**This is only a summary.** If you would like more details about your coverage and costs, you can get the complete terms in the policy or plan document at **lacare.org/members/member-materials/la-care-covered** or by calling 1-855-270-2327.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$650** member / **$1,300** family. Physician and specialist office visits, preventive care, and other services not subject to deductible. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. **$50** member /**$100** family. Calendar year pharmacy deductible per person. 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. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For participating providers **$2,600** person / **$5,200** family. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of contracted providers, please see **lacare.org** or call **1-855-270-2327**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. In some cases, a non-plan provider may provide covered services at an in-network facility where you have been authorized to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-network facilities where we have authorized you to receive care. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |

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| | | |
|---|---|---|
| **Do I need a referral to see a specialist?** | Yes. Your Primary Care Physician (PCP) has to refer you | This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the specialist. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) In some cases, a non-plan provider may provide covered services at an in-network facility where you have been authorized to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-network facilities where we have authorized you to receive care.
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 | Not covered | |
| | Other practitioner office visit | $15 | Not covered | |
| | Specialist visit | $25 | Not covered | |
| | Preventive care/screening/immunization | No charge | Not covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $15 for laboratory tests.<br>$30 for X-rays and diagnostic imaging. | Not covered | |
| | Imaging (CT/PET scans, MRIs) | $100 | Not covered | Prior Authorization is Required. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at lacare.org | Tier 1 (Most Generics) | Retail - $5<br><br>Mail Order $10 | Not covered | Up to 30-day supply for Retail Pharmacy.<br>Up to 90-day supply for Mail Order Pharmacy. |
| | Tier 2 (Preferred Brand) | Retail - $20<br><br>Mail Order $40 | Not covered | Up to 30-day supply for Retail Pharmacy.<br>Up to 90-day supply for Mail Order Pharmacy.<br>Subject to Pharmacy deductible. |
| | Tier 3 (Non-Preferred Brand) | Retail - $35<br><br>Mail Order $70 | Not covered | Up to 30-day supply for Retail Pharmacy.<br>Up to 90-day supply for Mail Order Pharmacy. Prior Authorization is Required.<br>Subject to Pharmacy deductible. |
| | Tier 4 (Specialty Drugs) | 15% up to $150 per script | Not covered | Prior Authorization is Required.<br>Subject to Pharmacy deductible. Not available through Mail Order. |
| **If you have outpatient surgery** | Surgery facility fee (e.g., ambulatory surgery center) | 15% | Not covered | Prior Authorization is Required. |
| | Physician/surgeon fees | 15% | Not covered | |
| | Outpatient visit | 15% | Not covered | |
| **If you need immediate medical attention** | Emergency room facility fee | $100 | $100 | Copay waived if admitted. |
| | Emergency room physician fee | No charge | No charge | |
| | Medical transportation (including emergency and non-emergency) | $75 | $75 | Subject to deductible. |
| | Urgent care | $15 | Not covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% | Not covered | Subject to deductible. Prior Authorization is Required. |
| | Physician/surgeon fee | 15% | Not covered | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral Health outpatient office visits | $15 | Not covered | Prior Authorization is Required for Psychological Testing. |
| | Mental/Behavioral Health other outpatient items and services | 15% up to $15 | Not covered | Prior Authorization is Required. Services include Partial hospitalization, Multidisciplinary intensive outpatient psychiatric treatment, Day treatment programs, Intensive outpatient programs, Behavioral health treatment for PDD/autism delivered at home, Other outpatient intermediate services that fall between inpatient care and regular outpatient office visits, Outpatient Partial Hospitalization, Outpatient Transcranial Stimulation |
| | Mental/Behavioral Health inpatient facility fee (e.g. hospital room) | 15% | Not covered | Subject to deductible. Prior Authorization is Required. |
| | Mental/Behavioral Health inpatient physician fee | 15% | Not covered | Prior Authorization is Required. |
| | Substance Use Disorder outpatient office visits | $15 | Not covered | Prior Authorization is Required for Substance Use Disorder Medical Treatment for Withdrawal. |
| | Substance Use Disorder other outpatient items and services | 15% up to $15 | Not covered | Prior Authorization is Required. Services include Partial hospitalization, Day treatment programs, Intensive outpatient programs. Other outpatient intermediate services that fall between inpatient care and regular outpatient office visits. |
| | Substance Use Disorder inpatient facility fee (e.g. hospital room) | 15% | Not covered | Prior Authorization is Required. Subject to deductible. |
| | Substance Use Disorder inpatient physician fee | 15% | Not covered | Prior Authorization is Required. |
| **If you are pregnant** | Prenatal care and preconception visits | No charge | Not covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Delivery and all inpatient services | 15% Hospital<br>15% Professional | Not covered | Subject to deductible. |
| **If you need help recovering or have other special health needs** | Home health care | $15 | Not covered | Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. Prior Authorization is Required. |
| | Outpatient Rehabilitation services | $15 | Not covered | Prior Authorization is Required. |
| | Outpatient Habilitation services | $15 | Not covered | Prior Authorization is Required. |
| | Skilled nursing care | 15% | Not covered | Up to a maximum of 100 days per Calendar Year per Member. Subject to deductible. Prior Authorization is Required. |
| | Durable medical equipment | 15% | Not covered | Prior Authorization is Required. |
| | Hospice service | No charge | Not covered | Prior Authorization is Required. |
| **If your child needs dental or eye care** | Eye exam | No charge | Not covered | 1 visit per calendar year |
| | Glasses | No charge | Not covered | 1 pair of glasses per year (or contact lenses in lieu of glasses) |
| | Dental check-up – Preventive and Diagnostic (includes oral exam, preventive cleaning and x-ray, sealants per tooth, topical fluoride application and space maintainers-fixed) | No charge | Not covered | |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

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

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Services related to Abortion
- Bariatric surgery
- Routine foot care

## 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 us at 1-855-270-2327. You may also contact your state insurance department at 1-888-466-2219.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: **1-888-466-2219**.

## Language Access Services:

**IMPORTANT**: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-855-270-2327. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219

**IMPORTANTE**: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1- 855-270-2327. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de Ayuda de HMO al 1-888-466-2219.

**MAHALAGA:** Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o sa planong pangkalusugan. Upang makakuha ng isang tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa Tagalog, mangyaring tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-800-XXX-XXXX. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng dagdag na tulong, tawagan ang Sentro na Tumutulong ng HMO 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, kwiijigo holne' 1-888-466-2219.]

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

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,862.50
- **Patient pays** $1,677.50

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $650 |
| Co-pays | $0 |
| Coinsurance | $1,027.50 |
| | |
| **Total** | **$1,677.50** |

## Managing type 2 diabetes
(routine maintenance of a well controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,527.50
- **Patient pays** $872.50

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $700 |
| Co-pays | $75 |
| Coinsurance | $97.50 |
| | |
| **Total** | **$872.50** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.