L.A. Care Covered Direct

Bronze 60 HMO

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$6,300 individual / $12,600 family** Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Family, physician, and specialist office visits, preventive care, and other services not subject to deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**$500 individual / $1,000 family** for prescription drug coverage. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	**$8,200 individual / $16,400 family** Per calendar year For participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limits.
Will you pay less if you use a network provider?	**Yes**. See lacare.lacare.org or call 1-855-270-2327 (TTY 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a participating provider in the plan's network. You will pay the most if you use an non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**Yes.**	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out of Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$65 copay / visit	Not covered	Subject to deductible after 1st 3 non-preventive visits. *
	Specialist visit	$95 copay / visit	Not covered	Subject to deductible after 1st 3 non-preventive visits. Referral is required. *
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay / test for laboratory tests. 40% coinsurance / test for X-rays diagnostic imaging and ultrasounds.	Not covered	X-rays, diagnostic imaging, and ultrasounds are subject to deductible. *
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible. *
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.lacare.org/members/getting-care/pharmacy-services	Tier 1 - Most Generics	Retail - $18 copay / script Mail Order - $36 copay / script	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 drugs	Retail – 40% coinsurance / script Mail service – 40% coinsurance / script	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. *

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Tier 3 - Non-preferred brand drugs	Retail – 40% coinsurance / script Mail service – 40% coinsurance / script	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 4 - Specialty drugs	40% coinsurance/ script	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% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible. *
	Physician / surgeon fees	40% coinsurance	Not covered	Subject to deductible. *
	Outpatient visit	40% coinsurance	Not covered	Subject to deductible. *
If you need immediate medical attention	Emergency room care	40% coinsurance Physician fee – no charge	40% coinsurance Physician fee – no charge	Copay waived if admitted. Subject to deductible. *
	Emergency medical transportation	40% coinsurance	40% coinsurance	Subject to deductible. *
	Urgent care	$65 copay / visit	$65 / visit	Subject to deductible after 1st 3 non-preventive visits. *
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible. *
	Physician/surgeon fees	40% coinsurance	Not covered	Subject to deductible. *
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$65 copay / office visit 40% coinsurance up to $65 copay for other outpatient services	Not covered	Office visit subject to deductible after 1st 3 non-preventive visits. Prior Authorization is Required for Psychological Testing. *

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Inpatient services	40% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible.*
If you are pregnant	Office visits	No charge	Not covered	For prenatal care and preconception visits.
	Childbirth/delivery professional services	40% coinsurance	Not covered	Subject to deductible.
	Childbirth/delivery facility services	40% coinsurance	Not covered	Subject to deductible. *
If you need help recovering or have other special health needs	Home health care	40% coinsurance / visit	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. Prior Authorization is Required. Subject to deductible. *
	Rehabilitation services	$65 copay / visit	Not covered	Prior Authorization is Required.*
	Habilitation services	$65 copay / visit	Not covered	Prior Authorization is Required. *
	Skilled nursing care	40% coinsurance	Not covered	Up to a maximum of 100 days per Calendar Year per Member. Prior Authorization is Required. Subject to deductible. *
	Durable medical equipment	40% coinsurance	Not covered	Prior Authorization is Required. Subject to deductible. *
	Hospice services	No charge	Not covered	Prior Authorization is Required. *
If your child needs dental or eye care	Children's Eye exam	No charge	Not covered	1 visit per calendar year.
	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	Oral exam and preventive cleaning limited to 1 every 6 months. See your plan document for additional information about services.

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

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage:

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

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

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

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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** **$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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$6,300
Copayments	$500
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,260**

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	**$5.600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$200
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

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

Getting Help in Other Languages

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

Arabic

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

Armenian

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

Cambodian

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

Chinese

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

Farsi

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

Hindi

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

Hmong

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

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Japanese

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

Korean

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

Punjabi

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

Russian

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

Spanish

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

Tagalog

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

Thai

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

Vietnamese

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