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, visit lacare.org/members/welcome-la-care/member-documents/la-care-covered or call 1-855-270-2327 (TTY 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-855-270-2327 (TTY 711) to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for the services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$4,500 person / $9,000 family Per calendar year</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limits.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See lacare.lacare.org or call 1-855-270-2327 (TTY 711) for a list of participating providers.</td>
<td>This plan uses a provider network. You will pay less if you use a participating provider in the plan’s network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your participating provider might use an non-participating provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes. Your Primary Care Physician (PCP) has to refer you.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>

Questions: Call 1-855-270-2327 (TTY 711) or visit us at lacare.org
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Platinum 90 HMO AI-AN

Coverage Period: 01/01/2020 – 12/31/2020
Coverage for: Individual + Family | Plan Type: HMO

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>$15</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>$30</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, ultrasound, laboratory work)</td>
<td>No charge</td>
<td>$15 for laboratory tests</td>
<td>$30 for x-rays, diagnostic imaging and ultrasounds</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>$75</td>
<td>Not covered</td>
<td>Prior authorization required.</td>
</tr>
</tbody>
</table>

Questions: Call 1-855-270-2327 (TTY 711) or visit us at lacare.org
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

#### Coverage Period: 01/01/2020 – 12/31/2020

**Coverage for:** Individual + Family | **Plan Type:** HMO

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**Platinum 90 HMO AI-AN**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| **If you need drugs to treat your illness or condition**
More information about [prescription drug coverage](#) is available at [www.lacare.org](http://www.lacare.org)

**Tier 1 (Most Generics)**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail</strong></td>
<td>No charge</td>
<td>Retail - $5 Mail order - $10</td>
<td>Not covered</td>
<td>Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Order Pharmacy</td>
</tr>
<tr>
<td><strong>Mail order</strong></td>
<td></td>
<td>Mail order - $10</td>
<td>Not covered</td>
<td>Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Order Pharmacy</td>
</tr>
</tbody>
</table>

**Tier 2 (Preferred Brand)**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail</strong></td>
<td>No charge</td>
<td>Retail - $15 Mail order - $30</td>
<td>Not covered</td>
<td>Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Order Pharmacy</td>
</tr>
<tr>
<td><strong>Mail order</strong></td>
<td></td>
<td>Mail order - $30</td>
<td>Not covered</td>
<td>Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Order Pharmacy</td>
</tr>
</tbody>
</table>

**Tier 3 (Non-Preferred Brand)**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail</strong></td>
<td>No charge</td>
<td>Retail - $25 Mail order - $50</td>
<td>Not covered</td>
<td>Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Order Pharmacy</td>
</tr>
<tr>
<td><strong>Mail order</strong></td>
<td></td>
<td>Mail order - $50</td>
<td>Not covered</td>
<td>Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Order Pharmacy</td>
</tr>
</tbody>
</table>

Prior Authorization is required.

**Tier 4 (Specialty drugs)**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail</strong></td>
<td>No charge</td>
<td>10% up to $250 per script</td>
<td>Not covered</td>
<td>Prior Authorization is required. Not available through Mail Order.</td>
</tr>
<tr>
<td><strong>Mail order</strong></td>
<td></td>
<td></td>
<td>Not covered</td>
<td>Prior Authorization is required. Not available through Mail Order.</td>
</tr>
</tbody>
</table>

**If you have outpatient surgery**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility fee (e.g., ambulatory surgery center)</strong></td>
<td>No charge</td>
<td>$100</td>
<td>Not covered</td>
<td>Prior Authorization is required.</td>
</tr>
<tr>
<td><strong>Physician/surgeon fees</strong></td>
<td>No charge</td>
<td>$25</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**If you need immediate medical attention**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency room care</strong></td>
<td>No charge</td>
<td>$150</td>
<td>$150</td>
<td>Co-pay waived if admitted</td>
</tr>
<tr>
<td><strong>Emergency medical transportation</strong></td>
<td>No charge</td>
<td>$150</td>
<td>$150</td>
<td>None</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>No charge</td>
<td>$15</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**If you have a hospital stay**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility fee (e.g., hospital room)</strong></td>
<td>No charge</td>
<td>$250 per day up to 5 days</td>
<td>Not covered</td>
<td>Prior Authorization is required.</td>
</tr>
<tr>
<td><strong>Physician/surgeon fees</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

---

**Questions:** Call **1-855-270-2327 (TTY 711)** or visit us at [lacare.org](http://lacare.org)
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

### Platinum 90 HMO AI-AN

**Coverage Period:** 01/01/2020 – 12/31/2020  
**Coverage for:** Individual + Family  |  **Plan Type:** HMO

### Common Medical Event

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay</th>
<th>Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>No charge</td>
<td>$15</td>
<td>Not covered</td>
<td>Prior Authorization is Required for Psychological Testing Substance Use Disorder Medical Treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Outpatient items and services</td>
<td>No charge</td>
<td>$15</td>
<td>Not covered</td>
<td>Prior Authorization is Required. Services outside if an office setting, such as a treatment center or home, that involve daily or weekly treatment delivered over several hours. Refer to plan documents for list of included services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>$250 per day up to 5 days</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal care and preconception visits</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child birth/delivery hospital inpatient services</td>
<td>No charge</td>
<td>$250 per day up to 5 days</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child birth/delivery inpatient professional services</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge</td>
<td>$20</td>
<td>Not covered</td>
<td>Up to a maximum of 100 visits per calendar year per member by home health care agency providers. Prior Authorization is required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient Rehabilitation services</td>
<td>No charge</td>
<td>$15</td>
<td>Not covered</td>
<td>Prior Authorization is required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient Habilitation</td>
<td>No charge</td>
<td>$15</td>
<td>Not covered</td>
<td>Prior Authorization is required</td>
<td></td>
</tr>
</tbody>
</table>

**Questions:** Call 1-855-270-2327 (TTY 711) or visit us at lacare.org
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

#### Coverage Period: 01/01/2020 – 12/31/2020
**Coverage for:** Individual + Family | **Plan Type:** HMO

**Platinum 90 HMO AI-AN**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Indian Health Care Provider (IHCP) (You will pay the least)</th>
<th>What You Will Pay</th>
<th>Non-IHCP Participating Provider (You will pay the least)</th>
<th>Non-IHCP Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>No charge</td>
<td>$150 per day up to 5 days</td>
<td>Not covered</td>
<td></td>
<td>Up to a maximum of 100 days per Calendar Year per Member. Prior Authorization is Required.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>No charge</td>
<td>10%</td>
<td>Not covered</td>
<td></td>
<td>Prior Authorization is required</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
<td>Prior Authorization is required</td>
</tr>
</tbody>
</table>

#### 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

#### Excluded Services & Other Covered Services:

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

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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
- Services related to Abortion

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**Questions:** Call 1-855-270-2327 (TTY 711) or visit us at lacare.org
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2020 – 12/31/2020
Coverage for: Individual + Family | Plan Type: HMO

Platinum 90 HMO AI-AN

Your Rights to Continue Coverage: Federal and State laws may provide protections that allow you to keep health this coverage as long as you pay your premium. There are exceptions, however, such as if:
- You commit Fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 1-855-270-2327 (TTY 711). You may also contact California Department of Managed Healthcare (DMHC) at 1-888-466-2219, or the Department of Health and Human Services or call Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: L.A. Care Covered Customer Service at 1-855-270-2327 (TTY 711). Additionally, you can contact the California Department of Managed Health Care Help line at 1-888-466-2219 or visit helpline@dmhc.ca.gov or visit http://www.healthhelp.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-888-466-2219.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-466-2219.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-466-2219.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne’ 1-888-466-2219.

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

Questions: Call 1-855-270-2327 (TTY 711) or visit us at lacare.org
The plan’s overall deductible $0
Specialist [cost sharing] $30
Hospital (facility) [cost sharing] $250
Per day up to 5 days
Other [cost sharing] $30

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

Total Example Cost $12,840

In this example, Peg would pay:
- Cost Sharing
  - Deductibles $0
  - Copayments $590
  - Coinsurance $0

What isn’t covered
- Limits or exclusions $60
- The total Peg would pay is $650

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

The plan’s overall deductible $0
Specialist [cost sharing] $30
Hospital (facility) [cost sharing] $250
Per day up to 5 days
Other [cost sharing] $15

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

Total Example Cost $7,460

In this example, Joe would pay:
- Cost Sharing
  - Deductibles $0
  - Copayments $770
  - Coinsurance $170

What isn’t covered
- Limits or exclusions $60
- The total Joe would pay is $1,000

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

The plan’s overall deductible $0
Specialist [cost sharing] $30
Hospital (facility) [cost sharing] $250
Per day up to 5 days
Other [cost sharing] $30

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

Total Example Cost $2,010

In this example, Mia would pay:
- Cost Sharing
  - Deductibles $0
  - Copayments $730
  - Coinsurance $0

What isn’t covered
- Limits or exclusions $0
- The total Mia would pay is $730

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