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

DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
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 *

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

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.

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
- Medically necessary routine foot care
- Services related to Abortion

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

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.

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	$1,000
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	**$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:
Free language assistance services are available. You can request interpreting or translation services, information in your language or in another format, or auxiliary aids and services. Call L.A. Care at 1.855.270.2327 (TTY 711), 24 hours a day, 7 days a week, including holidays. The call is free.

Spanish:
Los servicios de asistencia de idiomas están disponibles de forma gratuita. Puede solicitar servicios de traducción e interpretación, información en su idioma o en otro formato, o servicios o dispositivos auxiliares. Llame a L.A. Care al 1.855.270.2327 (TTY 711), las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.

Chinese:
提供免費語言協助服務。您可申請口譯或翻譯服務，您使用之語言版本或其他 格式的資訊，或輔助援助和服務。請致電 L.A. Care 電話 1.855.270.2327 (TTY 711） ， 服務時間為每週 7 天，每天 24 小時（包含假日）。上述電話均為免費。

Vietnamese:
Có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Quý vị có thể yêu cầu dịch vụ biên dịch hoặc phiên dịch, thông tin bằng ngôn ngữ của quý vị hoặc bằng các định dạng khác, hay các dịch vụ và thiết bị hỗ trợ ngôn ngữ. Xin vui lòng gọi L.A. Care tại 1.855.270.2327 (TTY 711), 24 giờ một ngày, 7 ngày một tuần, kể cả ngày lễ. Cuộc gọi này miễn phí.

Tagalog:
Available ang mga libreng serbisyo ng tulong sa wika. Maaari kang humiling ng mga serbisyo ng pag-interpret o pagsasaling-wika, impormasyon na nasa iyong wika o nasa ibang format, o mga karagdagang tulong at serbisyo. Tawagan ang L.A. Care sa 1.855.270.2327 (TTY 711), 24 na oras sa isang araw, 7 araw sa isang linggo, kabilang ang mga holiday. Libre ang tawag.

Korean:
무료 언어 지원 서비스를 이용하실 수 있습니다. 귀하는 통역 또는 번역 서비스, 귀하가 사용하는 언어 또는 기타 다른 형식으로 된 정보 또는 보조 지원 및 서비스 등을 요청하실 수 있습니다. 공휴일을 포함해 주 7일, 하루 24시간 동안 L.A. Care, 1.855.270.2327 (TTY 711)번으로 문의하십시오. 이 전화는 무료로 이용하실 수 있습니다.

Armenian:
Տրամադրելի են լեզվական օգնության անվճար ծառայություններ: Կարող եք խնդրել բանավոր թարգմանչական կամ թարգմանչական ծառայություններ, Ձեր լեզվով կամ տարբեր ձևաչափով տեղեկություն, կամ օժանդակ օգնություններ և ծառայություններ: Զանգահարեք L.A. Care
1.855.270.2327 համարով (TTY 711), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոնական օրերը: Այս հեռախոսազանգն անվճար է:

Farsi:
خدمات رایگان امداد زبانی موجود می باشد. می توانید برای خدمات ترجمه شفاهی یا کتبی، اطلاعات به زبان خودتان یا فرمت دیگر، یا امدادها و خدمات اضافی درخواست کنید. با L.A. Care به شماره 1.855.270.2327 (TTY 711) - این تماس رایگان است. در 24 ساعت شبانروز و 7 روز هفته شامل روزهای تعطیل تماس بگیرید.

Russian:

Мы предоставляем бесплатные услуги перевода. У Вас есть возможность подать запрос о предоставлении устных и письменных услуг перевода, информации на Вашем языке или в другом формате, а также вспомогательных средств и услуг. Звоните в L.A. Care по телефону 1.855.270.2327 (TTY 711) 24 часа в сутки, 7 дней в неделю, включая праздничные дни. Этот звонок является бесплатным.

Japanese:
言語支援サービスを無料でご利用いただけます。通訳・翻訳サービス、日本 語や他の形式での情報、補助具・サービスをリクエストすることができます。L.A. Care までフリーダイヤル1.855.270.2327 (TTY 711) にてご連絡ください。祝休日を含め毎日 24 時間、年中無休で受け付けています 。

Arabic:
خدمات المساعدة اللغوية متاحة مجانًا. يمكنك طلب خدمات الترجمة الفورية أو الترجمة التحريرية أو معلومات بلغتك أو بتنسيق آخر أو مساعدات وخدمات إضافية. اتصل بـ L.A. Care على مدار الساعة وطوال أيام الأسبوع، بما في ذلك أيام العطلات. المكالمة مجانية (711 TTY) 1.855.270.2327.

Panjabi:
ਪੰਜਾਬੀ: ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ।ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ, ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫੋਰਮੈਟ ਵਿੱਚ, ਜਾਂ ਸਹਾਇਕ ਉਪਕਰਣਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। L.A. Care ਨੰ 1.855.270.2327 (TTY 711) ਨੰਬਰ ਉੱਤੇ ਕਾਲ ਕਰੋ, ਇੱਕ ਦਿਨ ਵਿੱਚ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੱਚ 7 ਦਿਨ, ਛੁੱਟੀਆਂ ਸਮੇਤ। ਕਾਲ ਮੁਫ਼ਤ ਹੈ।

Khmer:
សេវាជំនួយខាងភាសា គឺមានដោយឥតគិតថ្លៃ។ អ្នកអាចស្នើសុំសេវាបកប្រែផ្ទាល់មាត់ ឬការបកប្រែ ស្នើសុំព័ត៌មាន ជាភាសាខ្មែរ ឬជាទំរង់មួយទៀត ឬជំនួយជ្រោមជ្រែង និងសេវា។ ទូរស័ព្ទទៅ L.A. Care តាមលេខ 1.855.270.2327 (TTY 711) បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។ ការហៅនេះគឺឥតគិតថ្លៃឡើយ។

Hmong:
Muaj kev pab txhais lus pub dawb rau koj. Koj tuaj yeem thov kom muab cov ntaub ntawv txhais ua lus lossis txhais ua ntawv rau koj lossis muab txhais ua lwm yam lossis muab khoom pab thiab lwm yam kev pab cuam. Hu rau L.A. Care ntawm tus xov tooj 1.855.270.2327 (TTY 711), tuaj yeem hu tau txhua txhua 24 teev hauv ib hnub, 7 hnub hauv ib vij thiab suab nrog cov hnub so tib si, tus xov tooj no hu dawb xwb.

Hindi:
मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। आप दुभाषिया या अनुवाद सेवाओं, आपकी भाषा या किसी अन्य प्रारूप में जानकारी, या सहायक उपकरण ं और सेवाओं के लिए अनुर ध कर सकते हैं। आप L.A. Care को 1.855.270.2327 (TTY 711) नंबर पर फ़ न करें, दिन में 24 घंटे, सप्ताह में 7 दिन, छुट्टिय ं सहित। कॉल मुफ्त है।

Thai:
มีบริการช่วยเหลือภาษาฟรี คุณสามารถขอรับบริการการแปลหรือล่าม ข้อมูลในภาษาของคุณหรือในรูปแบบอื่น หรือความช่วยเหลือและบริการเสริมต่าง ๆ ได้ โทร L.A. Care ที่ 1.855.270.2327 (TTY 711) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์รวมทั้งวันหยุด โทรฟรี

Lao:
ພາສາອ້ງກິດ ມີບໍລິການຊ່ວຍເຫືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍຮ້ບບໍລິການນາຍພາສາ ຫ ແປພາສາໄດ້, ສໍາລ້ບຂໍ້ມ້ນໃນພາສາຂອງທ່ານ ຫ ໃນຮ້ບແບບອ້ືນ, ຫ ເຄ່ືອງມ້ຊ່ວຍເຫ້ອ ແລະ ບໍລິການເສ້ມ. ໃຫ້ໂທຫາ L.A. Care ໄດ້ທ່ 1.855.270.2327 (TTY 711), 24 ຊ່ວໂມງຕ່ໍມ້, 7 ມ້ຕ່ໍອາທ້ດ, ລວມເຖ້ງວ້ນພ້ກຕ່ໍາງໆ. ການໂທແມ່ນບໍ່ເສຍຄ່າ.