

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

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$5,400 individual / \$10,800 family.</b> Per calendar year	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> Family, physician, and specialist office visits, preventive care, and other services not subject to <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	<b>Yes. \$150 individual / \$300 family</b> for <a href="#">prescription drug coverage</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$9,100 individual / \$18,200 family.</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limits</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="http://lacare.org">lacare.org</a> or call 1-855-270-2327 (TTY 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a participating <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use a <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">participating provider</a> might use a <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	<b>Yes.</b>	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider	Non-IHCP Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	\$50 / visit	Not covered	None
	<a href="#">Specialist</a> visit	No charge	\$90 / visit	Not covered	<a href="#">Referral</a> is required *
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	\$50 / test for laboratory tests. \$95 / test for X-rays, diagnostic imaging and ultrasound.	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	\$325 / test	Not covered	<a href="#">Prior Authorization</a> is Required.*
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.lacare.org/members/getting-care/pharmacy-services">http://www.lacare.org/members/getting-care/pharmacy-services</a>	Tier 1 - Most Generics	No charge	Retail - \$19 / script Mail Order - \$38 / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy.
	Tier 2 -Preferred brand drugs	No charge	Retail - \$60 / script Mail Order - \$120 / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. Pharmacy <a href="#">deductible</a> applies*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](http://lacare.org)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Tier 3 - Non-preferred brand drugs	No charge	Retail - \$90 / script Mail Order - \$180 / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. Pharmacy <a href="#">deductible</a> applies *
	Tier 4 - <a href="#">Specialty drugs</a>	No charge	20% <a href="#">coinsurance</a> up to \$250 per script	Not covered	<a href="#">Prior Authorization</a> is Required. Mail Order not available. Pharmacy <a href="#">deductible</a> applies *
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. *
	Physician / surgeon fees	No charge	30% <a href="#">coinsurance</a>	Not covered	None
	Outpatient visit	No charge	30% <a href="#">coinsurance</a>	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	\$450 No charge for physician fee	\$450 No charge for physician fee	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	\$250	\$250	None
	<a href="#">Urgent care</a>	No charge	\$50 / visit	\$50 / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. <a href="#">Deductible</a> applies *
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$50 / office visit 30% <a href="#">coinsurance</a> up to \$50 for other outpatient services	Not covered	<a href="#">Prior Authorization</a> is Required for Psychological Testing.*
	Inpatient services	No charge	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. <a href="#">Deductible</a> applies*
	Office visits	No charge	No charge	Not covered	For prenatal and preconception visits

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](http://lacare.org)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery professional services	No charge	30% <a href="#">coinsurance</a>	Not covered	None
	Childbirth/delivery facility services	No charge	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies*
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	\$45 / visit	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. <a href="#">Prior Authorization</a> is Required.*
	<a href="#">Rehabilitation services</a>	No charge	\$50 / visit	Not covered	Outpatient services <a href="#">Prior Authorization</a> is Required.*
	<a href="#">Habilitation services</a>	No charge	\$50 / visit	Not covered	Outpatient services <a href="#">Prior Authorization</a> is Required.*
	<a href="#">Skilled nursing care</a>	No charge	30% <a href="#">coinsurance</a>	Not covered	Up to a maximum of 100 days per Calendar Year per Member. <a href="#">Prior Authorization</a> is Required. <a href="#">Deductible</a> applies*
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required.*
	<a href="#">Hospice services</a>	No charge	No charge	Not covered	<a href="#">Prior Authorization</a> is Required.*
If your child needs dental or eye care	Children's Eye exam	No charge	No charge	Not covered	1 visit per calendar year
	Children's Glasses	No charge	No charge	Not covered	1 pair of glasses per year (or contact lenses in lieu of glasses).
	Children's Dental check-up	No charge	No Charge	Not covered	Oral exam and preventive cleaning limited to 1 every 6 months. See your <a href="#">plan</a> document for additional information about services.

#### Excluded Services & Other Covered Services:

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](#)

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

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

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture
- Bariatric surgery
- Medical necessary routine foot care
- Services related to Abortion

**Your Rights to Continue Coverage:**

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](http://lacare.org)

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

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

### **Does this plan provide Minimum Essential Coverage? Yes**

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

### **Does this plan meet the Minimum Value Standards? Yes**

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

### **Language Access Services:**

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

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

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

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

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$5,400
- [Specialist \[cost sharing\]](#) \$90
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) \$95

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,400
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$1,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,860</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$5,400
- [Specialist \[cost sharing\]](#) \$90
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) \$95

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,970</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$5,400
- [Specialist \[cost sharing\]](#) \$90
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) \$95

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$10
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$60
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,370</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.