Gold 80 HMO AI-AN

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2024 – 12/31/2024

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, **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?	**$8,700** person / **$17,400** family. 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 limit.
Will you pay less if you use a network provider?	**Yes**. For a list of contracted providers, please see lacare.org or call 1-855-270-2327	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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non- IHCP Participating Provider	Non-IHCP 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	$35 copay / visit	Not covered	None
	Specialist visit	No charge	$65 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	$40 copay / test for laboratory tests. $75 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 - $15 copay / script Mail Order - $30 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 - $60 copay / script Mail Order - $120 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 - $85 copay / script Mail Order - $170 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	20% up to $250 copay per script	Not covered	Prior Authorization is Required. Not available through Mail Order. *

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

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$130 copay	Not covered	Prior Authorization is Required. *
	Physician / surgeon fees	No charge	$40 copay	Not covered	None
	Outpatient visit	No charge	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	No charge	$350 copay for facility fee No charge for physician fee	$350 for facility fee No charge for physician fee	Copay waived if admitted. *
	Emergency medical transportation	No charge	$250 copay	$250	None
	Urgent care	No charge	$35 copay / visit	$35 / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$330 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	$35 copay / office visit $35 copay for other outpatient services	Not covered	Prior Authorization is Required for Psychological Testing. *
	Inpatient services	No charge	$330 copay per day up to 5 days No charge for physician fees	Not covered	Prior Authorization is Required.*
If you are pregnant	Office Visits	No charge	No charge	Not covered	For prenatal and preconception visits
	Childbirth/delivery professional services	No charge	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	$330 copay per day up to 5 days	Not covered	None
If you need help	Home health care	No charge	$30 copay / visit	Not covered	Up to a maximum of 100 visits per

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recovering or have other special health needs					Calendar Year per Member by home health care agency providers. Prior Authorization is Required. *
	Rehabilitation services	No charge	$35 copay / visit	Not covered	Outpatient services. Prior Authorization is Required. *
	Habilitation services	No charge	$35 copay / visit	Not covered	Prior Authorization is Required. *
	Skilled nursing care	No charge	$150 copay 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	20% coinsurance	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:

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

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**. We are available 24 hours a day, 7 days a week, including holidays. 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**. 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, 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	**$0**
Specialist *[cost sharing]*	**$65**
Hospital (facility) *[cost sharing]*	**$330**
Per day up to 5 days	
Other *[cost sharing]*	**$75**

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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]*	**$65**
Hospital (facility) *[cost sharing]*	**$330**
Per day up to 5 days	
Other *[cost sharing]*	**$75**

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	$0
Copayments	$1,500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$65**
Hospital (facility) *[cost sharing]*	**$330**
Per day up to 5 days	
Other *[cost sharing]*	**$75**

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	$0
Copayments	$1,300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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