


## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



Gold 80 HMO

Coverage Period: 01/01/2020 – 12/31/2020  
 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, visit [lacare.org/members/welcome-la-care/member-documents/la-care-covered](http://lacare.org/members/welcome-la-care/member-documents/la-care-covered) or call 1-855-270-2327 (TTY 711). 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](http://healthcare.gov/sbc-glossary) or call 1-855-270-2327 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for the services this <a href="#">plan</a> covers
Are there services covered before you meet your <a href="#">deductible</a> ?	No	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,800 person / \$15,600 family Per calendar year	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limits</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://lacare.org">lacare.org</a> or call 1-855-270-2327 (TTY 711) for a list of <a href="#">participating providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a participating <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use a <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">participating provider</a> might use a <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes. Your Primary Care Physician (PCP) has to refer you.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

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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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30	Not covered	None
	<a href="#">Specialist</a> visit	\$65	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, ultrasound, laboratory work)	\$40 for laboratory tests \$75 for x-rays, diagnostic imaging and ultrasounds	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$275	Not covered	Prior authorization is required
If you need drugs to treat your illness or condition <small>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.lacare.org</a></small>	Tier 1 (Most Generics)	Retail - \$15 Mail service - \$30	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy
	Tier 2 (Preferred Brand)	Retail - \$55 Mail service - \$110	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy
	Tier 3 (Non-Preferred Brand)	Retail - \$80 Mail service - \$160	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy Prior Authorization is required
	<a href="#">Tier 4 (Specialty drugs)</a>	20% up to \$250 per script	Not covered	Prior Authorization is required. Not available through Mail Service.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300	Not covered	Prior Authorization is required.
	Physician/surgeon fees	\$40	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350	\$350	Co-pay waived if admitted
	<a href="#">Emergency medical transportation</a>	\$250	\$250	None

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Urgent care</a>	\$30	Not covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$600 per day up to 5 days	Not covered	Prior Authorization is required
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30	Not covered	Prior Authorization is Required for Psychological Testing and Substance Use Disorder Medical Treatment
	Other Outpatient items and services	\$30	Not covered	Prior Authorization is Required. Services outside of an office setting, such as a treatment center or home, that involve daily or weekly treatment delivered over several hours. Refer to plan documents for list of included services
	Inpatient services	\$600 per day up to 5 days	Not covered	Prior Authorization required
<b>If you are pregnant</b>	Prenatal care and preconception visits	No charge	Not covered	None
	Child birth/delivery hospital inpatient services	\$600 per day up to 5 days	Not covered	None
	Child birth/delivery inpatient professional services	No charge	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30	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 <a href="#">Rehabilitation services</a>	\$30	Not covered	Prior Authorization is required

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Outpatient <a href="#">Habilitation services</a>	\$30	Not covered	Prior Authorization is required
	<a href="#">Skilled nursing care</a>	\$300 per day up to 5 days	Not covered	Up to a maximum of 100 days per Calendar Year per Member. Prior Authorization is Required.
	<a href="#">Durable medical equipment</a>	20%	Not covered	Prior Authorization is required
	<a href="#">Hospice services</a>	No charge	Not covered	Prior Authorization is required
<b>If your child needs dental or eye care</b>	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	

**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](#).)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|--|---|---|

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

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Services related to Abortion</li> </ul> |
|---|---|--|

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**Your Rights to Continue Coverage:** Federal and State laws may provide protections that allow you to keep health this 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 the plan at 1-855-270-2327 (TTY 711). You may also contact California Department of Managed Healthcare (DMHC) at 1-888-466-2219, or the Department of Health and Human Services or call Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [ccio.cms.gov](http://ccio.cms.gov). or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice or assistance, contact: L.A. Care Covered Customer Service at 1-855-270-2327 (TTY 711). Additionally, you can contact the California Department of Managed Health Care Help at 1-888-466-2219 or visit [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov) or visit <http://www.healthhelp.ca.gov>.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 1-888-466-2219.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag 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, kwijigo holne' 1-888-466-2219.

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$65
■ Hospital (facility) [ <i>cost sharing</i> ]	\$600
Per day up to 5 days	
■ Other [ <i>cost sharing</i> ]	\$85

#### 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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,480
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,540</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$65
■ Hospital (facility) [ <i>cost sharing</i> ]	\$600
Per day up to 5 days	
■ Other [ <i>cost sharing</i> ]	\$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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,190
Coinsurance	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,600</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$65
■ Hospital (facility) [ <i>cost sharing</i> ]	\$600
Per day up to 5 days	
■ Other [ <i>cost sharing</i> ]	\$85

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$910</b>