L.A. Care Health Plan
Individual Conversion Plan

Membership Agreement and Disclosure Form and Evidence of Coverage
(MEMBER HANDBOOK)

Effective January 1, 2013 through December 31, 2013

IN YOUR LANGUAGE

Dear Member,

We know that it is important to communicate clearly so you can get the health care services you need.

In the United States, there are laws, such as the Civil Rights Act of 1964, which protects you if you do not speak English. If you cannot hear or are hard of hearing (hearing impaired) or disabled, aged or blind, you are also protected by the Americans with Disabilities Act (ADA) of 1990. The ADA is a law that protects people with disabilities from discrimination. The ADA makes sure that there is equal opportunity for persons with disabilities in employment, state and local government services.

The doctor's office, clinic or hospital cannot deny services because you do not speak English or are hearing impaired. You have the right to free interpreter services when getting health care or any related service through your health plan. An interpreter is a person who translates orally what is said in one language to another language. This allows persons of different languages to speak with each other and understand each other.

The meanings of italicized words are found in the "Glossary Section" at the end of this Member Handbook.

L.A. Care Health Plan (L.A. Care) will cover you your legal spouse or registered domestic partner and your dependents that were covered under your group contract on the date of your termination from the group. Call L.A. Care Member Services at **1-888-839-9909** for more information.

About this Agreement

This Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage (Membership Agreement and Evidence of Coverage) describes the health care coverage of "L.A. Care Health Plan Individual Conversion Deductible 30/1500 Plan" and constitute the legally binding contract between L.A. Care and you (Member). This **Individual Conversion Plan Membership Agreement** and **Disclosure Form** and **Evidence of Coverage (Agreement)** and any amendments describe the health coverage of **L.A. Care Individual Conversion Plan"** and constitute the legally binding contract between L.A. Care and you (member).

The term of this Agreement begins when you, the member, first elect Conversion coverage.

The "L.A. Care Individual Conversion Deductible 30/1500 Plan" does not include dependent coverage.

The Service Area for this Membership Agreement and Evidence of Coverage is Los Angeles County. Please see the "Emergency Services" section for details on emergency care.

The Evidence of Coverage is also called the Member Handbook. The Member Handbook tells you how to get health care. It also has the terms and conditions of your health benefits coverage. You should read the Member Handbook completely and carefully. If you have special health needs, you should read the sections that apply to you.

We may amend this Membership Agreement and Evidence of Coverage (including Premiums and benefits) at any time by sending written notice to the Subscriber at least 60 days before the effective date of the amendment. The amendment may become effective earlier than the end of the period for which you have already paid your Premiums, and it may require you to pay additional Premiums for that period. All amendments are deemed accepted by the Member unless the Member gives us written notice of non-acceptance within 30 days of the date of the notice, in which case this *Membership Agreement and Evidence of Coverage* terminates the day before the effective date of the amendment. If we notified the Member that we have not received all necessary governmental approvals related to this *Membership Agreement and Evidence of Coverage*, we may amend this *Membership Agreement and Evidence of* Coverage by giving written notice to the Member after receiving all necessary governmental approval, in accord with "Notices" in the "Miscellaneous Provisions" section. Any such government-approved provisions go into effect on January 1, 2013 (unless the government requires a later effective date).

This Member Handbook and the Summary of Benefits Section are only a summary of L.A. Care policies and rules. Call L.A. Care if you have questions about covered services or specific provisions.

L.A. Care Health Plan
ATTN: Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: **1-888-839-9909**
TTY/TDD: **1-866-LACARE (1-866-522-2731)**
www.lacare.org

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WELCOME TO L.A. CARE

Thank you for choosing health care coverage with L.A. Care. Please review the information in this guidebook carefully. The information will help you use the Plan's medical services effectively.

Your medical care will be provided by qualified, health care professionals in one of our doctor offices, clinics or hospitals. Your Primary Care Provider will work with other doctors in all major specialties, pharmacists, nurses and other health professionals to assure that you receive the best health care.

If you have any questions or comments about L.A. Care or would like additional information about **Conversion Plan** health care benefits, please contact a Plan Representative at the clinic/doctor office where you have chosen to receive your medical care (refer to the L.A. Care Provider Directory), or you may write or call us at:

L.A. Care Health Plan
ATTN: Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: **1-888-839-9909**
TTY/TDD: **1-866-LACARE1 (1-866-522-2731)**

Along with this Member Handbook you should have received a L.A. Care identification (ID) card. The provider directory may be obtained by mail by contacting L.A. Care's Member Services Department or printed online through the internet at **www.lacare.org**.

We will be glad to answer your questions and listen to your comments.

YOUR RIGHTS AND RESPONSIBILITIES

MEMBER 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 from your health plan's providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about your care.

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 okay.

Choice and involvement in your care. You have the right to receive information about your health plan and its services. You have the right to choose your Primary Care Physician (doctor) from the doctors and clinics listed in your health plan's provider directory. You also have the right to get appointments within a reasonable amount of time. You have a right to talk with your doctor about any care your doctor provides or recommends. You have the right to a second opinion. You have 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.

Voice your concerns. You have the right to complain about L.A. Care, the health plans we work with, or our providers without fear of losing your benefits. L.A. Care will help you with the process. If you don't agree with a decision, you have a right to ask for a review. You have a right to disenroll from your health plan whenever you want.

Service outside of your health plan's provider network. You have a right to receive emergency services as well as family planning and sexually transmitted disease services outside of your health plan's network. You have the right to receive emergency treatment whenever and wherever you need it.

Service and information in your language. You have a right to request an interpreter at no charge and not use a family member or a friend to translate for you. You have the right to get the Member Handbook and other information in another language or format.

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

MEMBER RESPONSIBILITIES

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

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

Give up-to-date, accurate and complete information. You are responsible for giving correct information to all of your providers. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.

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

Use the Emergency Room only in an emergency. You are responsible for using the emergency room in cases of an emergency or as directed by your doctor.

Report wrong doing. You are responsible for reporting health care fraud or wrong doing to L.A. Care. You can do this without giving your name by calling the L.A. Care Fraud and Abuse Hotline toll-free at **1-800-400-4889**.

CONFIDENTIALITY

You have the right to keep your medical records confidential. **You can request a copy of our confidentiality policy.** Just call L.A. Care. Also, any results from genetic testing will not be disclosed. No one may tell others about the results of your genetic tests.

Health Information Privacy

At L.A. Care, we value the trust you have in us. We want to keep you as a 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 L.A. Care handles health information
- Follows all laws about the privacy of health information

All L.A. Care staff that have access to your health information are trained on privacy laws. They also follow L.A. Care guidelines. They even sign a note 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 appropriate health care services. This information includes:

- Name
- Gender
- Date of birth
- Language you speak
- Home address
- Home or work telephone number
- Occupation and employer
- Whether you are married or single
- Health history

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

- You
- A parent, guardian, or conservator
- Another health plan
- Your doctor
- Your application for the health care program
- Your health records

Before L.A. Care gives your health information to another person or group, we need your written approval. There are times when we may not get your written approval. 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 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

Sometimes, L.A. Care may also give out some information from your employer about job performance. This information will help determine your health coverage or manage our health plan.

If you have any questions or would like to know more about your health information, please call Member Services.

HOW TO USE L.A. CARE HEALTH PLAN

INDIVIDUAL CONVERSION PLAN

Conversion Plan coverage begins at the time your COBRA/Cal-COBRA coverage or group coverage ends, but only if you apply and pay the required premium no later than 63 days after termination of your COBRA/Cal-COBRA coverage or group coverage. If eligible, you must exhaust your COBRA/Cal-COBRA coverage before you become eligible for the Conversion Plan coverage.

ELIGIBILITY REQUIREMENTS

You are eligible to enroll in the Conversion Plan when your coverage under a group plan has been terminated.

You are <u>not</u> eligible to enroll in the Conversion Plan if:

- You are covered by or eligible for benefits under Title 28 of the United States Social Security Act.
- You are covered by or eligible for hospital, medical or surgical benefits under state or federal law.
- You are covered by or eligible for hospital, medical or surgical benefits under any arrangements of coverage for individuals in a group, whether insured or self-insured.
- You are covered for similar benefits by an individual policy or contract.
- You have not been continuously covered during the three-month period immediately preceding your termination of coverage.

YOUR IDENTIFICATION (ID) CARD

Your L.A. Care ID card lets people know you are our member. Carry your L.A. Care ID card with you at all times. Show your L.A. Care ID card when you:

- Have a doctor's appointment,
- Go to the hospital,
- Pick up a prescription, or
- Get any other medical care.

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

PRIMARY CARE PHYSICIAN (PCP)

A primary care physician (PCP) is your personal doctor. A PCP will be assigned to you upon enrollment based on:

- The language you speak.
- How far you live from the PCP's office.
- Specialty care most appropriate for a member's age.

He/she will make sure that you get all the health care you need. He/she will refer you to a specialist when needed. As your PCP learns more about you and your health, he/she can provide you with better quality care.

How to Change Your Primary Care Physician (PCP)

Choose a PCP
To change PCP's call L.A. Care.
You may change your PCP for any reason if you are not happy with the assignment. It is important that you visit your PCP regularly.

You can choose any PCP from the L.A. Care provider directory.

Points to remember when choosing a PCP.

- When you choose a PCP you are also choosing the specialists, hospitals and other health care providers within their network.
- Your PCP chooses from the providers within their network when referring you to needed services.
- You will be informed within 30 days if your PCP stops working with L.A. Care.

Our doctor's professional qualifications

We're 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.
L.A. Care can tell you about the medical school they attended, their residency or board certification.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

HOW TO GET HEALTH CARE SERVICES

HOW TO GET ROUTINE CARE

Regular health check-ups help you stay healthy. Routine care is when you go to your PCP for a regular health check-up, even when you are not sick. To get a regular health check-up you need to call and make an appointment.

Scheduling a Doctor's Appointment

Call your PCP's office.

Your PCP's phone number can be found on your ID card or in the provider directory. To request a provider directory, please call L.A. Care's Member Services Department or you may print the provider directory online at **www.lacare.org**.
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CANCELING OR RESCHEDULING A DOCTOR'S APPOINTMENT

Please call and let your doctor know right away if you need to cancel an appointment. By canceling your appointment you allow someone else to be seen by the doctor. If you miss your appointment, call your doctor right away to reschedule.

HOW TO SEE A SPECIALIST

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

If your PCP thinks it is medically necessary for you to see a specialist, your PCP will refer you.

HOW TO SEE A MENTAL HEALTH SPECIALIST

Specialized mental health services are provided through Los Angeles County Department of Mental Health (LACDMH). You may receive services from LACDMH with or without a referral from your PCP. LACDMH may be reached toll-free at 1-800-854-7771. Your PCP may treat some mental health conditions.

PRIOR AUTHORIZATIONS AND REFERRALS

Your PCP must approve all health care services before you receive them. This is called prior authorization. A referral is when you request health care services that your PCP does not normally provide. Some services do not require a referral. Emergency services do not require a prior authorization. Go to the "Summary of Benefits Section" for a list of services.

There are different types of referral requests:

- Routine or Regular
- Urgent
- Emergency

After you receive a referral request, it will be reviewed and responded to as follows:

- Routine - 5 business days
- Urgent - 24 to 48 hours
- Emergency - same day

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

All health care services are reviewed, approved or denied according to medical necessity. If you would like a copy of the policies and procedures L.A. Care uses to decide if a service is medically necessary, call L.A. Care.

How to Get a Second Opinion

A second opinion is a visit with another qualified health care professional when:

- You question the reasonableness or necessity of the recommended surgical procedures.
- You question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indicators are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and you request an additional diagnosis.
- The treatment is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.
- If you have attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

The second opinion must be from an appropriately qualified health care professional in your network. If there is no qualified health care professional who meets the standards, your doctor may authorize the referral to an out-of-plan provider. You have the right to ask for and to get a second opinion.

If your second opinion is approved either inside or outside of your provider network your travel to the doctor will be taken into account. If your second opinion request is approved you may be charged a copayment for similar referrals.

What do you need to do?

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

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

Step 3: Call the second opinion qualified health care professional to make an appointment.

If you have a life threatening condition, or other condition with the potential for significant negative impact on your health if not addressed immediately, a second medical opinion will be granted to you within 72 hours after the Plan's receipt of the request, whenever possible.

You can request a copy of L.A. Care's written second opinion policy statement by calling the Member Services.

If you do not agree with the second opinion, you may file a grievance with L.A. Care. Go to the "Grievances/Complaints and Appeals Section" for more information.

How to Get a Standing Referral

You may receive a "standing referral" to a specialist if your PCP and the specialist decide that you have a condition or disease that requires specialized medical care over a prolonged period of time.

A standing referral needs authorization. Once you have a standing referral, you will not need authorization for each visit with the specialist or appropriately qualified health care professional. A standing referral is made to a specialist or appropriately qualified health care professional who is in your network or who is with a contracted specialty care center. For a list of appropriately qualified health care professionals, call L.A. Care.

Your specialist or appropriately qualified health care professional will develop a treatment plan for you. The treatment plan will show how often you need to go to the doctor. Once the treatment plan is approved, the specialist or appropriately qualified health care professional will be your coordinator of care, according to the treatment plan.

Continuity of Care or How to Keep Seeing Your Doctor if Your Doctor Has Left the Plan

You will be informed if your doctor stops working with L.A. Care. You can ask to keep seeing your doctor, if your doctor is no longer working with L.A. Care and has been treating you for any of the following conditions:

- Acute condition
- Serious chronic condition
- Terminal Illness
- Pregnancy, including the duration of the pregnancy and immediate postpartum care
- Children, which are eligible dependents, between birth and age 36 months. Not to exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee
- Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee

If you have any of the above conditions, you can continue to get services from your doctor for 90 days (or a longer period of time, if necessary) until a safe transfer can be made.

If you are pregnant, you can continue to get services from your doctor until post partum services (healthcare six (6) weeks after delivery) are completed or until a safe transfer can be made, whichever is longer. If you have any questions, please call L.A. Care.

L.A. Care requires a terminated provider to accept in writing his/her previous contract terms and contract rates as set forth in their individual contracts. If the terminated provider does not agree to the terms, conditions and rates, L.A. Care is not obligated to continue to provide services.

If you want to complete the necessary treatment with a non-affiliated doctor, you should submit a written request to your new L.A. Care Primary Care Provider. Contact L.A. Care's Member Services at **1-888-839-9909** to obtain a copy of L.A. Care's Continuity of Care Policy.

Terminated Medical Groups
Should L.A. Care terminate its contract with a medical group or general acute care hospital to which you are assigned, you will receive at least 60 days prior written notice of the contract termination.

HOW TO GET EMERGENCY CARE

Emergency Care includes medical screening, examination, and evaluation by a physician, or, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by a physician that is necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Medical Condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

Emergency Services is twenty-four hour medical care that includes medical screening, examination, and evaluation by a physician, or, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by a physician that is necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Services are provided for members who present with conditions that are manifested by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention may result in placing the health of the individual or unborn child in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

Emergency Services include active labor, or labor at a time that either of the following would occur:

- Inadequate time to effect a safe transfer to another hospital prior to delivery,
- Or a transfer poses a threat to the health and safety of the member or unborn child

Emergency services also include ambulance and mental health services for emergency cases. L.A. Care covers all emergencies (this includes out-of-area emergencies or urgently needed services).

Examples of emergencies include:

- Hard to breathe
- Seizures (convulsions)
- Lots of bleeding
- Unconsciousness/blackouts (will not wake up)
- Severe pain (including chest pain)
- Swallowing of poison or medicine overdose
- Broken bones

What to do in an emergency:
Call 911, or go to the nearest emergency room.

After you receive emergency care:
Step 1: Follow the instructions of the emergency room doctor.

Step 2: Call your PCP to make an appointment for follow-up care.

Unsure if you need emergency care?
Step 1: Call your PCP or L.A. Care.

Step 2: Tell them about your condition and follow their instructions.

Urgently Needed Services are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area.

Urgently needed services includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

Nurse Advice Line

What is the Nurse Advice Line?

It is a telephone-based service available to all L.A. Care members. You can call them at any time when you have a health question. Caring registered nurses are on hand to answer your questions and help you make good health care choices.

Benefits of using the Nurse Advice Line:

- Get FREE professional help
- Phone line open 24 hours a day, 7 days a week
- No extra out-of-pocket fees
- Avoid needless time and travel

Do you have to call before going to the emergency room or doctor's office?
No. You don't need to call before getting care.

When you call the number, the nurse will ask you some questions. They can help decide if you need to see the doctor right away. Or, they can tell you what you can do at home to feel better. If you find that you don't need to get care right away, you will save the cost of your co-payment, plus any other out-of-pocket fees. The nurse will make sure that you and your family get the best care you need.

Other features of the Nurse Advice Line:

- Audio Health Library
  This feature has more than 1100 pre-recorded health messages. You can call to get information on health topics and recipes that are good for your health.
- Informed Decision Support
  This feature will give in-depth counseling and decision support to members. This way, members can make good care choices.
- Navigation Service

This service will give members referrals at the end of the advice line call if needed. Referrals can be made to other programs like disease management and behavioral health.

Nurse Advice Line:
1-800-249-3619

Do Not Use The Emergency Room For Routine Health Care Services.

How to Get Urgent Care

Urgent care is what you need 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.

For urgent care, follow these steps:

Step 1: Call your PCP.

Another doctor may answer your call if your PCP is not available. A doctor is available by phone 24 hours a day, 7 days a week.

Step 2: Tell the person who answers the phone that you are a L.A. Care member.

Step 3: Ask to speak to your PCP or the doctor on-call. Tell the doctor what has happened and follow his/her instructions.

Call L.A. Care if you cannot contact your PCP.

How to Get Emergency Transportation

Emergency transportation is available to you when you have an emergency medical condition. If you are not sure if you need emergency transportation, you may call your PCP and follow her/his advice or you may call the Plan's 24-hour Nurse Advice Line at **1-800-249-3619.**

Ambulances for medical emergencies are paid for by L.A. Care. You should seek emergency services and/or "911" services (including ambulance transportation) if you believe that a medical condition is an emergency medical condition in accordance with L.A. Care's definition of emergency services.

How to Get Non-Emergency Transportation

Many L.A. Care doctors offer non-emergency transportation. This may include litter (stretcher) and wheelchair van services to and from appointments. Please call the doctor's office or L.A. Care if you want help with transportation for your medical visits.

HOW TO GET YOUR PRESCRIPTIONS FILLED

L.A. Care covers drugs when prescribed by a Plan Physician (except as otherwise described under "Outpatient Prescription Drugs, Supplies, and Supplements") and in accordance with our drug formulary guidelines.

L.A. Care works with pharmacies in many neighborhoods. You must get your prescribed drugs (s) from a pharmacy in L.A. Care's network. A list of L.A. Care's pharmacies can be found in your provider directory, which is included in your welcome packet.

To get prescriptions filled:

Step 1: Find a pharmacy that accepts L.A. Care.

Step 2: Bring and show your prescription and your L.A. Care ID Card to the pharmacist.

PAYMENT RESPONSIBILITIES

Prepayment Fees

Monthly Premium Fees

The rate you pay for your coverage depends on your age and zip code.

Monthly Individual Conversion Plan Rates Subscriber only				
Rate Areas (RA)	RA 2	RA 3	RA 4	RA 7
Age on Jan 1, 2013	DHMO 30/1500	DHMO 30/1500	DHMO 30/1500	DHMO 30/1500
<1	615	649	680	714
1–18	307	324	340	357
19	317	334	350	367
20	329	348	365	382
21	343	362	379	397
22	357	375	396	414
23	372	391	411	430
24	387	408	428	448
25	402	423	445	465
26	416	438	460	482
27	430	452	476	498
28	443	467	491	513
29	455	479	503	527
30	467	493	516	542
31	477	503	528	554
32	487	513	538	566
33	496	523	549	574
34	506	533	561	586
35	515	542	569	596
36	521	550	578	605
37	530	559	586	615
38	537	566	595	622

Monthly Individual Conversion Plan Rates Subscriber only				
Rate Areas (RA)	RA 2	RA 3	RA 4	RA 7
Age on Jan 1, 2013	DHMO 30/1500	DHMO 30/1500	DHMO 30/1500	DHMO 30/1500
39	545	572	601	630
40	552	581	610	639
41	559	588	617	646
42	567	596	627	656
43	578	608	637	668
44	589	620	651	681
45	601	632	664	697
46	617	649	681	714
47	630	663	697	729
48	646	680	714	748
49	661	697	731	765
50	680	715	751	787
51	697	734	770	807
52	714	751	790	827
53	731	770	809	846
54	749	790	829	868
55	770	809	850	890
56	787	827	868	911
57	802	844	885	928
58	817	860	902	946
59	834	878	923	965
60	834	878	923	965
61	834	878	923	965
62	834	878	923	965
63	834	878	923	965
64	834	878	923	965
65+	2038	2145	2252	2359

2013 L.A. Care ZIP Code to Rate Area Chart

- **Rate Area 2**: 90004–39, 90041–51, 90053–57, 90060, 90062–76, 90078-84, 90086–90, 90093–96, 90189, 90209–13, 90230–33, 90245, 90272, 90291–96, 90301–09, 90311-12, 90401–11, 90620–24, 90630-33, 90637–39, 90680, 90720-21, 90740, 90742-43, 90895, 91001, 91003, 91006–12, 91016-17, 91020–21, 91023–25, 91030–31, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91501–08, 91510, 91521–23, 91709, 91754, 91756, 91775, 91780, 91801-04, 91896, 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018—30, 92033, 92037–40, 92046, 92049, 92051–52, 92054-61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081—86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134-40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190-93, 92195-99, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711-12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861, 92863–71, 92885–87, 92899, 93001–07, 93009-12, 93015-16, 93022, 93030–36, 93040–44, 93060–61, 93066
- **Rate Area 3**: 90001–03, 90040, 90052, 90058–59, 90061, 90091, 90101, 90103, 90201–02, 90220–24, 90239–42, 90247–51, 90254–55, 90260–62, 90266–67, 90270, 90274–75, 90277–78, 90280, 90310, 90501–10, 90601–10, 90640, 90650–52, 90660–62, 90670-71, 90701-03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 91701–02, 91706, 91708, 91710-11, 91714–16, 91722–24, 91729–35, 91737, 91739–41, 91743–50, 91752, 91755,mar 91758-59, 91761-73, 91776, 91778, 91784–86, 91788–93, 91795, 92220, 92223, 92305, 92307–08, 92313–18, 92320–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589-93, 92595–96, 92599, 92860, 92877–83
- **Rate Area 4**: 90077, 90263–65, 90290, 91040–43, 91301–11, 91313, 91316, 91319–22, 91324–31, 91333–35, 91337, 91340–46, 91350–62, 91364-65, 91367, 91371–72, 91376–77, 91380–81, 91383-87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91601–12, 91614–18, 93020–21, 93062–65, 93094, 93099, 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93261, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93510, 93518-19, 93531-32, 93534-36, 93539, 93543-44, 93550-53, 93560-61, 93563, 93581, 93584, 93586, 93590–91, 93599
- **Rate Area 7:** Out of area enrollees

2013 BENEFIT SUMMARY

Matrix for Conversion Deductible 30/1500 Plan

L.A. Care Health Plan

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available on the plan's or insurer's site.

Plan Name **L.A. Care Health Plan**	Plan Contact Name and Telephone Number Member Service Call Center **1-888-839-9909**

Coverage Summary

Eligibility requirements	An employee or member whose coverage under a group contract has been terminated by an employer who is eligible for individual conversion coverage. Such coverage is not required to be offered under the circumstances (*1)
The premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of the subscriber.
When and under what circumstances benefits cease	Benefits cease due to: Fraud Loss of eligibility (*****5) Failure to pay premiums or partial payment of premiums Member may terminate by written notice to plan Discontinuation of a product Benefits terminate as follows: Fraud–upon receipt of notice Loss of eligibility–the last day of the month in which you are no longer eligible Failure to pay premium due–on the 30th day after the date of the Late Notice Voluntary termination by member–the first of the month following adequate notice to plan

The terms under which coverage may be renewed	New sales are issued throughout the calendar year. All accounts renew annually.
Other coverage that may be available if benefits under the described benefit package cease	Not Applicable
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a primary care Plan physician from a list of available Plan physicians in the following specialties: internal medicine, obstetrics/gynecology, family medicine, and pediatrics. Members may change their primary care Plan physician at any time.
Lifetime and annual maximums	Lifetime maximum: None Annual out-of pocket maximum: $3,500
Deductibles	$1,500 per calendar year

Benefits Summary (2) & (***3)**		**Co-payments**	**Limitation**
Professional Services	Most primary and specialty care consultations, exams, and treatment	$30 per visit (Deductible doesn't apply)	
	Routine physical maintenance exams, including well-women exams	No Charge (Deductible doesn't apply)	
	Well-child preventive exams (through age 23 months)	No Charge (Deductible doesn't apply)	
	Family planning counseling and consultations	No Charge (Deductible doesn't apply)	
	Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No Charge (Deductible doesn't apply)	
	Eye exams for refraction	No Charge (Deductible doesn't apply)	

Benefits Summary (**2) & (***3)		Co-payments	Limitation
	Hearing exams	No Charge (Deductible doesn't apply)	
	Urgent care consultations, exams and treatment	$30 per visit (Deductible doesn't apply)	
	Chiropractic office visits	$15 per visit (Deductible doesn't apply)	Annual 20-visit maximum
	Physical, occupational, and speech therapy	$30 per visit after Deductible	
Outpatient Services	Outpatient surgery and certain other outpatient procedures	$250 per procedure after Deductible	
	Allergy injections (including allergy serum)	$5 per visit after Deductible	
	Most Immunizations (including the vaccine)	No Charge (Deductible doesn't apply)	
	Most X-rays and laboratory tests	$10 per encounter after Deductible	
	Preventive X-rays, screenings, and laboratory tests as described in the "Benefits and Cost Sharing" section of the Evidence of Coverage	No Charge (Deductible doesn't apply)	
	MRI, most CT, and PET scans	$50 per procedure after Deductible	

Benefits Summary (**2) & (***3)		Co-payments	Limitation
	Health education:		
	Covered individual health education counseling	No Charge (Deductible doesn't apply)	
	Covered group health education programs	No Charge (Deductible doesn't apply)	
	Acupuncture (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)	$30 per visit (Deductible doesn't apply)	
Hospitalization Services	Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per day after deductible	
Emergency Health Coverage	Emergency Department visits	$150 per visit after Deductible	After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing in the Evidence of Coverage.
Ambulance Services	Ambulance services	$150 per trip after Deductible	
Prescription Drug Benefits	Covered outpatient items in accord with our drug formulary guidelines:		

Benefits Summary (**2) & (***3)		Co-payments	Limitation
	Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31-to 60-day supply, or $30 for a 61-to 100-day supply (Deductible doesn't apply)	
	Most generic refills through your mail-order service	$10 for up to a 30-day supply or $20 for a 31-to 100-day supply (Deductible doesn't apply)	
	Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply (Deductible doesn't apply)	
	Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31-to 100-day supply (Deductible doesn't apply)	

Benefits Summary (2) & (***3)**		**Co-payments**	**Limitation**
Durable Medical Equipment	The durable medical equipment for home use listed in the "Health Plan Benefit Summary" section is in accord with our durable medical equipment formulary guidelines (most durable medical equipment is not covered)	30% Coinsurance (Deductible doesn't apply)	
Mental Health Services	Inpatient psychiatric hospitalization (up to 10 days per calendar year)	$500 per day after Deductible	Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the "Health Benefit Summary" section of the Evidence of Coverage.
	Outpatient mental health services evaluation and treatment		
	Up to a total of 10 individual and group visits per calendar year that include services for mental health evaluation treatment	$30 per individual visit (Deductible doesn't apply) $15 per group visit (Deductible doesn't apply)	
	Up to 30 additional group visits in the same calendar year that meet Medical Group criteria	$15 per visit (Deductible doesn't apply)	

Benefits Summary (2) & (***3)**		**Co-payments**	**Limitation**
Residential Treatment	Transitional residential recovery services	$100 per admission after deductible	Up to 60 days per calendar year, not to exceed 120 days in any five-year period
Chemical Dependency Services	Inpatient detoxification	$500 per day after Deductible	
	Individual outpatient chemical dependency evaluation and treatment	$30 per visit (Deductible doesn't apply)	
	Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)	
Home Health Services	Home health care	No charge (Deductible doesn't apply)	Part-time or intermittent home health covered up to: Up to 2 hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist and up to 4 hours per visit for visits by a home health aide Up to 3 visits per day Up to 100 visits per calendar year
Custodial Care and Skilled Nursing	Skilled Nursing Facility Care	$50 per day after Deductible	Up to 60 days per benefit period
	Custodial care	Not covered	

Benefits Summary (**2) & (***3)		Co-payments	Limitation
Other	The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the "Health Plan Benefit Summary" section (most external prosthetic and orthotic devices are not covered)	No charge (Deductible doesn't apply)	
	Hospice care (****4)	No charge (Deductible doesn't apply)	

(*1)
(a) the group contract terminated and is replaced with similar coverage under another contract within 15 days of the date of termination of group coverage or the subscriber's participation;
(b) coverage was terminated because the employee or member failed to pay amounts due the plan;
(c) the employee or member was terminated for cause as set forth in its evidence of coverage;
(d) the employee or member intentionally furnished incorrect information or otherwise improperly obtained benefits of the plan;
(e) the employer's insurance coverage is self-insured;
(f) the employee or member is covered by or eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
(g) the employee or member is covered for similar benefits under an individual contract or policy;
(h) the person has not been continuously covered during the 3 month period immediately preceding that person's termination of coverage.

(**2) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

(***3) Percentage co-payments present a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate. In a PPO, percentage co-payments for non-emergency services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges whichever is less, and enrollees are also responsible for any excess amount.

(****4) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.

(*****5) Once enrolled in Conversion Plan, an enrollee who subsequently becomes eligible for Medicare does not lose his/her eligibility to remain enrolled in Conversion Plan coverage.

When you pay a Copayment for these services, ask for and keep the receipt. When the receipts add up to the annual Copayment limit, you can stop making Copayments. You should photocopy the receipts and send then original receipts to:

L.A. Care Health Plan
ATTN: Member Services Department-Co-Pay Refund Request
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

The Plan will provide you with a "Copayment Certification" letter, which will verify that you are no longer required to make Copayments for the remainder of the benefit year. Keep the "Copayment Certification" letter with you whenever you obtain care and show it whenever you are asked about paying a Copayment. If you need assistance with a Copayment problem, contact your Primary Care Provider or the Member Services toll free at **1-888-839-9909 (TTY/TDD 1-866-522-2731).**

BENEFITS AND COST SHARING

We cover the Services described in this "Benefits and Cost Sharing" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
    - health care items and services for preventive care
    - health care items and services for diagnosis, assessment, or treatment
    - health education covered under "Health Education" in this "Benefits and Cost Sharing" section
    - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
    - drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section
    - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside your Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
    - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
    - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
    - hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section
- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

The only Services we cover under this Membership Agreement and Evidence of Coverage are those that this "Benefits and Cost Sharing" section says that we cover, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. The "Exclusions, Limitations, Coordination of Benefits, and Reductions" section describes exclusions, limitations, reductions, and coordination of benefits provisions that apply to all Services that would otherwise be covered. When an exclusion or limitation applies only to a particular benefit, it is listed in the description of that benefit in this "Benefits and Cost Sharing" section. Also, please refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care

COST SHARING

General rules, examples, and exceptions

Your Cost Sharing for covered Services will be the Cost Sharing in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this Membership Agreement and Evidence of Coverage, 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 evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of 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

Cost Sharing for Services received by newborns. During the 31 days of automatic coverage for newborn children, the parent or guardian of the baby must pay the Cost Sharing indicated in this "Benefits and Cost Sharing" section for any Services that the baby receives, whether or not the baby is enrolled.

Receiving a bill. In most cases, your provider will ask you to make a payment toward your Cost Sharing at the time you receive Services. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the covered Services you receive, and you will be billed for any additional Cost Sharing amounts that are due. In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for any Cost Sharing amounts that are due. For example, some Laboratory Departments do not collect Cost Sharing, and you will be billed for any 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 you will be asked 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 to diagnose your problem. You will be billed for any Cost Sharing that applies 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 you will be asked 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 will be billed for any Cost Sharing that applies for the unscheduled Services of the second provider, in addition to the Cost Sharing amount you paid at check-in for your diagnostic exam

- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in you will be asked 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 will be billed for any Cost Sharing that applies 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
- At check-in, you ask to be billed for some or all of the Cost Sharing for the Services you will receive, and the provider agrees to bill you
- Medical Group authorizes a referral to a Non–Plan Provider and the provider does not collect Cost Sharing at the time you receive Services

For more information about Cost Sharing. If you have questions about Cost Sharing for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please call L.A. Care Member Services at **1-888-839-9909**.

Noncovered Services. If you receive Services that are not covered under this Membership Agreement and Evidence of Coverage, you may be liable for the full price of those Services. Payments you make for noncovered Services are not Cost Sharing.

Deductibles
In any calendar year, you must pay Charges for Services subject to the Deductible until you meet the Deductible. The Deductible is $1,500 per calendar year.

After you meet the Deductible and for the remainder of the calendar year, you pay the applicable Copayment or Coinsurance subject to the limits described under "Annual out-of-pocket maximum" in this "Benefits and Cost Sharing" section.

Services that are subject to the Deductible. The Cost Sharing that you must pay for covered Services is in these "Benefits and Cost Sharing" and the "Chiropractic Services Amendment" sections. When the Cost Sharing is described as "subject to the Deductible," and you have not met the Deductible, you must pay Charges for those Services. Note: When we cover Services at "no charge" subject to the Deductible and you have not met your Deductible, you must pay Charges for the Services.

Note: If you pay a Deductible amount for a Service that has a visit limit, the Services count toward reaching the limit.

Keeping track of the Deductible. When you pay an amount toward your Deductible, Ask for and keep the receipt. When the receipts add up to the annual Deductible maximum, you stop making payments. Any overpayments will be refunded to you.

Copayments and Coinsurance
The Copayment or Coinsurance you must pay for each covered Service (after you meet any applicable Deductible) is described in this "Benefits and Cost Sharing" section.

Annual out-of-pocket maximum
There is a limit to the total amount of Cost Sharing you must pay under this Membership Agreement and Evidence of Coverage in a calendar year for all of the covered Services listed below that you receive in the same calendar year. The limit is $3,500 per calendar year.

Payments that count toward the maximum. Any amounts you pay for covered Services subject to the Deductible, as described under "Deductibles," apply toward the annual out-of-pocket maximum. Also, the Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum:

- Administered drugs
- Ambulance Services
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Behavioral health treatment for pervasive developmental disorder or autism
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care, except that for mental health hospital care, the only care that counts is care for these mental health conditions:
    - Serious Emotional Disturbances of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section
    - these Severe Mental Illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- Imaging, laboratory, and special procedures
- Intensive psychiatric treatment programs
- Outpatient surgery
- Prosthetic and orthotic devices
- Services performed during an office visit (including professional Services such as dialysis treatment, health education counseling and programs, and physical, occupational, and speech therapy). However, chemical dependency and chiropractic evaluation and treatment do not count toward the maximum, and the only mental health Services that count toward the maximum are Services for these mental health conditions:
    - Serious Emotional Disturbances of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section

    - these Severe Mental Illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- Skilled Nursing Facility care

Copayments and Coinsurance you pay for Services that are not listed above do not apply to the annual out-of-pocket maximum. For these Services, you must pay Copayments or Coinsurance even if you have already reached your annual out-of-pocket maximum.

Keeping track of the maximum. When you pay Cost Sharing that applies toward the annual out-of-pocket maximum, ask for and keep the receipt. When the receipts add up to the out-of-pocket maximum you stop making payments. You should photocopy the receipts and send the original receipts to:

L.A. Care Health Plan
ATTN: Member Services Department-Co-Pay Refund Request
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

The Plan will provide you with a “Copayment Cost Sharing Certification” letter, which will verify that you are no longer required to make Copayments for the remainder of the benefit year. Keep the “Certification” letter with you whenever you obtain care and show it whenever you are asked about paying a Copayment or Deductible. If you need assistance with a Copayment problem, contact your Primary Care Provider or the Member Services toll free at **1-888-839-9909 (TTY/TDD 1-866-522-2731).**

PREVENTIVE CARE SERVICES

We cover a variety of Preventive Care Services. This "Preventive Care Services" section explains Cost Sharing for some Preventive Care Services, but it does not otherwise explain coverage. For coverage of Preventive Care Services, please refer to the applicable benefit heading in this "Benefits and Cost Sharing" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. For example, for coverage of outpatient imaging Services, please refer to the "Outpatient Imaging, Laboratory, and Special Procedures" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

We cover at **no charge (not subject to the Deductible)** the Preventive Care Services on the health care reform preventive care Services list. This list is subject to change at any time. For more information call L.A. Care Member Services toll free at **1-888-839-9909 (TTY/TDD 1-866-522-2731).** Note: If you receive any other covered Services during a visit that includes Preventive Care Services on the list, you will pay the applicable Cost Sharing for those other Services.

The following are examples of Preventive Care Services that are included in our health care reform preventive care Services list:

- Routine physical maintenance exams, including well woman exams (refer to "Outpatient Care")

- Scheduled routine prenatal exams (refer to "Outpatient Care")
- Well-child exams for children 0-23 months (refer to "Outpatient Care")
- Health education counseling programs (refer to "Health Education")
- Immunizations (refer to "Outpatient Care")
- Routine preventive imaging and laboratory Services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

OUTPATIENT CARE

We cover the following outpatient care subject to the Cost Sharing indicated:

- Primary and specialty care consultations, exams, and treatment (other than those described below in this "Outpatient Care" section): a $**30 Copayment per visit (not subject to the Deductible)**
- Preventive Care Services:
    - routine physical maintenance exams, including well-woman exams: **no charge (not subject to the Deductible)**
    - screening and counseling Services, such as obesity counseling, routine vision and hearing screenings, health education, and depression screening: **no charge (not subject to the Deductible)**
    - well-child preventive exams for Members through age 23 months: **no charge (not subject to the Deductible)**
    - after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **no charge (not subject to the Deductible)**
    - comprehensive breastfeeding support and counseling: **no charge (not subject to the Deductible)**
    - alcohol and substance abuse screenings: **no charge (not subject to the Deductible)**
    - developmental screenings to diagnose and assess potential developmental delays: **no charge (not subject to the Deductible)**
    - immunizations (including the vaccine) administered to you in a Plan Medical Office: **no charge (not subject to the Deductible)**
    - flexible sigmoidoscopies: **no charge (not subject to the Deductible)**
    - screening colonoscopies: **no charge (not subject to the Deductible)**
- Allergy injections (including allergy serum): a **$5 Copayment per visit subject to the Deductible**
- Outpatient surgery: a **$250 Copayment per procedure subject to the Deductible** 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. Any other outpatient surgery is covered at a **$30 Copayment per procedure (not subject to the Deductible)**
- Outpatient procedures (other than surgery): a **$250 Copayment per procedure subject to the Deductible** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a

licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")
- Physical, occupational, and speech therapy: **a $30 Copayment per visit subject to the Deductible**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a $30 Copayment per day subject to the Deductible**
- Urgent Care consultations, exams, and treatment: **a $30 Copayment per visit (not subject to the Deductible)**
- Emergency Department visits: **a $150 Copayment per visit subject to the Deductible.** After you meet the Deductible, the Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). However, after you meet the Deductible, the Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) when care can best be provided in your home as determined by a Plan Physician: **no charge (not subject to the Deductible)**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a $30 Copayment per visit (not subject to the Deductible)**
- Blood, blood products, and their administration: **no charge subject to the Deductible**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge (not subject to the Deductible)**
- Some types of outpatient consultations, exams, and treatment may be available as group appointments, which we cover at **a $15 Copayment per visit (not subject to the Deductible)**

Services not covered under this "Outpatient Care" section
The following types of outpatient Services are covered only as described under these headings in this "Benefits and Cost Sharing" section:
- Bariatric Surgery
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care

- Hospice Care
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Transplant Services
- Vision Services

HOSPITAL INPATIENT CARE

We cover the following inpatient Services at **a $500 Copayment per day subject to the Deductible** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals:

- 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 Plan 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). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy
- Medical social services and discharge planning

Services not covered under this "Hospital Inpatient Care" section

The following types of inpatient Services are covered only as described under the following headings in this "Benefits and Cost Sharing" section:

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services

- Dialysis Care
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

AMBULANCE SERVICES

Emergency

We cover at **a $150 Copayment per trip subject to the Deductible** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Please refer to the "Post-Service Claims and Appeals" section for how to file a claim for reimbursement.

Nonemergency

Inside your Service Area, we cover nonemergency ambulance and psychiatric transport van Services at **a $150 Copayment per trip subject to the Deductible** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion

Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan Provider

BARIATRIC SURGERY

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

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success

- A Plan 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 Inpatient Care" in this "Benefits and Cost Sharing" section for the Cost Sharing that applies for hospital inpatient care.

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain travel and lodging expenses **(not subject to the Deductible)** if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. We will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage **(not subject to the Deductible)**
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage **(not subject to the Deductible)**
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage **(not subject to the Deductible)**
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage **(not subject to the Deductible)**

Services not covered under this "Bariatric Surgery" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section:

- "Qualified Autism Service Provider" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for pervasive developmental disorder or autism and is either of the following:

    - a person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies
    - a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist
- "Qualified Autism Service Professional" means a person who meets all of the following criteria:
    - provides behavioral health treatment
    - is employed and supervised by a Qualified Autism Service Provider
    - provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
    - is a behavioral health treatment provider approved as a vendor by a California regional center to provide Services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations
    - has training and experience in providing Services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code
- "Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
    - is employed and supervised by a Qualified Autism Service Provider
    - provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
    - meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code
    - has adequate education, training, and experience, as certified by a Qualified Autism Service Provider

We cover behavioral health treatment for pervasive developmental disorder or autism (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all of the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
    - a Qualified Autism Service Provider
    - a Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider
    - a Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider

- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
    - Describe the Member's behavioral health impairments to be treated
    - Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
    - Provide intervention plans that utilize evidence based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
    - Discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
    - for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
    - to reimburse a parent for participating in the treatment program

You pay the following for these covered Services:

- Individual visits: **a $30 Copayment per visit (not subject to the Deductible)**
- Group visits: **a $15 Copayment per visit (not subject to the Deductible)**

Effective as of the date that federal proposed final rulemaking for essential health benefits is issued, we will cover Services under this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section only if they are included in the essential health benefits that all health plans will be required by federal regulations to provide under section 1302(b) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act.

CHEMICAL DEPENDENCY SERVICES

Inpatient detoxification

We cover hospitalization at **a $500 Copayment per day subject to the Deductible** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual chemical dependency evaluation and treatment: **a $30 Copayment per visit (not subject to the Deductible)**
- Group chemical dependency treatment: **a $5 Copayment per visit (not subject to the Deductible)**

We cover methadone maintenance treatment at **no charge (not subject to the Deductible**) for pregnant Members during pregnancy and for two months after delivery at a licensed treatment center approved by the Medical Group. We do not cover methadone maintenance treatment in any other circumstances.

Transitional residential recovery Services We cover up to 60 days per calendar year of chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. We cover these Services at **a $100 Copayment per admission subject to the Deductible.** We do not cover more than 120 days of covered care in any five-consecutive-calendar-year period. These settings provide counseling and support services in a structured environment.

Services not covered under this "Chemical Dependency Services" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Chemical dependency Services exclusion
Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical Dependency Services" section

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

Dental Services for radiation treatment
We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist

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

- 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 "Benefits and Cost Sharing" section
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist.

Cost Sharing for dental and orthodontic Services
You pay the following for dental and orthodontic Services covered under this "Dental and Orthodontic Services" section:

- Hospital inpatient care: **a $500 Copayment per day subject to the Deductible**
- Outpatient consultations, exams, and treatment: **a $30 Copayment per visit (not subject to the Deductible)**
- Outpatient surgery: **a $250 Copayment per procedure subject to the Deductible** 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. Any other outpatient surgery is covered at **a $30 Copayment per procedure (not subject to the Deductible)**
- Outpatient procedures (other than surgery): **a $250 Copayment per procedure subject to the Deductible** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")

Services not covered under this "Dental and Orthodontic Services" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DIALYSIS CARE
We cover acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside your Service Area

- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

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 your Service Area at **no charge subject to the Deductible.** 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.

You pay the following for these covered Services related to dialysis:

- Inpatient dialysis care: **a $500 Copayment per day subject to the Deductible**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, exam, or treatment: **no charge (not subject to the Deductible)**
- Hemodialysis treatment at a Plan Facility: **a $30 Copayment per visit subject to the Deductible**
- All other outpatient consultations, exams, and treatment: **a $30 Copayment per visit (not subject to the Deductible)**

Services not covered under this "Dialysis Care" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Durable medical equipment for home use (refer to "Durable Medical Equipment for Home Use")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dialysis Care exclusions

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

DURABLE MEDICAL EQUIPMENT FOR HOME USE

Inside your Service Area, we cover the durable medical equipment specified in this "Durable Medical Equipment for Home Use" section for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment 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, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment is provided at **30% Coinsurance (not subject to the Deductible).** 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.

Inside your Service Area, we cover the following durable medical equipment for use in your home (or another location used as your home):

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- Nebulizer and supplies
- Peak flow meters
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns

Outside the Service Area
We do not cover most durable medical equipment for home use outside your Service Area. However, if you live outside the Service Area, we cover the following durable medical equipment (subject to the Cost Sharing and all other coverage requirements that apply to durable medical equipment for home use) when the item is dispensed at a Plan Facility:

- Standard curved handle cane
- Standard crutches
- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Insulin pumps and supplies to operate the pump (but not including insulin or any other drugs), after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

About our durable medical equipment formulary
Our durable medical equipment formulary includes the list of durable medical equipment that has been approved by our Durable Medical Equipment Formulary Executive Committee for our Members. Our durable medical equipment formulary was developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with durable medical equipment expertise (for example: physical, respiratory, and enterostomal therapists and home health). A

multidisciplinary Durable Medical Equipment Formulary Executive Committee is responsible for reviewing and revising the durable medical equipment formulary. Our durable medical equipment formulary is periodically updated to keep pace with changes in medical technology and clinical practice.

Our formulary guidelines allow you to obtain nonformulary durable medical equipment (equipment not listed on our durable medical equipment formulary for your condition) if the equipment would otherwise be covered and the Medical Group determines that it is Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Breastfeeding Supplies
We will cover at **no charge (not subject to the Deductible)** one retail-grade breast pump per pregnancy and the necessary supplies to operate it, such as one set of bottles. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements or the formulary guidelines.

Inside your Service Area, if you or your baby has a medical condition that requires the use of a breast pump, we will cover at **no charge (not subject to the Deductible)** a hospital-grade breast pump and the necessary supplies to operate it, in accord with our durable medical equipment formulary guidelines. We will determine whether to rent or purchase the equipment and we choose the vendor. Hospital-grade breast pumps on our formulary are subject to the durable medical equipment prior authorization requirements as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section. For more information about our durable medical equipment formulary, see the "About our durable medical equipment formulary" in this "Durable Medical Equipment for Home Use" section.

Services not covered under this "Durable Medical Equipment for Home Use" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")

Durable medical equipment for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described under "Breastfeeding supplies" in this "Durable Medical Equipment for Home Use" section
- Repair or replacement of equipment due to loss or Misuse

FAMILY PLANNING SERVICES

We cover the following family planning Services subject to the Cost Sharing indicated:

- Family planning counseling: **no charge (not subject to the Deductible)**
- Consultations for internally implanted time-release contraceptives or intrauterine devices (IUDs): **no charge (not subject to the Deductible)**
- Female sterilization procedures: **no charge (not subject to the Deductible)**
- Male sterilization procedures: **a $30 Copayment per visit (not subject to the Deductible)**, except that you pay **a $250 Copayment per procedure subject to the Deductible** if the procedure is provided in an outpatient or ambulatory surgery center or in a hospital operating room
- Medically Necessary termination of pregnancy: **a $30 Copayment per procedure subject to the Deductible**
- Voluntary termination of pregnancy: **a $30 Copayment per procedure subject to the Deductible**

Services not covered under this "Family Planning Services" section

- Laboratory and outpatient imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Family Planning Services exclusions

- Reversal of voluntary sterilization

HEALTH EDUCATION

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this "Benefits and Cost Sharing" section.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma).

You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge (not subject to the Deductible)**
- Individual counseling when the office visit is solely for health education: **no charge (not subject to the Deductible)**
- Health education provided during an outpatient consultation or exam covered in another part of this "Benefits and Cost Sharing" section: **no additional Cost Sharing beyond the Cost Sharing required in that other part of this "Benefits and Cost Sharing" section**
- Covered health education materials: **no charge (not subject to the Deductible)**

HEARING SERVICES

We do not cover hearing aids (other than internally implanted devices as described in the "Prosthetic and Orthotic Devices" section). However, we do cover the following:

- Routine hearing screenings that are Preventive Care Services: **no charge (not subject to the Deductible)**
- Hearing exams to determine the need for hearing correction: **no charge (not subject to the Deductible)**

Services not covered under this "Hearing Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Cost Sharing" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

HOME HEALTH CARE

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care at **no charge (not subject to the Deductible)** only if all of the following are true:

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

We cover only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per calendar year (counting all home health visits)

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours,

then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

Services not covered under this "Home Health Care" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

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 at **no charge (not subject to the Deductible)** only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside your Service Area or inside California but within 15 miles or 30 minutes from your Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan 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:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call Member Services for the current list of these drugs)
- 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

MENTAL HEALTH SERVICES

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

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa
- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental

disorder" in the DSM, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- the child displays psychotic features, or risk of suicide or violence due to a mental disorder
- the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

For Mental Disorders other than Severe Mental Illness of a person of any age and Serious Emotional Disturbance of a child under age 18, we cover evaluation and treatment only when a Plan Physician or other Plan Provider who is a licensed health care professional acting within the scope of his or her license believes the condition will significantly improve with relatively short-term therapy.

Outpatient mental health Services
We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Up to a combined visit limit of 10 individual and group visits per Member per calendar year that include Services for mental health evaluation and treatment as described in this "Outpatient mental health Services" section. Members who have exhausted the 10-visit limit and who meet Medical Group criteria may receive up to 30 additional group visits in the same calendar year. These visit limits do not apply to mental health Services for Severe Mental Illness of a person of any age or Serious Emotional Disturbance of a child under age 18
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $30 Copayment per visit (not subject to the Deductible)**
- Group mental health treatment: **a $15 Copayment per visit (not subject to the Deductible)**

Note: Outpatient intensive psychiatric treatment programs are not covered under this "Outpatient mental health Services" section (refer to "Intensive psychiatric treatment programs" under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Mental Health Services" section).

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at **a $500 Copayment per day subject to the Deductible.**

Intensive psychiatric treatment programs. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover at **no charge subject to the Deductible** the following intensive psychiatric treatment programs at a Plan Facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-aday monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs. There is a combined day limit of 10 days per Member per calendar year for psychiatric care described under "Inpatient psychiatric hospitalization" and "Intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, except that the day limit does not apply to mental health Services for Severe Mental Illnesses of a person of any age or Serious Emotional Disturbance of a child under age 18. The number of days is determined by adding up the number of days of inpatient psychiatric hospitalization and intensive psychiatric treatment program Services we cover in a calendar year that are subject to the limit as follows:

- Each day of inpatient psychiatric hospitalization counts as one day
- Two days of hospital-based intensive outpatient care (partial hospitalization) count as one day
- Three days of treatment in an intensive outpatient psychiatric treatment program count as one day
- Each day of treatment in a crisis residential program counts as one day
- Two psychiatric observation treatment periods of 23 consecutive hours or less count as one day

If you reach the day limit, we will not cover any more inpatient psychiatric hospitalization or intensive psychiatric treatment program Services in that calendar year if they are subject to the day limit.

Services not covered under this "Mental Health Services" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Ostomy and Urological Supplies

Inside your Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines at **no charge (not subject to the Deductible).** We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

About our soft goods formulary

Our soft goods formulary includes the list of ostomy and urological supplies that have been approved Our soft goods formulary is periodically updated to keep pace with changes in medical technology and clinical practice. To find out whether a particular ostomy or urological supply is included in our soft goods formulary, please call Member Services toll free at **1-888-839-9909 (TTY/TDD 1-866-522-2731).**

Our formulary guidelines allow you to obtain nonformulary ostomy and urological supplies (those not listed on our soft goods formulary for your condition) if they would otherwise be covered and the Medical Group determines that they are Medically Necessary

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or Features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Sharing indicated only when prescribed as part of care covered under other headings in this "Benefits and Cost Sharing" section:

- Imaging Services that are Preventive Care Services:
    - preventive mammograms: **no charge (not subject to the Deductible)**
    - preventive aortic aneurysm screenings: **no charge (not subject to the Deductible)**
    - bone density CT scans: **no charge (not subject to the Deductible)**
    - bone density DEXA scans: **no charge (not subject to the Deductible)**
- All other CT scans, and all MRIs and PET scans: **a $50 Copayment per procedure subject to the Deductible**
- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **a $10 Copayment per encounter subject to the Deductible** except that certain imaging procedures are covered at **a $250 Copayment per procedure subject to the Deductible** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are 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
- Nuclear medicine: **a $10 Copayment per encounter subject to the Deductible**
- Laboratory tests:

    - laboratory tests to monitor the effectiveness of dialysis: **no charge subject to the Deductible**
    - fecal occult blood tests: **no charge (not subject to the Deductible)**
    - routine laboratory tests and screenings that are Preventive Care Services, such as cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), fasting blood glucose tests, glucose tolerance tests, certain sexually transmitted disease (STD) tests, and HIV tests: **no charge (not subject to the Deductible)**
    - all other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **a $10 Copayment per encounter subject to the Deductible**
- Routine preventive retinal photography screenings: **no charge (not subject to the Deductible)**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **a $10 Copayment per encounter subject to the Deductible** except that certain diagnostic procedures are covered at **a $250 Copayment per procedure subject to the Deductible** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are 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
- Radiation therapy: **no charge subject to the Deductible**
- Ultraviolet light treatments: **no charge (not subject to the Deductible)**

OUTPATIENT PRESCRIPTION DRUGS, SUPPLIES, AND SUPPLEMENTS

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

- Items prescribed by Plan Physicians in accord with our drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
    - Dentists if the drug is for dental care
    - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) 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 described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)

How to obtain covered items

You must obtain covered drugs, supplies, and supplements at a Plan Pharmacy or through our mail order service unless the item is obtained as part of covered

Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section.

Refills. You may be able to order refills at a Plan Pharmacy, through our mail-order service Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether or not your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Outpatient contraceptive drugs and devices
We cover the following contraceptive drugs and devices:

- Oral contraceptives (including emergency contraception pills)
- Contraceptive rings
- Contraceptive patches
- Diaphragms
- Cervical caps

Cost Sharing for outpatient contraceptive drugs and items. The Cost Sharing for these items is as follows:

- Diaphragms and cervical caps: no charge (not subject to the Deductible)
- Generic contraceptive rings, contraceptive patches, and oral contraceptives (other than emergency contraceptive pills): no charge (not subject to the Deductible) for up to a 100-day supply
- Brand-name contraceptive rings, contraceptive patches, and oral contraceptives (other than emergency contraceptive pills): no charge (not subject to the Deductible) for up to a 100-day supply
- Emergency contraceptive pills: no charge (not subject to the Deductible)

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

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Cost Sharing for outpatient drugs, supplies, and supplements. The Cost Sharing for these items is as follows:

- Generic items (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) at a Plan Pharmacy: **a $10 Copayment** for up to a 30-day supply, **a $20 Copayment** for a 31- to 60-day supply, or **a $30 Copayment** for a 61- to 100-day supply
- Generic items (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) through our mail-order service: **a $10 Copayment** for up to a 30-day supply or **a $20 Copayment** for a 31- to 100-day supply

- Brand-name items and compounded products (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) at a Plan Pharmacy: **a $35 Copayment** for up to a 30-day supply, **a $70 Copayment** for a 31- to 60-day supply, or **a $105 Copayment** for a 61- to 100-day supply
- Brand-name items and compounded products (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) through our mail-order service: **a $35 Copayment** for up to a 30-day supply or **a $70 Copayment** for a 31-to 100-day supply
- Drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Hematopoietic agents for dialysis: **no charge** for up to a 30-day supply
- Continuity drugs (if this Membership Agreement and Evidence of Coverage is amended to exclude a drug that we have been covering and providing to you under this Membership Agreement and 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 federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

Note: If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount.

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) at **no charge** for up to a 30-day supply and the supplies and equipment required for their administration at **no charge**. Note: Injectable drugs and insulin are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" paragraph).

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 at no charge for up to a 100-day supply.

We cover the following insulin-administration devices at **a $10 Copayment** for up to a 100-day supply: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Day supply limit
The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30-, 60-, or 100-day supply for you. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply

prescribed up to the day supply limit also specified in this section. The day supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit. Note: We cover episodic drugs prescribed for the treatment of sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period.

The pharmacy may reduce the day supply dispensed at the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About our drug formulary

L.A. Care uses a list of approved drugs called a drug formulary.Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file a grievance as described in the "Dispute Resolution" section. Also, our formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

Services not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")

Outpatient prescription drugs, supplies, and supplements exclusions

- 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

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, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits and Cost Sharing" section. We cover these devices at **no charge subject to the Deductible.**

External devices

We cover the following external prosthetic and orthotic devices at **no charge (not subject to the Deductible):**

- 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 and 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 Plan Physician or by a Plan 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

Services not covered under this "Prosthetic and Orthotic Devices" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Contact lenses to treat aniridia or aphakia (refer to "Vision Services")

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, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

You pay the following for covered reconstructive surgery Services:

- Outpatient consultations, exams, and treatment: **a $30 Copayment per visit (not subject to the Deductible)**
- Outpatient surgery: **a $250 Copayment per procedure subject to the Deductible** 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. Any other outpatient surgery is covered at a $30 Copayment per procedure (not subject to the Deductible)
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **a $500 Copayment per day subject to the Deductible**

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" 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, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

SERVICES ASSOCIATED WITH CLINICAL TRIALS

We cover Services associated with cancer clinical trials if all of the following requirements are met:

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Plan Physician, or your treating Non–Plan Physician if the Medical Group authorizes a written referral to the Non–Plan Physician for treatment of cancer (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section), recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you
- The Services would be covered under this Membership Agreement and Evidence of Coverage if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

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.** For example, see "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section for the Cost Sharing that applies for hospital inpatient care.

Services associated with clinical trials exclusions

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

Skilled Nursing Facility Care

Inside your Service Area, we cover at **a $50 Copayment per day subject to the Deductible** up to 60 days per benefit period (including any days we covered under any other evidence of coverage) of skilled inpatient Services in a Plan 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 Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan 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
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy

Services not covered under this "Skilled Nursing Facility Care" section
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

TRANSPLANT SERVICES

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the 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, Plan Hospitals, the Medical Group, and Plan 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 Service Contact Center

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 "Benefits and Cost Sharing" section for the Cost Sharing that applies for hospital inpatient care.

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 at **no charge (not subject to the Deductible).**

Services not covered under this "Transplant Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services
We do not cover eyeglasses or contact lenses (except for special contact lenses described in this "Vision Services" section). However, we do cover the following:

- Routine vision screenings that are Preventive Care Services: **no charge (not subject to the Deductible)**
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge (not subject to the Deductible)**

Special contact lenses for aniridia and aphakia. We cover the following special contact lenses at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris): **no charge (not subject to the Deductible).** We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage)
- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge (not subject to the Deductible).** We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year (including when we provided an allowance toward, or otherwise covered, one or more aphakic contact lenses under any other evidence of coverage)

Services not covered under this "Vision Services" section
Coverage for the following Services is described under other headings in this "Benefits and Cost Sharing" section:

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Cost Sharing" section)

VISION SERVICES EXCLUSIONS

- Industrial frames
- Eyeglass lenses and frames

- Contact lenses, including fitting and dispensing (except for special contact lenses to treat aphakia or aniridia as described under this "Vision Services" section)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low-vision devices

EXCLUSIONS, LIMITATIONS, COORDINATION OF BENEFITS, AND REDUCTIONS

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 Membership Agreement and Evidence of Coverage 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 "Benefits and Cost Sharing" section.

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).

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 Plan Physician determines that the Services are Medically Necessary.

Chiropractic Services
Chiropractic Services and the Services of a chiropractor, except as described in the "Chiropractic Services Amendment."

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 "Benefits and Cost Sharing" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" 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

Note: Having a mental health condition does not make cosmetic Services become reconstructive surgery

Custodial care
Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.

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

This exclusion does not apply to Services covered under "Dental and Orthodontic Services" in the "Benefits and Cost Sharing" 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 Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section.

Experimental or investigational Services
A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

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

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment
Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Infertility Services
Services related to the diagnosis and treatment of infertility.

Intermediate care
Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "Benefits and Cost Sharing" section.

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 for the purpose of increasing 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, except that this exclusion for "teaching play" does not apply to Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Cost Sharing" section
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Hospital Inpatient Care," "Outpatient Care," "Home Health Care, "Hospice Services," or "Skilled Nursing Facility Care" in the "Benefits and Cost Sharing" section

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.

Massage therapy
Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Hospital Inpatient Care," "Outpatient Care," "Home Health Care, "Hospice Services," or "Skilled Nursing Facility Care" in the "Benefits and Cost Sharing" section.

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

This exclusion does not apply to any of the following:

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

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 crisis residential Services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery Services covered under the "Chemical Dependency 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 applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

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

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people
Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to Services covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Cost Sharing" section.

Services related to a noncovered Service
When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered 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 (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. 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 obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses
Travel and lodging expenses, except for the following:

- In some situations if the Medical Group refers you to a Non–Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines not subject to the Deductible. Our travel and lodging guidelines are available from our Member Service Contact Center
- Reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Benefits and Cost Sharing" section

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 Membership Agreement and Evidence of Coverage, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, 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" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

COORDINATION OF BENEFITS
If you have Medicare coverage, we will coordinate benefits with your Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is

"primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call our Member Service Contact Center to find out which Medicare rules apply to your situation, and how payment will be handled.

REDUCTIONS

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by third parties

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we obtain against a third party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

L.A. Care Health Plan
ATTN: Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: **1-888-839-9909**
TTY/TDD: **1-866-LACARE1 (1-866-522-2731)**
www.lacare.org

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Some providers have contracted with L.A. Care to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to recover all or a portion of the difference between the fees paid by L.A. Care and their General Fees by means of a lien claim under California Civil Code Sections 3045.1–3045.6 against a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

Medicare benefits
Your benefits are reduced by any benefits you have under Medicare except for Members whose Medicare benefits are secondary by law.

Surrogacy arrangements
If you enter into a Surrogacy Arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and

on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

L.A. Care Health Plan
ATTN: Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: **1-888-839-9909**
TTY/TDD: **1-866-LACARE1 (1-866-522-2731)**
www.lacare.org

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

U.S. Department of Veterans Affairs
For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits
You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether

you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

SPECIAL SERVICES

SPECIAL SERVICES FOR CHILDREN

California Children Services (CCS)
CCS is open to persons under the age of 21 with a disability. If your child has a chronic medical illness, he/she may be eligible for services under CCS. Talk to your child's PCP about CCS. Should your child be ineligible for CCS services or CCS fails to provide otherwise covered services, L.A. Care will provide coverage for covered services.

Child Health and Disability Prevention (CHDP)
Your child may receive CHDP through your child's local school. You may call CHDP at (323) 890-7941, if you have any questions.

SPECIAL SERVICES FOR NATIVE AMERICAN INDIANS

Native American Indians have the right to receive health care services at Indian Health Centers and Native American Health Clinics. You do not need to disenroll from L.A. Care to get health care services from an Indian Health Center or Native American Health Clinic. You may also disenroll from L.A. Care any time and for any reason. Please call Indian Health Services at 1-916-930-3927 for more information. You may visit the Indian Health Services website at www.ihs.gov for more information. American Indians can access medical services from Indian Health Clinics without prior referral from Primary Care Providers

WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM

The Women, Infants and Children (WIC) Supplemental Nutrition Program gives pregnant women, new mothers, and their babies nutrition information and food stamps. Ask your doctor or maternity nurse for more information about WIC. You may call WIC directly at **1-888-942-2229** or **1-888-WIC-Baby**.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

FQHCs are health centers that receive money from the federal government. FQHCs are located in areas that do not have a lot of health care services. As a member of L.A. Care, you have the right to receive your health care at a FQHC that is contracted with L.A. Care. Call L.A. Care for the names and addresses of the FQHCs that contract with L.A. Care.

GRIEVANCES/ COMPLAINTS AND APPEALS

GRIEVANCES/APPEALS

L.A. Care is interested in resolving any problems you may have with the services you receive.

We encourage you to first speak with your doctor and to work with your PCP to solve your grievance. But, if you are unhappy you may always write, visit, or call L.A. Care at the address below. You may also file a grievance on-line through L.A. Care's website at **www.lacare.org**.

L.A. Care Health Plan
ATTN: Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Toll free: **1-888-839-9909**
TTY/TDD Service: **1-866-LACARE1 (1-866-522-2731)**
www.lacare.org

Non-Urgent Grievance
L.A. Care will send you an acknowledgment letter within five (5) calendar days of getting your grievance. Your grievance will be resolved within 30 calendar days after it has been received by L.A. Care**.**

Urgent Grievance
An urgent grievance is when you are not happy with a health care service you received and feel that any delay with a decision can lead to a life-threatening or debilitating condition. An urgent grievance will be resolved within three (3) calendar days after it has been received by L.A. Care. L.A. Care will send you an acknowledgment letter within 24 hours of receiving your grievance.

If you are not happy with the outcome of your grievance, you can appeal that decision to the Department of Managed Health Care (DMHC).

APPEALS TO 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 **(1-888-839-9909)** 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 calendar 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-HMO-2219)** and a TTY/TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website **www.hmohelp.ca.gov** has complaint forms IMR application forms and instructions online."

Independent Medical Review

INDEPENDENT MEDICAL REVIEW (IMR)
The Independent Medical Review (IMR) is another appeal process that you may use if you believe a health care service should not have been denied, changed, or delayed by L.A. Care. You have up to six (6) months from the date of denial to file an IMR. You must first go through the L.A. Care grievance process, before applying for an IMR. In an urgent situation, you may file for an IMR with DMHC within a shorter time period.

There are no fees for an IMR. You have the right to give information in support of 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 any statutory right to pursue legal action against L.A. Care.

The IMR is filed with the Department of Managed Health Care (DMHC). You will receive information on how to file an IMR with your denial letter. You may reach the DMHC at toll-free **1-888-HMO-2219** or **1-888-466-2219.**

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

1. a) Your doctor has recommended a health care service as medically necessary and it was denied; or
   b) You have received urgent care or emergency services that a PCP determined was necessary and payment was denied; or
   C) You have been seen by a network doctor or a PCP for the diagnosis or treatment of the medical condition for which you seek independent review (even if the health care service was not recommended by a network provider).

2. The disputed health care service has been denied, changed, or delayed by L.A. Care. Care based in whole or in part on a decision that the health care service is not medically necessary.

3. You have filed a grievance with L.A. Care and the service is still denied, modified, delayed, or the grievance remains unresolved after 30 calendar days.

The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make a decision as to whether the requested treatment is or is not likely to be more beneficial than any available standard therapy. You will receive a copy of the IMR decision from the DMHC. If it is decided that the service is medically necessary, L.A. Care will provide the health care service.

If your grievance requires an expedited review, you do not have to participate in L.A. Care's grievance process for more than three (3) calendar days.

If there is an imminent and serious threat to your health as your information is reviewed by an independent medical review organization (within 24 hours of approval of request review) the DMHC may waive the requirement that you follow L.A. Care's grievance process.

Non-Urgent Cases
The IMR decision will be made within 30 calendar days. The 30 calendar days is counted from the time your application and documents are received by the DMHC.

Urgent Cases
If your grievance is urgent and requires fast (expedited) review you may contact the DMHC right away. You will not be required to remain in L.A. Care's grievance process for more than three (3) calendar days.

The urgent IMR decision will be made within three (3) calendar days from the time your information was received. Urgent cases include, but are not limited to:

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

If a medical service, treatment, drug, or device is denied because it is experimental or investigational, you will be informed of:

- the decision in writing within 5 business days from the decision to deny coverage; AND
- your right to file an Independent Medical Review for Experimental or Investigational Therapies (IMR-EIT)

IMRs FOR EXPERIMENTAL OR INVESTIGATIONAL THERAPIES (IMR-EIT)

You are not required to submit a grievance with L.A. Care before requesting an IMR-EIT through the Department of Managed Health Care (DMHC).
You can request an IMR-EIT through the DMHC when a medical service, drug or equipment is denied because it is experimental or investigational in nature. You have up to 6 months from the date of denial to file an IMR-EIT. You may provide information to the IMR-EIT panel. If your Primary Care Provider determines that the requested therapy is greatly less effective if not promptly initiated, you will receive a decision within seven (7) calendar days of the request for an expedited review. In urgent cases the IMR-EIT panel will give you a decision within three (3) business days from the time your information is received.

The IMR-EIT is filed with the Department of Managed Health Care (DMHC). You will receive information on how to file an IMR-EIT with your denial letter. You may reach the DMHC at toll-free **1-888-HMO-2219** or **1-888-466-2219.**

When to file an IMR-EIT:

You may file an IMR-EIT, if you meet all of the following requirements:

1. Have a very serious condition (life-threatening or seriously debilitating)
2. Your doctor must certify that:
    a. The standard treatments were not effective; or
    b. The standard treatments were not medically appropriate; or
    c. The proposed treatment will be the most effective.
3. Your doctor certifies in writing that:
    a. A drug, device, procedure, or other therapy is likely to work better than the standard treatment; or
    b. You or your doctor may request a therapy which, based on two medical and scientific documents, is likely to work better than the standard treatment.
4. You have been denied a drug, device, procedure, or other therapy requested by your doctor.
5. The drug, device, procedure or other therapy normally would be covered as a benefit, but L.A. Care has determined that it is experimental or investigational in nature.

The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR-EIT. The specialist will make a decision as to whether the requested treatment is or is not likely to be more beneficial than any available standard therapy. You will receive a copy of the IMR-EIT decision from the DMHC. If it is decided that the service is medically necessary, L.A. Care will provide the health care service.

For more information or help with the IMR-EIT process, or to request an application form, please call L.A. Care.

ARBITRATION

1. By enrolling in L.A. Care, all Members agree to submit any and all disputes and claims (including malpractice claims) between the Member (or any person submitting a dispute or claim on behalf of the Member) and L.A. Care and L.A. Care's medical providers to binding neutral arbitration, rather than being heard before a court or jury. This means that both L.A. Care and the Member agree to forego rights to jury or court trial.

2. The arbitration costs will be shared equally by the Member and the parties (L.A. Care, L.A. Care's medical providers) involved with the Member's claim or dispute, unless the Member is unable to pay his/her share of the costs of the neutral arbitrator's fees.

3. Any arbitration proceeding will be held under the Commercial Rules of the American Arbitration Association. Copies of the current rules and details of the

format and information required for an arbitration demand may be obtained by writing to L.A. Care Member Services Department at 1055 West 7th Street, 10th Floor, Los Angeles, CA 90017, or call L.A. Care Member Services at **1-888-839-9909.**

DISENROLLMENTS

L.A. Care coverage for members will end if any of the following has occurred:

- Fraud
- Loss of eligibility
- Failure to pay premiums
- Failure to make only partial of premiums due
- Nonpayment of any amounts due the Plan, Plan hospitals, a medical group or copayment due to a plan provider
- Plan hospitals, a medical group or copayment due a plan provider

If you are cancelled for non-payment of premium, your coverage will be renewed as if it had never been cancelled if payment is received on or before the due date of your next monthly premium payment.

Mandatory members will be involuntarily disenrolled from L.A. Care if any of the following has occurred:

- You allow someone else to use your L.A. Care ID card
- Your behavior is abusive or disruptive to the extent that it threatens the safety of employees, providers, members and/or patients
- Your repeated behavior substantially impairs the plan's ability to furnish or arrange services for you or other members or a provider's ability to provide services to other patients.

If you are disenrolled from L.A. Care we will send you a letter that says when your coverage will end and why. You may file an appeal with L.A. Care**.** Go to the "Grievances/Complaints and Appeals Section" for more information. You may also ask for a review from DMHC. Call L.A. Care for more information.

TERMINATION OF BENEFITS

Termination for Cause
If your membership terminates, all rights to benefits end at 12:00 a.m. on the termination date (for example, if your termination date is January 1, 2004, your last moment of coverage was at 11:59 p.m. on December 31, 2003). You will be billed as a non-Member for any Services you receive after your membership terminates. When your membership terminates under this section, Health Plan and Plan Providers have no further liability or responsibility under this Agreement, except as provided under "Payments after Termination" in this "Termination of Membership" section.

PLAN CONTRACT CANCELLATION

How you May Terminate your Membership
You may terminate your Individual Conversion Plan membership by sending written notice to the address below (the notice must be signed by the Subscriber). If we receive your notice on or before the last day of the month, your termination date will be the first of the following month. For example, if we received your notice on December 31, 2003, your last moment of coverage was at 11:59 p.m. on December 31, 2003 and your termination date was January 1, 2004. Also, you must include with your notice all amounts payable related to this Agreement, including Dues, for the period prior to the termination effective date.

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

L.A. Care managed care coverage will terminate if any of the following has occurred:

- The Member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan.
- Loss of eligibility the last day of the month in which you are no longer eligible.
- Failure to pay the entire premium (individual premium and/or family premium) due 15 days after the date of mailing of the prior written notification of cancellation of enrollment notice.
- Non-payment of other charges at least 15 days after receipt of written notice
- Voluntary termination by member the first of the month following adequate notice to plan.
- The member was terminated by L.A. Care from the Individual Conversion Plan for good cause.
- The employer's hospital, medical or surgical expense benefit program is self-insured.

Your Primary Care Provider will assist you in obtaining alternative coverage to ensure continuity of care if you become disenrolled due to non-payment of premiums or periodic charges while hospitalized or while receiving treatment for an ongoing medical condition. You will be notified in writing of the effective date of disenrollment. Benefits shall cease as of 12:00 a.m. midnight on such effective date.

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

MORE INFORMATION: WHAT ELSE DO I NEED TO KNOW?

IF YOU MOVE

When you move it is important to call the following people:

- Call L.A. Care. You will need to update your information (address and phone number). This allows L.A. Care to send you your ID Card and important information about your health care benefits.

IF YOU GET A BILL

L.A. Care pays for all covered medical costs approved by your PCP or for an emergency. You should not receive a bill for any services covered by L.A. Care. Please call L.A. Care if you receive a bill for medical services.

IF YOU HAVE OTHER INSURANCE

If you have any health insurance other than L.A. Care, it is important to let us know. If you are covered by more than one group health plan or group insurance coverage, L.A. Care will coordinate benefits with the other carrier. Please call L.A. Care if you have any questions. We will send all bills to the correct place for payment.

HOW A PROVIDER GETS PAID

Health care providers are paid in the following one way:

- Capitation - a flat rate paid each month per member

Please call L.A. Care if you would like to know more about how your doctor is paid, or about financial incentives or bonuses.

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

To ensure that all L.A. Care members receive the most appropriate medical care available, we have a team of people who review certain treatments, tests or hospital stays in a process called Utilization Management (UM). We require that all UM employees contracted physicians and management staff who deal with utilization management activities to sign an affirmative statement acknowledging the following:

- Utilization Management decision making is based only on appropriateness of care and service and existence of coverage.
- L.A. Care does not directly or indirectly reward practitioners or other individuals for issuing denials of coverage, service or care.
- L.A. Care does not provide financial incentives or compensation to Utilization Management decision makers to encourage underutilization of services.

- If you have any questions regarding the Affirmative Statement About Incentives, please call L.A. Care Member Services at **1-888-839-9909.**

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. If you are unhappy with the Plan's decision on new technology, you can file a complaint (also known as a grievance). Please refer to the section **"Grievances/Complaints and Appeals"**. The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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 of Managed Health Care also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website, **www.hmohelp.ca.gov**, has complaint forms, IMR application forms, and instructions online.

ORGAN DONATION

There is a need for organ donors in the United States. You can agree to donate your organs in the event of your death. The California Department of Motor Vehicles (DMV) will give you a donor card if you wish to become an organ or tissue donor. The DMV will also give you a donor sticker to place on your driver's license or I.D. card.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive allows you to select a person to make your health care choices for you when you cannot make them yourself. For example, when you are in a coma. An advance directive must be signed when you are able to make your own decisions. Ask your PCP or call L.A. Care for more information about advance directives.

WORKERS' COMPENSATION

L.A. Care will not pay for work related injuries covered by Workers' Compensation. L.A. Care will provide health care services you need while there are questions about an injury being work related. Before L.A. Care will do this, you must agree to give L.A. Care all information and documents needed to recover costs for any services provided.

GOVERNING LAW

L.A. Care coverage is subject to the requirements of the California Knox-Keene Act, Chapter 2.2 of Division 2 of the California Health and Safety Code, and the regulations set forth at Subchapters 5.5 and 5.8 of Chapter 3 of Title 28 of the California Administrative Code. Any provision required to be in this benefit program by either the Knox-Keene Act or the regulations shall be binding on L.A. Care even if it is not included in this Evidence of Coverage or the Group Service Agreement.

THIRD PARTY LIABILITY& COORDINATION OF BENEFITS

THIRD PARTY LIABILITY

If you are injured through the act or omission of another person (a "third party"), L.A. Care shall, with respect to services required as a result of that injury, provide the Benefits under L.A. Care only on the condition that the Member agrees in writing:

- to immediately upon collection of damages, whether by action at law, settlement, or otherwise, reimburse L.A. Care the sum of the costs actually paid by
- L.A. Care, medical group, or independent practice association for health care services not provided on a capitated basis or

- for health care services provided on a capitated basis, to reimburse L.A. Care 80% of the usual and customary charges for the same services by medical providers that provide health care services on a noncapitated basis.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan or group insurance coverage, L.A. Care will coordinate benefits with the other carrier. If another carrier covering you under a group health plan is primary, then L.A. Care or its L.A. Care Providers will seek compensation from that carrier for benefits provided under L.A. Care coverage. You will receive all of the Benefits to which you are entitled under this Plan, but no more than these benefits. This coordination of benefits will be done by L.A. Care in accordance with the rules of the California Department of Managed Health Care.

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

When coordinating benefits, L.A. Care determines the primary carrier as follow:

- If you are the Subscriber, then the coverage that you obtain through employment is primary.

Note: Even if you have other coverage, benefits will only be covered under L.A. Care if provided by L.A. Care providers and authorized in accordance with L.A. Care rules.

PARTICIPATING IN PUBLIC POLICY MEETINGS

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

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

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

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

RCAC's meet once a month. RCAC members include L.A. Care members, member advocates (supporters), and health care providers. For more information about RCACs, call **L.A. Care Community Outreach and Education at 1-888-522-2732**. This call is free.

OTHER SERVICES

Questions about your health can come up at any time and the L.A. Care Nurse Advice Line gives you information, 24 hours a day, 7 days a week, at no cost to you. Call **1-800-249-3619**. Hearing- or speech- impaired members can contact L.A. Care Nurse Advice Line through the California Telecommunications Relay Service at **1-866-735-2929** (TTY/TDD) or **1-800-854-7784** (speech-to-speech). Staff will inform you on what type of care you may need, based on your health condition/symptoms.

MISCELLANEOUS PROVISIONS

Administration of Agreement
L.A. Care may adopt reasonable policies, procedures and interpretations to promote orderly and efficient administration of this Agreement.

Agreement Binding on Members
By electing coverage or accepting benefits under the Agreement, all members legally capable of contracting and the legal representatives of all members incapable of contracting, agree to all provisions of this Agreement.

Amendment of Agreement

Upon 30 days written notice to the member, L.A. Care may amend this Agreement. All such amendments are deemed accepted by the member unless the member gives L.A. Care written notice of nonacceptance within 30 days of the notice in which case this Agreement terminates the day before the effective date of the amendment.

If L.A. Care notified the member that L.A. Care had not received all necessary governmental approvals related to this Agreement, L.A. Care may amend this Agreement by giving written notice to the member after receiving all necessary governmental approval. Such government approved provisions go into effect on September 1, 2003 (unless the government requires a later effective date).

In addition, L.A. Care may amend this Agreement at any time by giving written notice to the member, in order to address any law or regulatory requirement, which may include amending the L.A. Care monthly premium fees to reflect an increase in costs to L.A. Care or its Providers (or any of their activities).

Applications and Statements
You must complete any applications, forms or statements that L.A. Care requests in our normal course of business or as specified in this Agreement.

Assignment
You may not assign this Agreement or any of the rights, interests, claims for money due, benefits or obligations hereunder without our prior written consent.

No Waiver
L.A. Care's failure to enforce any provision of this Agreement will not constitute a waiver of that or any other provision, or impair L.A. Care's right thereafter to require your strict performance of any provision.

Non discrimination
We do not discriminate in our employment practices or in the delivery of services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation or physical or mental disability.

Notices
Notices will be sent to the most recent address we have for the member. The member is responsible for notifying L.A. Care of any changes in address. Members who move should call the Member Service toll free at **1-888-839-9909 (TTY/TDD 1-866-522-2731)**, as soon as possible.

Term of Agreement
This Agreement is effective when you, the member, first elects Conversion coverage, unless terminated as set forth in the "Termination of Benefits" Section.

GLOSSARY

This glossary may be used to help you understand words and terms used in this Member Handbook. Please call L.A. Care if you have any questions about the words listed here or a word you cannot find.

Acute/Acute Condition is a term used for a serious and sudden condition that lasts a short time. Not chronic. Examples include a heart attack, pneumonia, or appendicitis.

Appropriately qualified health care professional(s) is a professional who is licensed to practice medicine. The doctor also has the training and expertise to treat the person's specific medical condition. When requesting a second opinion or standing referral the member will be referred to this doctor (PCP or specialist).

Authorize/Authorization is when a health plan approves treatment for covered health care services. Members must pay for all non-approved treatment.

Benefits are the health care services, supplies, drugs, and equipment that are medically necessary.

Chronic is a term used for a condition that is long-term and on-going. Not acute. Examples include diabetes, asthma, allergies, and hypertension.

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

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section. Note: The dollar amount of the Copayment can be $0 (no charge).

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

Cost Sharing: The amount you are required to pay for a covered Service, for example: the Deductible, Copayment, or Coinsurance.

Curative is having the ability to cure or heal.

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Please refer to the "Benefits and Cost Sharing" section for the Services that are subject to the Deductible(s) and the Deductible amount(s).

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

Disability/Disabled/Disabling is a physical or mental problem that totally or seriously limits one or more major life activity.

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

Eligible/Eligibility means a member whose coverage under a group contract has been terminated is eligible for individual conversion coverage.

Experimental or investigational in nature is new medical treatment that is still being tested, but has not been proven to treat a condition.

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

Grievance/Complaint is the process used when a member is not happy with his/her health care. Grievances are about services of care received or not received.

Health care services include some of the following:

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

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

Hospital provides inpatient and outpatient care from doctors or nurses.

Incarceration is when a person is placed in jail, prison or a mental institution for a long time.

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

Inpatient is when a person is admitted to (stays overnight in) a hospital or other health care facility.
Involuntary/Involuntarily is when something is done without choice.

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

Medi-Cal is a state and federal health coverage program for low-income families.

Medical group is a group of PCPs, specialists, and other health care providers that work together.

Medically necessary/Medical necessity are those services provided to treat an illness or injury according to established and accepted medical practice standards.

Subscriber/Member is a person who has joined a health plan.

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

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

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

Occupational therapy is used to improve and maintain a patient's daily living skills, because of a disability.

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

Outpatient is the medical treatment in a hospital or clinic without an overnight stay.

Pharmacy is a place to get prescribed drugs.

Physical therapy uses exercise to improve and maintain a patient's ability to function after an illness or injury.

Physician is a doctor.

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

Primary care physician (PCP) is a personal doctor. The PCP takes care of health care needs and works with members to keep them healthy. The PCP will also make specialty referrals when medically necessary.

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

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

- Doctors
- Hospitals
- Skilled nursing facilities
- Home health agencies
- Pharmacies

- Laboratories
- X-ray facilities
- Durable medical equipment suppliers

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

Serious chronic condition is a medical condition due to disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

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

Speech therapy is used to treat speech problems.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.

Urgently Needed Services are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area.

IMPORTANT PHONE NUMBERS

California State Services	
Department of Health Care Services (DHCS)	1-916-445-4171
DHCS Ombudsman Office	1-888-452-8609
Department of Social Services	1-800-952-5253
Department of Managed Health Care (DMHC)	1-888-466-2219 1-888-HMO-2219
Supplemental Social Income (SSI)	1-800-772-1213
Children Services and Programs	
California Children Services (CCS)	1-800-288-4584
Child Health and Disability Prevention (CHDP)	1-800-993-CHDP (1-800-993-2437)
Medi-Cal	1-877-481-1044
Disability Services	
Americans Disabilities Act Coordinator	1-916-324-4695
Hearing Impaired/California Relay Service (TTY/TDD)	1-800-735-2929

L.A. Care Health Plan Services	
L.A. Care Member Services	1-888-839-9909
Authorizations	1-877-431-2273
Pharmacy (MedImpact)	1-800-788-2949
L.A. Care Nurse Advice Line	1-800-249-3619
L.A. Care Compliance Line	1-800-400-4889

Los Angeles County Services	
Department of Public and Social Services (DPSS)	1-888-678-4477
Los Angeles County Department of Health Services	1-213-250-8055
Los Angeles County Department of Mental Health	1-800-854-7771
Women, Infant and Children (WIC) Program	1-888-942-2229 1-888-WIC-Baby

L.A. Care Health Plan
ATTN: Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: **1-888-839-9909**
TTY/TDD**: 1-866-LACARE1 (1-866-522-2731)**
www.lacare.org

How to Get Your **Prescription Drugs**

L.A. Care HEALTH PLAN®

www.lacare.org

Sometimes when you are sick or have a health condition like asthma or diabetes, your doctor may give you a prescription. Your doctor will give you a prescription based on your health status.

For New Prescriptions:

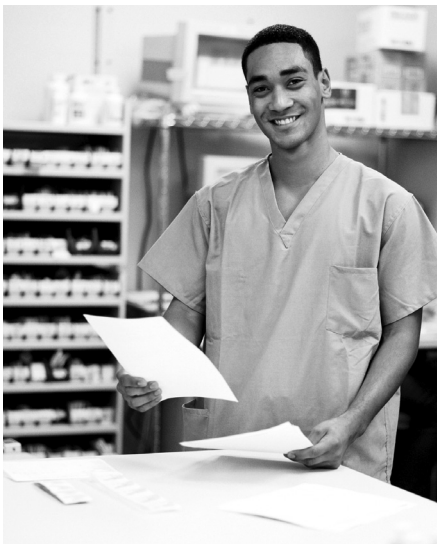
If you are filling a prescription for the first time, you must get your prescribed medications (drugs) from a pharmacy that works with L.A. Care. L.A. Care partners with pharmacies throughout Los Angeles County (including Albertson's /Sav-On, CVS, Rite Aid, Target, Vons, Wal-Mart, and Walgreens). You may also find a list of pharmacies in L.A. Care's provider directory, or to find pharmacies near you, please call **Member Services toll-free at 1-888-839-9909**.

For Prescription Refills:

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

How to Get a Prescription Filled at the Pharmacy:

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



L.A. Care
HEALTH PLAN®
www.lacare.org

Stay Healthy

Preventive Health Guidelines for Adults 2013

For the latest update on immunizations and health screenings, visit the L.A. Care website **www.lacare.org**

- Click on **I Am A Member**
- On the left, click the name of your program, then
- On the left, click on **Health Topics**, scroll down to **Staying Healthy**,
- Select "**How to Stay Healthy**" (PDF)

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Stay Healthy

Go to your doctor for regular wellness visits to help you stay healthy.

Use this guide to:

- Know when to go to the doctor
- Know what needs to be done at each visit

*Ask your doctor which tests/exams are right for you.

Remember:

If you are a new member, see your doctor right away

- Get a wellness visit every year
- Regular wellness visits help you stay healthy

Well Care Guidelines for Adults*

Tests/Exams/Visits	19 to 39 Years	40 to 64 Years	65+ Years
☐ **Checkup:** Medical and family history, physical exam, height, weight, and Body Mass Index (BMI, a measure for a healthy weight)	Every year		
☐ **Blood Pressure**	Every year		
☐ **Cholesterol Screening**	Age 20 and older if at risk for heart disease		
☐ **Colon and Rectal Cancer Screening**	**Age 50 to 75** Your doctor will talk with you about having one of these tests: • **Fecal Occult blood test** Every year Test to see if there is blood in your stool (bowel movement) • **Flexible sigmoidoscopy** Every 5 years Test to check the lower part of your colon for cancer • **Colonoscopy** Every 10 years Test to check the larger part of your colon for cancer		
☐ **Diabetes Screening** Check for diabetes and pre-diabetes	Adults whose blood pressure is greater than 135/80 and as recommended by your doctor		
☐ **Hearing and Vision**	As recommended by your doctor		
☐ **Hepatitis C**	Adults born between 1945-1965, one-time testing. Testing for at risk as recommended by your doctor		
☐ **Human Immunodeficiency** (HIV) **Screening** Check for the virus that causes HIV infection	Screening at least once for adults ages 19-65. Screening for pregnant women and all age groups at risk as recommended by your doctor		
☐ **Tuberculosis** (TB) **Risk Screening and Test**	Risk screening recommended for all adults as part of their first checkup. Doctors will also test those at a higher risk for TB		

Immunizations/Shots for Adults*

Immunizations (Shots)	19 to 39 Years	40 to 64 Years	65+ Years
☐ **Hepatitis B** A disease of the liver	Shot may be recommended by your doctor if you are at risk		
☐ **Human Papilloma Virus** (HPV) Virus can cause cervical cancer and genital warts	For women up to age 26 and men up to age 21 (3 doses), if not immunized before	No recommendation	
☐ **Influenza** (Flu) Influenza or flu virus	**Every year!** During flu season in fall or winter		
☐ **Measles, Mumps, and Rubella** (MMR)	If born after 1957 (1 or 2 doses)		As recommended by your doctor
☐ **Pneumococcal** Bacteria can cause lung or blood infection	As recommended by your doctor		One dose
☐ **Tetanus-Diphtheria, Pertussis** (Td/Tdap) Lockjaw tightening of the jaw muscle	One dose then a Td booster every 10 years		
☐ **Zoster** (Shingles) Virus - can cause painful skin rash with blisters	No recommendation		One dose, starting at age 60 if recommended by your doctor

** Your doctor may recommend other screenings or immunizations (shots), if you are at high risk.*

Stay Healthy

Well Care Guidelines for Women

Tests/Exams/Visits	16 to 49 Years	50 to 64 Years	65+ Years
☐ **Breast Cancer Screening Mammogram** X-ray of the breasts	No recommendation	Every 2 years for women 50 to 74 years. Ask your doctor if you need a mammogram before age 50	
☐ **Cervical Cancer Screening** Pap smear to check for cancer	Every three years ages 21 to 65		No recommendation
☐ **Chlamydia Screening** Test for a sexually transmitted disease (STD)	To be done regularly for women 16 to 24 years if sexually active and only for women over age 25 who are at high risk		
☐ **Osteoporosis** Thinning of the bone	Screening for 65 years and older or as recommended by your doctor		

Stay Healthy When You are Pregnant*

Before Pregnancy Care:

- Talk with your doctor about the vitamin (folic acid) that helps prevent birth defects.
- See your doctor RIGHT AWAY! As soon as you think or know you are pregnant.
- Know your HIV status RIGHT AWAY as soon as you think or know you are pregnant.

During Pregnancy (Prenatal) Care:

Checkups:	How Often?
First 28 weeks	Every 4 weeks
29 - 36 weeks	Every 2 - 3 weeks
36 weeks and beyond	Weekly

After Pregnancy (Postpartum) Care:

- Get your postpartum checkup between 21 and 56 days after you have your baby, whether you had a C-section (surgical delivery) or not.
  - You will be screened for healing and postpartum depression.
  - Your doctor will also talk with you about birth control/family planning.
- Get your C-section (surgical delivery) checkup about 1-2 weeks after giving birth.

Each checkup is important to help keep you and your baby healthy

- Needed tests are done at each visit.
- Your doctor may want to see you more often.

Stay Healthy

Well Care Guidelines for Men

Tests/Exams/Visits	19 to 39 Years	40 to 64 Years	65+ Years
☐ **Abdominal Aortic Aneurysm** Screening Ultrasound	No recommendation		One-time screening if you have ever smoked

You may also talk to your doctor about:

(check the ones you want to talk with your doctor about)

- ☐ Abuse and Violence
- ☐ Aspirin
- ☐ Asthma
- ☐ Dental Health
- ☐ Depression
- ☐ Diabetes
- ☐ Drug and Alcohol Problems
- ☐ Exercise
- ☐ Family Planning/Birth Control/ Breast Feeding
- ☐ High Blood Pressure
- ☐ How to Quit Smoking
- ☐ Medications
- ☐ Mental Health Concerns
- ☐ Nutrition
- ☐ Pain Management
- ☐ Parenting
- ☐ Prenatal Health (for pregnant women)
- ☐ Safety
- ☐ STDs and HIV
- ☐ Weight Concerns
- ☐ Any other concerns you may have

Nurse Advice Line
24/7 for health questions

Call 1-800-249-3619
TTY/TDD 1-866-735-2929

Member Services

Call 1-888-839-9909
TTY /TDD 1-866-522-2731

Source for all information in this document: U.S. Preventive Services Task Force, Centers for Disease Control and Prevention (CDC) and The American College of Obstetricians and Gynecologists Guideline for Perinatal Care (7th edition). Updated 01/13

Notice of **Privacy Practices**

L.A. Care Health Plan

Please read carefully.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

You get your health care through L.A. Care Health Plan (L.A. Care). By law L.A. Care must safeguard your Protected Health Information (PHI). We must also give you this notice. This notice tells you how we may use and share your PHI. It tells you what your rights are.

I. What is "Protected Health Information"?

Protected Health Information ("PHI") is health information that has your name, Social Security number, race/ethnicity, language, or other information that can let others know who you are. For example, your health record is PHI because it has your name on it.

II. How We Protect Your PHI

PHI can be spoken, written, or electronic (on a computer). By law L.A. Care must protect your PHI and tell you about our legal duties and privacy practices. We must tell you if there is a breach of your unsecured PHI.

L.A. Care staff is trained on how to use or share PHI at L.A. Care. Staff has access only to the information they need to do their job. Staff protects what they say about your PHI. For example, staff may not speak about you in common areas such as hallways. Staff also protects written or electronic documents that have your PHI.

L.A. Care computer systems protect your PHI at all times. Passwords are one way we do this.

Fax machines, printers, copiers, computer screens, work stations, and portable media disks with your PHI are not shared with others who do not have access. Staff must pick up PHI from fax machines, printers, and copiers. They must make sure it is received by only those who need it. Portable media devices with PHI are password protected. Computer screens and work stations are locked when not in use. Drawers and cabinets are also locked.

III. Your Information is Personal and Private

L.A. Care gets information about you when you join our health plan. We use this information to give you the care you need. We also get PHI from your doctors, labs, and hospitals. We use this PHI to approve and pay for your health care.

IV. Changes to this Notice

L.A. Care must adhere to the notice we are now using. We have the right to change these privacy practices. Any changes will apply to all your PHI, including information we had before the changes. We will let you know when we make changes to this notice.

V. How We May Use and Share Information About You

L.A. Care may use or share your information only for health care reasons. Some of the information we use and share is:

- Your name
- Address
- Health care given to you
- The cost of your care
- Your health history

Here are some of the things we do with your PHI:

- Check if you are covered
- Approve, give, and pay for care
- Check the quality of your care
- Make sure you get all the care you need

Here are some ways we may use and share PHI:

- **Treatment:** Some care must be approved before you get it. We will share PHI with doctors, hospitals and others to get you the care you need.
- **Payment:** We may send bills to other health plans or doctors for payment.
- **Health Care Operations**: We may use PHI to check the quality of your health care. We may also use PHI for audits, programs to stop fraud, planning, and day-to-day functions.

VI. Other Uses for Your PHI

By law L.A. Care may use or share some PHI.

L.A. Care may use your PHI to review payment decisions or to check how well L.A. Care is giving care. We may also share your PHI with people giving you health care, or with your designee.

L.A. Care must share your PHI with the U.S. government when it is checking on how well L.A. Care meets privacy rules.

We may share your information with other groups that help us with our work. But we won't do this unless those groups agree in writing to keep your information private.

We may give out your PHI for public health reasons to:

- Prevent or control disease, injury or disability
- Report births and deaths
- Report child abuse or neglect
- Report problems with medications and other health products
- Tell people of product recalls
- Tell a person they may be at risk for getting or spreading a disease.

We may also tell the authorities if we think you have been the victim of abuse, neglect, or family violence. We will do this only if you agree or if required by law.

By law L.A. Care can give out PHI to an oversight agency for audits, inspections, or disciplinary actions. The government uses these to monitor the health care system, government programs, and to check compliance with civil rights laws.

If you are part of a lawsuit or dispute, we may give out your PHI in response to a court order. We may also give out your PHI in response to a subpoena, discovery request, or other lawful process by someone else in the dispute. We will do this only if the person asking for it has tried to tell you about the request or if the person asking for your PHI has made reasonable efforts to get an order protecting the information.

We may give out PHI if asked by a law enforcement official:

- In response to a court order, subpoena, warrant, or summons
- To find a suspect, fugitive, material witness or missing person
- About the victim of a crime when we are not able to get the person's okay
- About a death we think may be caused by criminal conduct
- About criminal conduct at our health plan.

We may give out PHI to a coroner or medical examiner to identify a deceased person or find out the cause of death. We may give PHI to funeral directors so they can do their job.

If you are an organ donor, we may give your PHI to groups that work with organ and tissue donations.

In some cases, we may use and give out your PHI for health research. All research projects undergo a special approval process.

We may use and give out PHI to stop a serious threat to the health and safety of a person or the public. We would only give it to someone who could help stop the threat. We may also use or give out information needed for law enforcement to catch a criminal.

If you are a member of the armed forces, we may release your PHI to military authorities. We may also release information about foreign military personnel to foreign military authorities.

We may give out PHI to federal officials for national security purposes. These officials would use it to protect the President, other persons or heads of state, or to conduct investigations.

We may give out PHI to comply with workers' compensation or other laws.

VII. When Written Permission is Needed

If we want to use your PHI in a way not listed here, we must get your written okay. For example, using or sharing PHI for marketing or sale needs your written okay. If we use or share psychotherapy notes, we may also need your okay. If you give us your okay, you may take it back in writing at any time.

VIII. What Are Your Privacy Rights?

You have the right to ask us not to use or share your PHI. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. We may not be able to grant your request. If we cannot grant your request, we will let you know.

You have the right to ask us to contact you only in writing or at a different address, post office box, or by phone. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. We will grant requests within reason.

You have the right to look at and get a copy of your PHI. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. You may have to pay the costs for copying and mailing. By law we have the right to keep you from seeing some parts of your records.

You have the right to ask that your records be changed if they are not correct. We will send you a form to fill out to tell us what you want changed. Or, we can fill out the form for you. We will let you know if we can make the changes. If we can't make the changes, we will send you a letter telling you why. You may ask that we review our decision if you disagree with it. You may also send a statement telling us why you disagree. We will keep your statement with your records.

You have the right to get a list of when we shared your PHI including:

- With whom we shared the information
- When we shared it
- For what reasons
- What information was shared

The list will cover the last six years unless you want a shorter timeframe. The list will not have information shared before April 14, 2003. The list will not include when we share information with you, with your okay, or for treatment, payment, or health plan operations.

You have the right to ask for a paper copy of this notice. You can find this notice on the L.A. Care website at **www.lacare.org.** Or, you can call our Member Services Department at (888) 839-9909.

IX. How Do You Contact Us to Use Your Rights?

If you want to use the rights in this notice, please call or write us at:

L.A. Care Privacy Officer
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: 1-888-839-9909
TTY/TDD: 1-866-LACARE1 (1-866-522-2731)
Email: PrivacyOfficer@lacare.org

X. Complaints

If you think L.A. Care has not protected your PHI, you have the right to complain. You may file a complaint (or grievance) by contacting us at:

L.A. Care Member Services
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: 1-888-839-9909
TTY/TDD: 1-866-LACARE1 (1-866-522-2731)
Email: PrivacyOfficer@lacare.org

You may also contact:

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone:1-800-368-1019
Fax:1-415-437-8329
TTY/TDD: 1-800-537-7697

Medi-Cal Members Only:
California Department of Health Care Services
Office of HIPAA Compliance
Privacy Officer
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Phone: 1-916-445-4646
Fax: 1-916-440-7680
E-mail address: privacyofficer@dhcs.ca.gov

XI. Use Your Rights Without Fear

L.A. Care cannot take away your health care or hurt you in any way if you file a complaint or use the privacy rights in this notice.

XII. Effective Date

L.A. Care's privacy policies are effective April 14, 2003. This notice was revised and is effective on September 1, 2013.

XIII. Questions

If you have questions about this notice and want to learn more, please call or write us at:

L.A. Care Privacy Officer
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Phone: 1-888-839-9909
TTY/TDD: 1-866-LACARE1
(1-866-522-2731)
Email: PrivacyOfficer@lacare.org

XIV. Do You Need this Notice in Another Language or Format?

To get this notice in other languages (Armenian, Chinese, Farsi, Khmer, Korean, Russian, Spanish, Tagalog, or Vietnamese), large print, audio, or other alternative format (upon request), call L.A. Care's Member Services Department at 1-866-839-9909, 24 hours a day, 7 days a week, including holidays. TTY/TDD users should call 1-866-522-2731.

You can also write us at:

L.A. Care Privacy Officer
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Email: PrivacyOfficer@lacare.org

Nurse Advice Line

List of Audio Health Topics

1-800-249-3619

L.A. Care HEALTH PLAN®

www.lacare.org

For life-threatening or limb-threatening emergencies, call 911 or the appropriate local emergency services.

How do you use the AudioHealth Library®?

The AudioHealth Library® is easy to use. Simply call the same toll-free number you call to speak with a nurse. You can call anytime for information on a variety of health care topics. If you are calling from a touchtone phone, just follow the directions below. If you are calling from a dial phone (rotary phone), please stay on the line and a nurse can direct you to a topic.

Call instructions:

- Look up the 4-digit number for the topic you want to hear.
- Call the toll-free number.
- Select the option for the AudioHealth Library®. You will hear the AudioHealth Library® menu. Follow the instructions to select a topic.
- Listen to the recording. Topics are usually 2 to 5 minutes in length.

Allergies and Immune System

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Controlling Your Environment When You HaveAllergies	3102
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Food Allergy	3109
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National Support Services for People Who Have Allergies	3101
Poison Ivy, Sumac, and Oak	3112
Scleroderma	3231
Severe Allergic Reaction	3113
Shots for Travel	4443
Sjogren's Syndrome	4867
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Mental & Behavioral Health

Abuse and Domestic Violence in Adults	3301
Abuse of Older Adults	3001
ADHD Medicines	4280
ADHD or Attention Deficit Hyperactivity Disorder in Adults	3311
ADHD or Attention Deficit Hyperactivity Disorder in Children	3312
Aggressive Behavior in Children	3302
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Alcohol Abuse and Dependence	3004
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Alcohol Dependence	3304
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Anger and Teaching Children to Manage It	3788
Anger Management	3307
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Anorexia	3308
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Autistic Spectrum Disorders	3377
Binge Eating Disorder or Compulsive Overeating	3313
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Bullying and How to Help the Victim	3370
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Blood and Cancer

Bones, Muscles and Joints

Brain and Nervous System

Cancer

Children

Diabetes

Tests and Diagnostic Procedures

Diet and Exercise

Digestive System

Ear, Nose and Throat

Emergency Medicine

Eyes

Foot Problems

General Health

Genes and Heredity

Heart and Blood Vessels

Hormones

Infectious Disease

Injuries

Respiratory and Lung Problems

Medicines

Men's Health

Mouth and Teeth

Pain Management

Physical and Sports Medicine

Pregnancy

Preventive Health

Sexual and Reproductive Health

Skin

Sleep Disorders

Social and Family

Surgery

Urinary Problems

Women's Health