only
D1355	Caries preventive medicament, per tooth	covered at 100%	1 (D1355) per tooth every 6 months, subject to medical necessity review for the first treatment only
D1510	Space maintainer, fixed, unilateral, per quadrant	covered at 100%	1 of (D1510, D1520) per quadrant per patient, under age 18
D1516	Space maintainer, fixed, bilateral, maxillary	covered at 100%	1 of (D1516, D1526) under age 18
D1517	Space maintainer, fixed, bilateral, mandibular	covered at 100%	1 of (D1517, D1527) under age 18
D1520	Space maintainer, removable, unilateral, per quadrant	covered at 100%	1 of (D1510, D1520) per quadrant per patient under age 18
D1526	Space maintainer, removable, bilateral, maxillary	covered at 100%	1 of (D1516, D1526) under age 18
D1527	Space maintainer, removable, bilateral, mandibular	covered at 100%	1 of (D1517, D1527) under age 18
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	covered at 100%	1 (D1551) every 12 months under age 18
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	covered at 100%	1 (D1552) every 12 months under age 18
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	covered at 100%	1 (D1553) per quad every 12 months under age 18
D1556	Removal of fixed unilateral space maintainer, per quadrant	covered at 100%	
D1557	Removal of fixed bilateral space maintainer, maxillary	covered at 100%	
D1558	Removal of fixed bilateral space maintainer, mandibular	covered at 100%	
D1575	Distal shoe space maintainer, fixed, per quadrant	covered at 100%	
	Restorative Services		
D2140	Amalgam, one surface, primary or permanent	covered at 100% after the deductible is met	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	covered at 100% after the deductible is met	
D2160	Amalgam, three surfaces, primary or permanent	covered at 100% after the deductible is met	
D2161	Amalgam, four or more surfaces, primary or permanent	covered at 100% after the deductible is met	
D2330	Resin-based composite, one surface, anterior	covered at 100% after the deductible is met	
D2331	Resin-based composite, two surfaces, anterior	covered at 100% after the deductible is met	
D2332	Resin-based composite, three surfaces, anterior	covered at 100% after the deductible is met	
D2335	Resin-based composite, four or more surfaces	covered at 100% after the deductible is met	
D2390	Resin-based composite crown, anterior	covered at 100% after the deductible is met	primary teeth - 1 (D2390) per tooth every 12 months permanent teeth - 1 (D2390) per tooth every 36 months
D2391	Resin-based composite, one surface, posterior	covered at 100% after the deductible is met	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	covered at 100% after the deductible is met	
D2393	Resin-based composite, three surfaces, posterior	covered at 100% after the deductible is met	
D2394	Resin-based composite, four or more surfaces, posterior	covered at 100% after the deductible is met	
D2542	Onlay, metallic, two surfaces	not covered	
D2543	Onlay, metallic, three surfaces	not covered	
D2544	Onlay, metallic, four or more surfaces	not covered	
D2642	Onlay, porcelain/ceramic, two surfaces	not covered	
D2643	Onlay, porcelain/ceramic, three surfaces	not covered	
D2644	Onlay, porcelain/ceramic, four or more surfaces	not covered	
D2662	Onlay, resin-based composite, two surfaces	not covered	

CDT Code	Description	Patient Responsibility	Limitation
D2663	Onlay, resin-based composite, three surfaces	not covered	
D2664	Onlay, resin-based composite, four or more surfaces	not covered	

LIBERTY Dental Plan of California, Inc.

Children's Dental HMO – L.A. Care Covered Direct Minimum Coverage

CDT Code	Description	Patient Responsibility	Limitation
	Restorative Services (continued)		
D2710	Crown, resin-based composite (indirect)	covered at 100% after the deductible is met	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D2712	Crown, ¾ resin-based composite (indirect)	covered at 100% after the deductible is met	
D2720	Crown, resin with high noble metal	not covered	
D2721	Crown, resin with predominantly base metal	covered at 100% after the deductible is met	
D2722	Crown, resin with noble metal	not covered	
D2740	Crown, porcelain/ceramic	covered at 100% after the deductible is met	
D2750	Crown, porcelain fused to high noble metal	not covered	
D2751	Crown, porcelain fused to predominantly base metal	covered at 100% after the deductible is met	
D2752	Crown, porcelain fused to noble metal	not covered	
D2753	Crown, porcelain fused to titanium and titanium alloys	not covered	
D2780	Crown, ¾ cast high noble metal	not covered	
D2781	Crown, ¾ cast predominantly base metal	covered at 100% after the deductible is met	
D2782	Crown, ¾ cast noble metal	not covered	
D2783	Crown, ¾ porcelain/ceramic	covered at 100% after the deductible is met	
D2790	Crown, full cast high noble metal	not covered	
D2791	Crown, full cast predominantly base metal	covered at 100% after the deductible is met	
D2792	Crown, full cast noble metal	not covered	
D2794	Crown, titanium and titanium alloys	not covered	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	covered at 100% after the deductible is met	1 (D2910) per tooth every 12 months, per provider
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	covered at 100% after the deductible is met	
D2920	Re-cement or re-bond crown	covered at 100% after the deductible is met	after 12 months of initial placement with same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp	covered at 100% after the deductible is met	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	covered at 100% after the deductible is met	1 of (D2928, D2931) per tooth every 36 months
D2929	Prefabricated porcelain/ceramic crown, primary tooth	covered at 100% after the deductible is met	1 of (D2929, D2930) per tooth every 12 months
D2930	Prefabricated stainless steel crown, primary tooth	covered at 100% after the deductible is met	
D2931	Prefabricated stainless steel crown, permanent tooth	covered at 100% after the deductible is met	1 of (D2928, D2931) per tooth every 36 months
D2932	Prefabricated resin crown	covered at 100% after the deductible is met	primary - 1 of (D2932, D2933) per tooth every 12 months
D2933	Prefabricated stainless steel crown with resin window	covered at 100% after the deductible is met	permanent - 1 of (D2932, D2933) per tooth every 36 months
D2940	Protective restoration	covered at 100% after the deductible is met	1 (D2940) per tooth every 6 months, per provider
D2941	Interim therapeutic restoration, primary dentition	covered at 100% after the deductible is met	
D2949	Restorative foundation for an indirect restoration	covered at 100% after the deductible is met	
D2950	Core buildup, including any pins when required	covered at 100% after the deductible is met	
D2951	Pin retention, per tooth, in addition to restoration	covered at 100% after the deductible is met	1 (D2951) per tooth
D2952	Post and core in addition to crown, indirectly fabricated	covered at 100% after the deductible is met	1 (D2952) per tooth
D2953	Each additional indirectly fabricated post, same tooth	covered at 100% after the deductible is met	
D2954	Prefabricated post and core in addition to crown	covered at 100% after the deductible is met	1 (D2954) per tooth
D2955	Post removal	covered at 100% after the deductible is met	
D2957	Each additional prefabricated post, same tooth	covered at 100% after the deductible is met	
D2971	Additional procedure to customize new crown, existing partial denture frame	covered at 100% after the deductible is met	
D2976	Band stabilization, per tooth	covered at 100% after the deductible is met	
D2980	Crown repair necessitated by restorative material failure	covered at 100% after the deductible is met	after 12 months of initial crown placement with same provider
D2989	Excavation of a tooth resulting in the determination of non-restorability	covered at 100% after the deductible is met	
D2991	Application of hydroxyapatite regeneration medicament, per tooth	covered at 100% after the deductible is met	
D2999	Unspecified restorative procedure, by report	covered at 100% after the deductible is met	
	Endodontic Services		
D3110	Pulp cap, direct (excluding final restoration)	covered at 100% after the deductible is met	
D3120	Pulp cap, indirect (excluding final restoration)	covered at 100% after the deductible is met	
D3220	Therapeutic pulpotomy (excluding final restoration)	covered at 100% after the deductible is met	1 (D3220) per primary tooth
D3221	Pulpal debridement, primary and permanent teeth	covered at 100% after the deductible is met	1 (D3221) per tooth
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	covered at 100% after the deductible is met	1 (D3222) per tooth
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	covered at 100% after the deductible is met	1 of (D3230, D3240) per tooth
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	covered at 100% after the deductible is met	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	covered at 100% after the deductible is met	1 of (D3310, D3320, D3330) per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	covered at 100% after the deductible is met	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	covered at 100% after the deductible is met	
D3331	Treatment of root canal obstruction; non-surgical access	covered at 100% after the deductible is met	
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	not covered	
D3333	Internal root repair of perforation defects	covered at 100% after the deductible is met	

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CDT Code	Description	Patient Responsibility	Limitation
D3346	Retreatment of previous root canal therapy, anterior	covered at 100% after the deductible is met	1 of (D3346-D3348) after 12 months of initial treatment
D3347	Retreatment of previous root canal therapy, premolar	covered at 100% after the deductible is met	
D3348	Retreatment of previous root canal therapy, molar	covered at 100% after the deductible is met	
D3351	Apexification/recalcification, initial visit	covered at 100% after the deductible is met	1 (D3351) per tooth
	Endodontic Services (continued)		
D3352	Apexification/recalcification, interim medication replacement	covered at 100% after the deductible is met	1 (D3352) per tooth
D3353	Apexification/recalcification, final visit	not covered	
D3410	Apicoectomy, anterior	covered at 100% after the deductible is met	
D3421	Apicoectomy, premolar (first root)	covered at 100% after the deductible is met	
D3425	Apicoectomy, molar (first root)	covered at 100% after the deductible is met	
D3426	Apicoectomy, (each additional root)	covered at 100% after the deductible is met	
D3428	Bone graft in conjunction with periradicular surgery, per tooth, single site	covered at 100% after the deductible is met	
D3429	Bone graft in conjunction with periradicular surgery, each add'l tooth, same site	covered at 100% after the deductible is met	
D3430	Retrograde filling, per root	covered at 100% after the deductible is met	
D3431	Biologic materials, soft osseous tissue regeneration with periradicular surgery	covered at 100% after the deductible is met	
D3432	Guided tissue regeneration, per site, with periradicular surgery	not covered	
D3450	Root amputation, per root	not covered	
D3471	Surgical repair of root resorption, anterior	covered at 100% after the deductible is met	
D3472	Surgical repair of root resorption, premolar	covered at 100% after the deductible is met	
D3473	Surgical repair of root resorption, molar	covered at 100% after the deductible is met	
D3910	Surgical procedure for isolation of tooth with rubber dam	covered at 100% after the deductible is met	
D3920	Hemisection, not including root canal therapy	not covered	
D3950	Canal preparation and fitting of preformed dowel or post	not covered	
D3999	Unspecified endodontic procedure, by report	covered at 100% after the deductible is met	
	Periodontal Services		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	covered at 100% after the deductible is met	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	covered at 100% after the deductible is met	
D4240	Gingival flap procedure, four or more teeth per quadrant	not covered	
D4241	Gingival flap procedure, one to three teeth per quadrant	not covered	
D4249	Clinical crown lengthening, hard tissue	covered at 100% after the deductible is met	
D4260	Osseous surgery, four or more teeth per quadrant	covered at 100% after the deductible is met	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	covered at 100% after the deductible is met	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	not covered	
D4264	Bone replacement graft, retained natural tooth, each additional site	not covered	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	covered at 100% after the deductible is met	
D4266	Guided tissue regeneration, natural teeth, resorbable barrier, per site	not covered	
D4267	Guided tissue regeneration, natural teeth, non-resorbable barrier, per site	not covered	
D4270	Pedicle soft tissue graft procedure	not covered	
D4273	Autogenous connective tissue graft procedure, first tooth	not covered	
D4275	Non-autogenous connective tissue graft, first tooth	not covered	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4286	Removal of non-resorbable barrier	not covered	
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	covered at 100% after the deductible is met	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	covered at 100% after the deductible is met	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	covered at 100% after the deductible is met	1 of (D1110, D1120, D4346) every 6 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	covered at 100% after the deductible is met	
D4381	Localized delivery of antimicrobial agent/per tooth	covered at 100% after the deductible is met	
D4910	Periodontal maintenance	covered at 100% after the deductible is met	1 (D4910) every 3 months
D4920	Unscheduled dressing change (other than treating dentist or staff)	covered at 100% after the deductible is met	1 (D4920) per patient per provider, age 13 and over
D4999	Unspecified periodontal procedure, by report	covered at 100% after the deductible is met	
	Removable Prosthodontic Services		
D5110	Complete denture, maxillary	covered at 100% after the deductible is met	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 - complete denture.
D5120	Complete denture, mandibular	covered at 100% after the deductible is met	
D5130	Immediate denture, maxillary	covered at 100% after the deductible is met	1 (D5130) 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.

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CDT Code	Description	Patient Responsibility	Limitation
D5140	Immediate denture, mandibular	covered at 100% after the deductible is met	1 (D5140) 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.
D5211	Maxillary partial denture, resin base	covered at 100% after the deductible is met	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 - complete denture.
D5212	Mandibular partial denture, resin base	covered at 100% after the deductible is met	
D5213	Maxillary partial denture, cast metal, resin base	covered at 100% after the deductible is met	
D5214	Mandibular partial denture, cast metal, resin base	covered at 100% after the deductible is met	
	Removable Prosthodontic Services (continued)		
D5221	Immediate maxillary partial denture, resin base	covered at 100% after the deductible is met	1 of (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	covered at 100% after the deductible is met	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	covered at 100% after the deductible is met	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	covered at 100% after the deductible is met	
D5225	Maxillary partial denture, flexible base	not covered	
D5226	Mandibular partial denture, flexible base	not covered	
D5227	Immediate maxillary partial denture, flexible base	not covered	
D5228	Immediate mandibular partial denture, flexible base	not covered	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	not covered	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	not covered	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	not covered	
D5286	Removable unilateral partial denture, one piece resin, per quadrant	not covered	
D5410	Adjust complete denture, maxillary	covered at 100% after the deductible is met	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider
D5411	Adjust complete denture, mandibular	covered at 100% after the deductible is met	
D5421	Adjust partial denture, maxillary	covered at 100% after the deductible is met	
D5422	Adjust partial denture, mandibular	covered at 100% after the deductible is met	
D5511	Repair broken complete denture base, mandibular	covered at 100% after the deductible is met	1 (D5511) per date of service per provider, 2 every 12 months per provider
D5512	Repair broken complete denture base, maxillary	covered at 100% after the deductible is met	1 (D5512) per date of service per provider, 2 every 12 months per provider
D5520	Replace missing or broken teeth, complete denture	covered at 100% after the deductible is met	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider
D5611	Repair resin partial denture base, mandibular	covered at 100% after the deductible is met	1 (D5611) per date of service per provider, 2 every 12 months per provider
D5612	Repair resin partial denture base, maxillary	covered at 100% after the deductible is met	1 (D5612) per date of service per provider, 2 every 12 months per provider
D5621	Repair cast partial framework, mandibular	covered at 100% after the deductible is met	1 (D5621) per date of service per provider, 2 every 12 months per provider
D5622	Repair cast partial framework, maxillary	covered at 100% after the deductible is met	1 (D5622) per date of service per provider, 2 every 12 months per provider
D5630	Repair or replace broken retentive clasping materials, per tooth	covered at 100% after the deductible is met	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider
D5640	Replace broken teeth, per tooth	covered at 100% after the deductible is met	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider
D5650	Add tooth to existing partial denture	covered at 100% after the deductible is met	3 (D5650) per arch per provider per date of service, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	covered at 100% after the deductible is met	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	not covered	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	not covered	
D5710	Rebase complete maxillary denture	not covered	
D5711	Rebase complete mandibular denture	not covered	
D5720	Rebase maxillary partial denture	not covered	
D5721	Rebase mandibular partial denture	not covered	
D5730	Reline complete maxillary denture, direct	covered at 100% after the deductible is met	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, direct	covered at 100% after the deductible is met	
D5740	Reline maxillary partial denture, direct	covered at 100% after the deductible is met	
D5741	Reline mandibular partial denture, direct	covered at 100% after the deductible is met	
D5750	Reline complete maxillary denture, indirect	covered at 100% after the deductible is met	
D5751	Reline complete mandibular denture, indirect	covered at 100% after the deductible is met	
D5760	Reline maxillary partial denture, indirect	covered at 100% after the deductible is met	
D5761	Reline mandibular partial denture, indirect	covered at 100% after the deductible is met	
D5850	Tissue conditioning, maxillary	covered at 100% after the deductible is met	2 (D5850) every 36 months
D5851	Tissue conditioning, mandibular	covered at 100% after the deductible is met	2 (D5851) every 36 months
D5862	Precision attachment, by report	covered at 100% after the deductible is met	
D5863	Overdenture, complete, maxillary	covered at 100% after the deductible is met	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 - complete denture.
D5864	Overdenture, partial, maxillary	covered at 100% after the deductible is met	
D5865	Overdenture, complete, mandibular	covered at 100% after the deductible is met	
D5866	Overdenture, partial, mandibular	covered at 100% after the deductible is met	
D5876	Add metal substructure to acrylic full denture (per arch)	not covered	
D5899	Unspecified removable prosthodontic procedure, by report	covered at 100% after the deductible is met	
	Maxillofacial Prosthetic Services		
D5911	Facial moulage (sectional)	covered at 100% after the deductible is met	

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CDT Code	Description	Patient Responsibility	Limitation
D5912	Facial moulage (complete)	covered at 100% after the deductible is met	
D5913	Nasal prosthesis	covered at 100% after the deductible is met	
D5914	Auricular prosthesis	covered at 100% after the deductible is met	
D5915	Orbital prosthesis	covered at 100% after the deductible is met	
D5916	Ocular prosthesis	covered at 100% after the deductible is met	
D5919	Facial prosthesis	covered at 100% after the deductible is met	
D5922	Nasal septal prosthesis	covered at 100% after the deductible is met	
	Maxillofacial Prosthetic Services (continued)		
D5923	Ocular prosthesis, interim	covered at 100% after the deductible is met	
D5924	Cranial prosthesis	covered at 100% after the deductible is met	
D5925	Facial augmentation implant prosthesis	covered at 100% after the deductible is met	
D5926	Nasal prosthesis, replacement	covered at 100% after the deductible is met	
D5927	Auricular prosthesis, replacement	covered at 100% after the deductible is met	
D5928	Orbital prosthesis, replacement	covered at 100% after the deductible is met	
D5929	Facial prosthesis, replacement	covered at 100% after the deductible is met	
D5931	Obturator prosthesis, surgical	covered at 100% after the deductible is met	
D5932	Obturator prosthesis, definitive	covered at 100% after the deductible is met	
D5933	Obturator prosthesis, modification	covered at 100% after the deductible is met	2 (D5933) every 12 months
D5934	Mandibular resection prosthesis with guide flange	covered at 100% after the deductible is met	
D5935	Mandibular resection prosthesis without guide flange	covered at 100% after the deductible is met	
D5936	Obturator prosthesis, interim	covered at 100% after the deductible is met	
D5937	Trismus appliance (not for TMD treatment)	covered at 100% after the deductible is met	
D5951	Feeding aid	covered at 100% after the deductible is met	under age 18
D5952	Speech aid prosthesis, pediatric	covered at 100% after the deductible is met	under age 18
D5953	Speech aid prosthesis, adult	covered at 100% after the deductible is met	age 18 and over
D5954	Palatal augmentation prosthesis	covered at 100% after the deductible is met	
D5955	Palatal lift prosthesis, definitive	covered at 100% after the deductible is met	
D5958	Palatal lift prosthesis, interim	covered at 100% after the deductible is met	
D5959	Palatal lift prosthesis, modification	covered at 100% after the deductible is met	2 (D5959) every 12 months
D5960	Speech aid prosthesis, modification	covered at 100% after the deductible is met	2 (D5960) every 12 months
D5982	Surgical stent	covered at 100% after the deductible is met	
D5983	Radiation carrier	covered at 100% after the deductible is met	
D5984	Radiation shield	covered at 100% after the deductible is met	
D5985	Radiation cone locator	covered at 100% after the deductible is met	
D5986	Fluoride gel carrier	covered at 100% after the deductible is met	
D5987	Commissure splint	covered at 100% after the deductible is met	
D5988	Surgical splint	covered at 100% after the deductible is met	
D5991	Vesiculobullous disease medicament carrier	covered at 100% after the deductible is met	
D5999	Unspecified maxillofacial prosthesis, by report	covered at 100% after the deductible is met	
	Implant Services		
D6010	Surgical placement of implant body, endosteal	covered at 100% after the deductible is met	Only a Plan Benefit when exceptional medical conditions are met
D6011	Surgical access to an implant body (second state implant surgery)	covered at 100% after the deductible is met	
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	covered at 100% after the deductible is met	
D6013	Surgical placement of mini implant	covered at 100% after the deductible is met	
D6040	Surgical placement: eposteal implant	covered at 100% after the deductible is met	
D6050	Surgical placement: transosteal implant	covered at 100% after the deductible is met	
D6055	Connecting bar, implant supported or abutment supported	covered at 100% after the deductible is met	
D6056	Prefabricated abutment, includes modification and placement	covered at 100% after the deductible is met	
D6057	Custom fabricated abutment, includes placement	covered at 100% after the deductible is met	
D6058	Abutment supported porcelain/ceramic crown	covered at 100% after the deductible is met	
D6059	Abutment supported porcelain fused to high noble crown	covered at 100% after the deductible is met	
D6060	Abutment supported porcelain fused to base metal crown	covered at 100% after the deductible is met	
D6061	Abutment supported porcelain fused to noble metal crown	covered at 100% after the deductible is met	
D6062	Abutment supported cast metal crown, high noble	covered at 100% after the deductible is met	
D6063	Abutment supported cast metal crown, base metal	covered at 100% after the deductible is met	
D6064	Abutment supported cast metal crown, noble metal	covered at 100% after the deductible is met	
D6065	Implant supported porcelain/ceramic crown	covered at 100% after the deductible is met	
D6066	Implant supported crown, porcelain fused to high noble alloys	covered at 100% after the deductible is met	
D6067	Implant supported crown, high noble alloys	covered at 100% after the deductible is met	

CDT Code	Description	Patient Responsibility	Limitation
D6068	Abutment supported retainer, porcelain/ceramic FPD	covered at 100% after the deductible is met	
D6069	Abutment supported retainer, metal FPD, high noble	covered at 100% after the deductible is met	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	covered at 100% after the deductible is met	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	covered at 100% after the deductible is met	
D6072	Abutment supported retainer, cast metal FPD, high noble	covered at 100% after the deductible is met	
D6073	Abutment supported retainer, cast metal FPD, base metal	covered at 100% after the deductible is met	
D6074	Abutment supported retainer, cast metal FPD, noble	covered at 100% after the deductible is met	
D6075	Implant supported retainer for ceramic FPD	covered at 100% after the deductible is met	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	covered at 100% after the deductible is met	
	Implant Services (continued)		
D6077	Implant supported retainer for metal FPD, high noble alloys	covered at 100% after the deductible is met	
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	covered at 100% after the deductible is met	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	covered at 100% after the deductible is met	
D6082	Implant supported crown, porcelain fused to predominantly base alloys	covered at 100% after the deductible is met	
D6083	Implant supported crown, porcelain fused to noble alloys	covered at 100% after the deductible is met	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	covered at 100% after the deductible is met	
D6085	Interim implant crown	covered at 100% after the deductible is met	
D6086	Implant supported crown, predominantly base alloys	covered at 100% after the deductible is met	
D6087	Implant supported crown, noble alloys	covered at 100% after the deductible is met	
D6088	Implant supported crown, titanium and titanium alloys	covered at 100% after the deductible is met	
D6089	Accessing and retorquing loose implant screw, per screw	covered at 100% after the deductible is met	
D6090	Repair implant supported prosthesis, by report	covered at 100% after the deductible is met	
D6091	Replacement part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	covered at 100% after the deductible is met	
D6092	Re-cement or re-bond implant/abutment supported crown	covered at 100% after the deductible is met	
D6093	Re-cement or re-bond implant/abutment supported FPD	covered at 100% after the deductible is met	
D6094	Abutment supported crown, titanium, and titanium alloys	covered at 100% after the deductible is met	
D6095	Repair implant abutment, by report	covered at 100% after the deductible is met	
D6096	Remove broken implant retaining screw	covered at 100% after the deductible is met	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	covered at 100% after the deductible is met	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	covered at 100% after the deductible is met	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	covered at 100% after the deductible is met	
D6100	Surgical removal of implant body	covered at 100% after the deductible is met	
D6105	Removal of implant body not requiring bone removal or flap elevation	covered at 100% after the deductible is met	Only a Plan Benefit when exceptional medical conditions are met
D6110	Implant/abutment supported removable denture, maxillary	covered at 100% after the deductible is met	
D6111	Implant/abutment supported removable denture, mandibular	covered at 100% after the deductible is met	
D6112	Implant/abutment supported removable denture, partial, maxillary	covered at 100% after the deductible is met	
D6113	Implant/abutment supported removable denture, partial, mandibular	covered at 100% after the deductible is met	
D6114	Implant/abutment supported fixed denture, maxillary	covered at 100% after the deductible is met	
D6115	Implant/abutment supported fixed denture, mandibular	covered at 100% after the deductible is met	
D6116	Implant/abutment supported fixed denture for partial, maxillary	covered at 100% after the deductible is met	
D6117	Implant/abutment supported fixed denture for partial, mandibular	covered at 100% after the deductible is met	
D6118	Implant/abutment supported interim fixed denture, mandibular	covered at 100% after the deductible is met	
D6119	Implant/abutment supported interim fixed denture, maxillary	covered at 100% after the deductible is met	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	covered at 100% after the deductible is met	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	covered at 100% after the deductible is met	
D6122	Implant supported retainer for metal FPD, noble alloys	covered at 100% after the deductible is met	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	covered at 100% after the deductible is met	
D6190	Radiographic/surgical implant index, by report	covered at 100% after the deductible is met	
D6191	Semi-precision abutment, placement	covered at 100% after the deductible is met	
D6192	Semi-precision attachment, placement	covered at 100% after the deductible is met	
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	covered at 100% after the deductible is met	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	covered at 100% after the deductible is met	
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	covered at 100% after the deductible is met	
D6198	Remove interim implant component	covered at 100% after the deductible is met	
D6199	Unspecified implant procedure, by report	covered at 100% after the deductible is met	
	Fixed Prosthodontic Services		
D6205	Pontic, indirect resin based composite	not covered	

CDT Code	Description	Patient Responsibility	Limitation
D6210	Pontic, cast high noble metal	not covered	
D6211	Pontic, cast predominantly base metal	covered at 100% after the deductible is met	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D6212	Pontic, cast noble metal	not covered	
D6214	Pontic, titanium, and titanium alloys	not covered	
D6240	Pontic, porcelain fused to high noble metal	not covered	
D6241	Pontic, porcelain fused to predominantly base metal	covered at 100% after the deductible is met	
D6242	Pontic, porcelain fused to noble metal	not covered	
D6243	Pontic, porcelain fused to titanium and titanium alloys	not covered	
D6245	Pontic, porcelain/ceramic	covered at 100% after the deductible is met	
D6250	Pontic, resin with high noble metal	not covered	
D6251	Pontic, resin with predominantly base metal	covered at 100% after the deductible is met	
	Fixed Prosthodontic Services (continued)		
D6252	Pontic, resin with noble metal	not covered	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	not covered	
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	not covered	
D6549	Resin retainer, for resin bonded fixed prosthesis	not covered	
D6608	Retainer onlay, porcelain/ceramic, two surfaces	not covered	
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	not covered	
D6610	Retainer onlay, cast high noble metal, two surfaces	not covered	
D6611	Retainer onlay, cast high noble metal, three or more surfaces	not covered	
D6612	Retainer onlay, cast base metal, two surfaces	not covered	
D6613	Retainer onlay, cast base metal, three or more surfaces	not covered	
D6614	Retainer onlay, cast noble metal, two surfaces	not covered	
D6615	Retainer onlay, cast noble metal three or more surfaces	not covered	
D6634	Retainer onlay, titanium	not covered	
D6710	Retainer crown, indirect resin based composite	not covered	
D6720	Retainer crown, resin with high noble metal	not covered	
D6721	Retainer crown, resin with predominantly base metal	covered at 100% after the deductible is met	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D6722	Retainer crown, resin with noble metal	not covered	
D6740	Retainer crown, porcelain/ceramic	covered at 100% after the deductible is met	
D6750	Retainer crown, porcelain fused to high noble metal	not covered	
D6751	Retainer crown, porcelain fused to predominantly base metal	covered at 100% after the deductible is met	
D6752	Retainer crown, porcelain fused to noble metal	not covered	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	not covered	
D6781	Retainer crown, ¾ cast predominantly base metal	covered at 100% after the deductible is met	
D6782	Retainer crown, ¾ cast noble metal	not covered	
D6783	Retainer crown, ¾ porcelain/ceramic	covered at 100% after the deductible is met	
D6784	Retainer crown ¾, titanium and titanium alloys	covered at 100% after the deductible is met	
D6791	Retainer crown, full cast predominantly base metal	covered at 100% after the deductible is met	
D6794	Retainer crown, titanium and titanium alloys	not covered	
D6930	Re-cement or re-bond fixed partial denture	covered at 100% after the deductible is met	
D6980	Fixed partial denture repair, restorative material failure	covered at 100% after the deductible is met	
D6999	Unspecified fixed prosthodontic procedure, by report	covered at 100% after the deductible is met	
	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	covered at 100% after the deductible is met	
D7140	Extraction, erupted tooth or exposed root	covered at 100% after the deductible is met	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	covered at 100% after the deductible is met	
D7220	Removal of impacted tooth, soft tissue	covered at 100% after the deductible is met	
D7230	Removal of impacted tooth, partially bony	covered at 100% after the deductible is met	
D7240	Removal of impacted tooth, completely bony	covered at 100% after the deductible is met	
D7241	Removal impacted tooth, complete bony, complication	covered at 100% after the deductible is met	
D7250	Removal of residual tooth roots (cutting procedure)	covered at 100% after the deductible is met	
D7260	Oroantral fistula closure	covered at 100% after the deductible is met	
D7261	Primary closure of a sinus perforation	covered at 100% after the deductible is met	
D7270	Tooth reimplantation and/or stabilization, accident	covered at 100% after the deductible is met	1 (D7270) per arch
D7280	Exposure of an unerupted tooth	covered at 100% after the deductible is met	
D7283	Placement, device to facilitate eruption, impaction	covered at 100% after the deductible is met	

CDT Code	Description	Patient Responsibility	Limitation
D7284	Excisional biopsy of minor salivary glands	covered at 100% after the deductible is met	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	covered at 100% after the deductible is met	1 (D7285) per arch per date of service
D7286	Incisional biopsy of oral tissue, soft	covered at 100% after the deductible is met	up to 3 (D7286) per date of service
D7287	Exfoliative cytological sample collection	not covered	
D7288	Brush biopsy, transepithelial sample collection	not covered	
D7290	Surgical repositioning of teeth	covered at 100% after the deductible is met	1 (D7290) per arch, for active orthodontic treatment only
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	covered at 100% after the deductible is met	1 (D7291) per arch, for active orthodontic treatment only
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	covered at 100% after the deductible is met	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	covered at 100% after the deductible is met	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	covered at 100% after the deductible is met	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	covered at 100% after the deductible is met	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	covered at 100% after the deductible is met	1 (D7340) per arch every 5 year period
D7350	Vestibuloplasty, ridge extension	covered at 100% after the deductible is met	1 (D7350) per arch
D7410	Excision of benign lesion, up to 1.25 cm	covered at 100% after the deductible is met	
	Oral & Maxillofacial Services (continued)		
D7411	Excision of benign lesion, greater than 1.25 cm	covered at 100% after the deductible is met	
D7412	Excision of benign lesion, complicated	covered at 100% after the deductible is met	
D7413	Excision of malignant lesion, up to 1.25 cm	covered at 100% after the deductible is met	
D7414	Excision of malignant lesion, greater than 1.25 cm	covered at 100% after the deductible is met	
D7415	Excision of malignant lesion, complicated	covered at 100% after the deductible is met	
D7440	Excision of malignant tumor, up to 1.25 cm	covered at 100% after the deductible is met	
D7441	Excision of malignant tumor, greater than 1.25 cm	covered at 100% after the deductible is met	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	covered at 100% after the deductible is met	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	covered at 100% after the deductible is met	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	covered at 100% after the deductible is met	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	covered at 100% after the deductible is met	
D7465	Destruction of lesion(s) by physical or chemical method, by report	covered at 100% after the deductible is met	
D7471	Removal of lateral exostosis, maxilla or mandible	covered at 100% after the deductible is met	1 (D7471) per quadrant
D7472	Removal of torus palatinus	covered at 100% after the deductible is met	1 (D7472) per lifetime
D7473	Removal of torus mandibularis	covered at 100% after the deductible is met	1 (D7473) per quadrant
D7485	Reduction of osseous tuberosity	covered at 100% after the deductible is met	1 (D7485) per quadrant
D7490	Radical resection of maxilla or mandible	covered at 100% after the deductible is met	
D7509	Marsupialization of odontogenic cyst	covered at 100% after the deductible is met	
D7510	Incision & drainage of abscess, intraoral soft tissue	covered at 100% after the deductible is met	1 (D7510) per quadrant, same date of service
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	covered at 100% after the deductible is met	1 (D7511) per quadrant, same date of service
D7520	Incision & drainage of abscess, extraoral soft tissue	covered at 100% after the deductible is met	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	covered at 100% after the deductible is met	
D7530	Remove foreign body, mucosa, skin, tissue	covered at 100% after the deductible is met	1 (D7530) per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	covered at 100% after the deductible is met	1 (D7540) per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	covered at 100% after the deductible is met	1 (D7550) per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	covered at 100% after the deductible is met	
D7610	Maxilla, open reduction (teeth immobilized, if present)	covered at 100% after the deductible is met	
D7620	Maxilla, closed reduction (teeth immobilized, if present)	covered at 100% after the deductible is met	
D7630	Mandible, open reduction (teeth immobilized, if present)	covered at 100% after the deductible is met	
D7640	Mandible, closed reduction (teeth immobilized, if present)	covered at 100% after the deductible is met	
D7650	Malar and/or zygomatic arch, open reduction	covered at 100% after the deductible is met	
D7660	Malar and/or zygomatic arch, closed reduction	covered at 100% after the deductible is met	
D7670	Alveolus, closed reduction, may include stabilization of teeth	covered at 100% after the deductible is met	
D7671	Alveolus, open reduction, may include stabilization of teeth	covered at 100% after the deductible is met	
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	covered at 100% after the deductible is met	
D7710	Maxilla, open reduction	covered at 100% after the deductible is met	
D7720	Maxilla, closed reduction	covered at 100% after the deductible is met	
D7730	Mandible, open reduction	covered at 100% after the deductible is met	
D7740	Mandible, closed reduction	covered at 100% after the deductible is met	
D7750	Malar and/or zygomatic arch, open reduction	covered at 100% after the deductible is met	
D7760	Malar and/or zygomatic arch, closed reduction	covered at 100% after the deductible is met	
D7770	Alveolus, open reduction stabilization of teeth	covered at 100% after the deductible is met	
D7771	Alveolus, closed reduction stabilization of teeth	covered at 100% after the deductible is met	
D7780	Facial bones, complicated reduction with fixation and multiple approaches	covered at 100% after the deductible is met	

CDT Code	Description	Patient Responsibility	Limitation
D7810	Open reduction of dislocation	covered at 100% after the deductible is met	
D7820	Closed reduction of dislocation	covered at 100% after the deductible is met	
D7830	Manipulation under anesthesia	covered at 100% after the deductible is met	
D7840	Condylectomy	covered at 100% after the deductible is met	
D7850	Surgical discectomy, with/without implant	covered at 100% after the deductible is met	
D7852	Disc repair	covered at 100% after the deductible is met	
D7854	Synovectomy	covered at 100% after the deductible is met	
D7856	Myotomy	covered at 100% after the deductible is met	
D7858	Joint reconstruction	covered at 100% after the deductible is met	
D7860	Arthrotomy	covered at 100% after the deductible is met	
D7865	Arthroplasty	covered at 100% after the deductible is met	
D7870	Arthrocentesis	covered at 100% after the deductible is met	
D7871	Non-arthroscopic lysis and lavage	covered at 100% after the deductible is met	
D7872	Arthroscopy, diagnosis, with or without biopsy	covered at 100% after the deductible is met	
D7873	Arthroscopy: lavage and lysis of adhesions	covered at 100% after the deductible is met	
	Oral & Maxillofacial Services (continued)		
D7874	Arthroscopy: disc repositioning and stabilization	covered at 100% after the deductible is met	
D7875	Arthroscopy: synovectomy	covered at 100% after the deductible is met	
D7876	Arthroscopy: discectomy	covered at 100% after the deductible is met	
D7877	Arthroscopy: debridement	covered at 100% after the deductible is met	
D7880	Occlusal orthotic device, by report	covered at 100% after the deductible is met	
D7881	Occlusal orthotic device adjustment	covered at 100% after the deductible is met	
D7899	Unspecified TMD therapy, by report	covered at 100% after the deductible is met	
D7910	Suture of recent small wounds up to 5 cm	covered at 100% after the deductible is met	
D7911	Complicated suture, up to 5 cm	covered at 100% after the deductible is met	
D7912	Complicated suture, greater than 5 cm	covered at 100% after the deductible is met	
D7920	Skin graft (identify defect covered, location and type of graft)	covered at 100% after the deductible is met	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	covered at 100% after the deductible is met	
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	covered at 100% after the deductible is met	
D7940	Osteoplasty, for orthognathic deformities	covered at 100% after the deductible is met	
D7941	Osteotomy, mandibular rami	covered at 100% after the deductible is met	
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	covered at 100% after the deductible is met	
D7944	Osteotomy, segmented or subapical	covered at 100% after the deductible is met	
D7945	Osteotomy, body of mandible	covered at 100% after the deductible is met	
D7946	LeFort I (maxilla, total)	covered at 100% after the deductible is met	
D7947	LeFort I (maxilla, segmented)	covered at 100% after the deductible is met	
D7948	LeFort II or LeFort III, without bone graft	covered at 100% after the deductible is met	
D7949	LeFort II or LeFort III, with bone graft	covered at 100% after the deductible is met	
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	covered at 100% after the deductible is met	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	covered at 100% after the deductible is met	
D7952	Sinus augmentation via a vertical approach	covered at 100% after the deductible is met	
D7955	Repair of maxillofacial soft and/or hard tissue defect	covered at 100% after the deductible is met	
D7956	Guided tissue regeneration, edentulous area, resorbable barrier, per site	not covered	
D7957	Guided tissue regeneration, edentulous area, non-resorbable barrier, per site	not covered	
D7961	Buccal / labial frenectomy (frenulectomy)	covered at 100% after the deductible is met	1 (D7961) per arch per date of service
D7962	Lingual frenectomy (frenulectomy)	covered at 100% after the deductible is met	1 (D7962) per arch per date of service
D7963	Frenuloplasty	covered at 100% after the deductible is met	1 (D7963) per arch per date of service
D7970	Excision of hyperplastic tissue, per arch	covered at 100% after the deductible is met	1 (D7970) per arch per date of service
D7971	Excision of pericoronal gingiva	covered at 100% after the deductible is met	
D7972	Surgical reduction of fibrous tuberosity	covered at 100% after the deductible is met	1 (D7972) per arch per date of service
D7979	Non – surgical sialolithotomy	covered at 100% after the deductible is met	
D7980	Surgical Sialolithotomy	covered at 100% after the deductible is met	
D7981	Excision of salivary gland, by report	covered at 100% after the deductible is met	
D7982	Sialodochoplasty	covered at 100% after the deductible is met	
D7983	Closure of salivary fistula	covered at 100% after the deductible is met	
D7990	Emergency tracheotomy	covered at 100% after the deductible is met	
D7991	Coronoidectomy	covered at 100% after the deductible is met	
D7995	Synthetic graft, mandible or facial bones, by report	covered at 100% after the deductible is met	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	covered at 100% after the deductible is met	1 (D7997) per arch per date of service

LIBERTY Dental Plan of California, Inc.

Children's Dental HMO – L.A. Care Covered Direct Minimum Coverage

CDT Code	Description	Patient Responsibility	Limitation
D7999	Unspecified oral surgery procedure, by report	covered at 100% after the deductible is met	
	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	covered at 100% after the deductible is met	age 13 and over
D8210	Removable appliance therapy	covered at 100% after the deductible is met	1 (D8210) per patient, age 6 through 12
D8220	Fixed appliance therapy	covered at 100% after the deductible is met	1 (D8220) per patient, age 6 through 12
D8660	Pre-orthodontic treatment examination to monitor growth and development	covered at 100% after the deductible is met	1 (D8660) every 3 months for a maximum of 6
D8670	Periodic orthodontic treatment visit	covered at 100% after the deductible is met	1 (D8670) per calendar quarter
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	covered at 100% after the deductible is met	1 (D8680) per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment	covered at 100% after the deductible is met	
D8696	Repair of orthodontic appliance, maxillary	covered at 100% after the deductible is met	1 of (D8696, D8697) per arch, per appliance
D8697	Repair of orthodontic appliance, mandibular	covered at 100% after the deductible is met	
D8698	Re-cement or re-bond fixed retainer, maxillary	covered at 100% after the deductible is met	1 of (D8698, D8699) per arch, per provider
D8699	Re-cement or re-bond fixed retainer, mandibular	covered at 100% after the deductible is met	
D8701	Repair of fixed retainer, includes reattachment, maxillary	covered at 100% after the deductible is met	
D8702	Repair of fixed retainer, includes reattachment, mandibular	covered at 100% after the deductible is met	

LIBERTY Dental Plan of California, Inc.

Children's Dental HMO – L.A. Care Covered Direct Minimum Coverage

CDT Code	Description	Patient Responsibility	Limitation
	Orthodontic Services (continued)		
D8703	Replacement of lost or broken retainer, maxillary	covered at 100% after the deductible is met	1 of (D8703, D8704) per arch
D8704	Replacement of lost or broken retainer, mandibular	covered at 100% after the deductible is met	
D8999	Unspecified orthodontic procedure, by report	covered at 100% after the deductible is met	
	Adjunctive General Services		
D9110	Palliative treatment of dental pain, per visit	covered at 100% after the deductible is met	1 (D9110) per date of service
D9120	Fixed partial denture sectioning	covered at 100% after the deductible is met	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	covered at 100% after the deductible is met	1 (D9210) per date of service
D9211	Regional block anesthesia	covered at 100% after the deductible is met	
D9212	Trigeminal division block anesthesia	covered at 100% after the deductible is met	
D9215	Local anesthesia in conjunction with operative or surgical procedures	covered at 100% after the deductible is met	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	covered at 100% after the deductible is met	
GUIDELINE: Deep Sedation and IV Conscious Sedation are covered benefits when it is documented local anesthesia is not possible, in such cases as a severe mental or physical handicap, extensive surgical procedures, an uncooperative child, an acute infection at the injection site, or a failure of a local anesthetic to control pain. Services covered 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 minute increment	covered at 100% after the deductible is met	
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	covered at 100% after the deductible is met	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	covered at 100% after the deductible is met	
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	covered at 100% after the deductible is met	
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	covered at 100% after the deductible is met	
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	covered at 100% after the deductible is met	
D9310	Consultation, other than requesting dentist	covered at 100% after the deductible is met	
D9311	Consultation with a medical health care professional	covered at 100%	
D9410	House/extended care facility call	covered at 100% after the deductible is met	
D9420	Hospital or ambulatory surgical center call	covered at 100% after the deductible is met	
D9430	Office visit, observation, regular hours, no other services	covered at 100% after the deductible is met	1 (D9430) per date of service per provider
D9440	Office visit, after regularly scheduled hours	covered at 100% after the deductible is met	1 (D9440) per date of service per provider
D9450	Case presentation, subsequent, detailed, extensive treatment planning	not covered	
D9610	Therapeutic parenteral drug, single administration	covered at 100% after the deductible is met	4 (D9610) per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	covered at 100% after the deductible is met	4 (D9612) per date of service
D9910	Application of desensitizing medicament	covered at 100% after the deductible is met	1 (D9910) per tooth every 12 months, for permanent teeth only
D9930	Treatment of complications, post surgical, unusual, by report	covered at 100% after the deductible is met	1 (D9930) per date of service per provider
D9942	Repair and/or reline of occlusal guard	not covered	
D9943	Occlusal guard adjustment	not covered	
D9944	Occlusal guard, hard appliance, full arch	not covered	
D9945	Occlusal guard, soft appliance, full arch	not covered	
D9946	Occlusal guard, hard appliance, partial arch	not covered	
D9950	Occlusion analysis, mounted case	covered at 100% after the deductible is met	1 (D9950) every 12 months, age 13 and over
D9951	Occlusal adjustment, limited	covered at 100% after the deductible is met	1 (D9951) per quad every 12 months per provider, age 13 and over
D9952	Occlusal adjustment, complete	covered at 100% after the deductible is met	1 (D9952) every 12 months, age 13 and over
D9995	Teledentistry, synchronous; real-time encounter	covered at 100%	To the extent the dental plans can offer Teledentistry, it would be offered at no charge
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	covered at 100%	
D9997	Dental case management, patients with special health care needs	covered at 100%	
D9999	Unspecified adjunctive procedure, by report	covered at 100%	

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.

LIBERTY Dental Plan of California, Inc.
Children's Dental HMO – L.A. Care Covered Direct Minimum Coverage

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 unless service qualifies under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 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
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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