**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**

**Bronze 60 HMO**

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

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**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.**

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<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>$6,300 individual or $12,600 family.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Family, physician, and specialist office visits, preventive care, and other services not subject to deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount, but a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>$500 individual or $1,000 family for prescription drug coverage. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$7,800 individual or $15,600 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><strong>What is not included in the out-of-pocket limit?</strong></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 limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></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 an non-participating provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes. Your Primary Care Physician (PCP) needs 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>

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**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>Network Provider (You will pay the least)</th>
<th>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>$65</td>
<td>Not covered</td>
<td>Subject to deductible after 1st 3 non-preventive visits</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$95</td>
<td>Not covered</td>
<td>Includes therapy visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Subject to deductible after 1st 3 non-preventive visits</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, ultrasound, laboratory work)</td>
<td>$40 for laboratory tests 40% for x-rays, diagnostic imaging and ultrasounds</td>
<td>Not covered</td>
<td>X-rays, diagnostic imaging, and ultrasounds are subject to deductible</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>40%</td>
<td>Not covered</td>
<td>Prior authorization is required Subject to deductible</td>
</tr>
</tbody>
</table>

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### Summary of Benefits and Coverage

**What this Plan Covers & What You Pay For Covered Services**

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#### Bronze 60 HMO

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<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
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</tbody>
</table>
| If you need drugs to treat your illness or condition | Tier 1 (Most Generics) | Retail - $18  
Mail service - $36 | Not covered | Up to 30-day supply for Retail Pharmacy  
Up to 90-day supply for Mail Service Pharmacy  
Prior Authorization is Required.  
Subject to pharmacy deductible |
|                      | Tier 2 (Preferred Brand) | Retail – 40% up to $500 per script after deductible  
Mail service – 40% up to $500 per script after deductible | Not covered | Up to 30-day supply for Retail Pharmacy  
Up to 90-day supply for Mail Service Pharmacy  
Subject to pharmacy deductible up to $500 maximum per script |
|                      | Tier 3 (Non-Preferred Brand) | Retail – 40% up to $500 per script after deductible  
Mail service – 40% up to $500 per script after deductible | Not covered | Up to 30-day supply for Retail Pharmacy  
Up to 90-day supply for Mail Service Pharmacy  
Prior Authorization is required.  
Subject to pharmacy deductible up to $500 maximum per script  
Prior Authorization is required |
|                      | Tier 4 (Specialty drugs) | 40% up to $500 per script after deductible | Not covered | Prior Authorization is required.  
Not available through Mail Service.  
Subject to pharmacy deductible up to $500 maximum per script |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 40% | Not covered | Prior Authorization is required.  
Subject to deductible |
|                      | Physician/surgeon fees | 40% | Not covered | Subject to deductible |
| If you need immediate medical attention | Emergency room care | 40% | 40% | Subject to deductible |
|                      | Emergency medical transportation | 40% | 40% | Subject to deductible |
|                      | Urgent care | $65 | Not covered | Subject to deductible after 1st 3 non-preventive visits. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% | Not covered | Subject to deductible. Prior Authorization is required |

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<tr>
<td></td>
<td></td>
<td>40%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>$65</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Other Outpatient items and services</td>
<td>40% up to $65</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>40%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></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>Not covered</td>
</tr>
<tr>
<td></td>
<td>Child birth/delivery hospital inpatient services</td>
<td>40%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Child birth/delivery inpatient professional services</td>
<td>40%</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong></td>
<td>40%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Outpatient <strong>Rehabilitation services</strong></td>
<td>$65</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Outpatient <strong>Habilitation services</strong></td>
<td>$65</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>40%</td>
<td>Not covered</td>
</tr>
</tbody>
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<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
</tbody>
</table>
| Durable medical equipment | 40% | Not covered | Prior Authorization is required  
Subject to deductible. |
| Hospice services      | No charge         | Not covered         | Prior Authorization is required  
Subject to deductible |

**If your child needs dental or eye care**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| Children’s eye exam   | No charge         | Not covered 1 visit per calendar year  
Deductible waived |
| Children’s glasses    | No charge         | Not covered 1 pair of glasses per year (or contact lenses in lieu of glasses). |
| Children’s dental check-up | 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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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 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.

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, kwijjigo 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 would be responsible for the other costs of these EXAMPLE covered services.

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

- The **plan’s overall deductible** $6,300
- **Specialist [cost sharing]** $95
- **Hospital (facility) [cost sharing]** 40%
- **Other [cost sharing]** 40%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,470</td>
<td>$680</td>
<td>$3,650</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $60

The **total Peg would pay is** $7,860

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

- The **plan’s overall deductible** $6,300
- **Specialist [cost sharing]** $95
- **Hospital (facility) [cost sharing]** 40%
- **Other [cost sharing]** $40

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,130</td>
<td>$1,930</td>
<td>$2,120</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $60

The **total Joe would pay is** $6,240

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

- The **plan’s overall deductible** $6,300
- **Specialist [cost sharing]** $95
- **Hospital (facility) [cost sharing]** 40%
- **Other [cost sharing]** 40%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$540</td>
<td>$580</td>
<td>$340</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $60

The **total Mia would pay is** $1,460

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.