L.A. Care Covered Direct

Bronze 60 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 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 or call 1-855-270-2327 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$6,300 individual or $12,600 family.**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
Are there other deductibles for specific services?	**$500 individual or $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?	**$7,800 individual or $15,600 family.** Per calendar year	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. See lacare.lacare.org or call 1-855-270-2327 (TTY 711) for a list of participating 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. Your Primary Care Physician (PCP) needs 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 a referral before you see the specialist.

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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 provider's office or clinic	Primary care visit to treat an injury or illness	$65	Not covered	Subject to deductible after 1st 3 non-preventive visits
	Specialist visit	$95	Not covered	Includes therapy visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Subject to deductible after 1st 3 non-preventive visits
	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, ultrasound, laboratory work)	$40 for laboratory tests 40% 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%	Not covered	Prior authorization is required Subject to deductible

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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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at lacare.org	Tier 1 (Most Generics)	Retail - $18 Mail service - $36	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)	Retail – 40% up to $500 per script after deductible Mail service – 40% up to $500 per script after deductible	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 3 (Non-Preferred Brand)	Retail – 40% up to $500 per script after deductible Mail service – 40% up to $500 per script after deductible	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 up to $500 maximum per script Prior Authorization is required
	Tier 4 (Specialty drugs)	40% up to $500 per script after deductible	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%	Not covered	Prior Authorization is required. Subject to deductible
	Physician/surgeon fees	40%	Not covered	Subject to deductible
If you need immediate medical attention	Emergency room care	40%	40%	Subject to deductible
	Emergency medical transportation	40%	40%	Subject to deductible
	Urgent care	$65	Not covered	Subject to deductible after 1st 3 non-preventive visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	40%	Not covered	Subject to deductible. Prior Authorization is required

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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)	
	Physician/surgeon fees	40%	Not covered	Subject to deductible
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$65	Not covered	Subject to deductible after 1st 3 non-preventive visits. Prior Authorization is Required for Psychological Testing and Substance Use Disorder Medical Treatment.
	Other Outpatient items and services	40% up to $65	Not covered	Subject to deductible. Prior Authorization is Required. Services outside if 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	40%	Not covered	Prior Authorization required Subject to deductible
If you are pregnant	Prenatal care and preconception visits	No charge	Not covered	None
	Child birth/delivery hospital inpatient services	40%	Not covered	Subject to deductible
	Child birth/delivery inpatient professional services	40%	Not covered	Subject to deductible
If you need help recovering or have other special health needs	Home health care	40%	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
	Outpatient Rehabilitation services	$65	Not covered	Prior Authorization is required
	Outpatient Habilitation services	$65	Not covered	Prior Authorization is required
	Skilled nursing care	40%	Not covered	Up to a maximum of 100 days per Calendar

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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)	
				Year per Member. Prior Authorization is Required. Subject to deductible.
	Durable medical equipment	40%	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 Deductible waived
	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.)

- 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)
- Routine foot care
- 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
- Services related to Abortion

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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 cciio.cms.gov. or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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 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.

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, kwiijigo holne' 1-888-466-2219.

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,470
Copayments	$680
Coinsurance	$3,650
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,130
Copayments	$1,930
Coinsurance	$2,120
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$6,240**

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$540
Copayments	$580
Coinsurance	$340
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,460**

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