



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 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 ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. There is no 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?	No	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan ?	\$4,500/ individual / \$9,000 family.	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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Please see lacare.org or call 1-855-270-2327 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			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the Least)	Network Provider	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	No charge	\$15 copay / visit	Not covered	None
	Specialist visit	No charge	\$30 copay / visit	Not covered	Referral is required *
	Preventive care/screening/immunization	No charge	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)	No charge	\$15 copay / test for laboratory tests. \$30 copay / test for X-rays diagnostic imaging and ultrasounds.	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	\$75 copay / test	Not covered	Prior Authorization is Required. *
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	No charge	Retail - \$7 copay / script Mail Order - \$14 copay / 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 - \$16 copay / script Mail Order - \$32 copay / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. *
	Tier 3 - Non-preferred brand drugs	No charge	Retail - \$25 copay / script Mail Order - \$50 copay / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. *
	Tier 4 - Specialty drugs	No charge	10% coinsurance up to \$250 copay per script	Not covered	Prior Authorization is Required. Not available through Mail Order.*
	Facility fee (e.g., ambulatory)	No charge	\$75 copay	Not covered	Prior Authorization is Required. *

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)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	surgery center)				
	Physician / surgeon fees	No charge	\$20 copay	Not covered	None
	Outpatient visit	No charge	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	No charge	\$150 copay for facility fee No charge for physician fee	\$150 for facility fee No charge for physician fee	Copay waived if admitted.
	Emergency medical transportation	No charge	\$150 copay	\$150	None
	Urgent care	No charge	\$15 copay / visit	\$15 / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$225 copay per day up to 5 days	Not covered	Prior Authorization is Required.*
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$15 copay / visit for office visits \$15 copay for other outpatient services	Not covered	Prior Authorization is Required for Psychological Testing.*
	Inpatient services	No charge	\$225 copay per day up to 5 days	Not covered	Prior Authorization is Required.*
If you are pregnant	Office visits	No charge	No charge	Not covered	For prenatal care and preconception visits
	Childbirth/delivery professional services	No charge	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	\$225 copay per day up to 5 days	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	\$20 copay / 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.*
	Rehabilitation services	No charge	\$15 copay / visit	Not covered	Prior Authorization is Required.*

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)	Network Provider	Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge	\$15 copay / visit	Not covered	Prior Authorization is Required. *
	Skilled nursing care	No charge	\$125 copay / visit per day up to 5 days	Not covered	Up to a maximum of 100 days per Calendar Year per Member. Prior Authorization is Required. *
	Durable medical equipment	No charge	10%	Not covered	Prior Authorization is Required. *
	Hospice services	No charge	No charge	Not covered	Prior Authorization 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 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](#).)

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|-----------------------|--|----------------------------|
| • Chiropractic care | • Infertility treatment | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency services while travelling outside the United States. | • Weight loss programs |
| • Hearing aids | | |

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

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

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance 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 L.A. Care Health Plan at **1- 855-270-2327**. We are available 24 hours a day, 7 days a week, including holidays. You may also contact the California Department of Managed Health Care (DMHC) at **1-888-466-2219** or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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.

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](#) \$0
- [Specialist \[cost sharing\]](#) \$30
- Hospital (facility) [\[cost sharing\]](#) \$225
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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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Deductibles	\$0
Copayments	\$600
Coinsurance	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$60
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The total Peg would pay is	\$660
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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) [\[cost sharing\]](#) \$225
Per day up to 5 days
- Other [\[cost sharing\]](#) \$30

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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Deductibles	\$0
Copayments	\$600
Coinsurance	\$80

<i>What isn't covered</i>	
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Limits or exclusions	\$20
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The total Joe would pay is	\$700
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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) [\[cost sharing\]](#) \$225
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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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Deductibles	\$0
Copayments	\$700
Coinsurance	\$20

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Mia would pay is	\$720
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