L.A. Care Covered Direct

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 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?	**$0**	See the Common Medical Events chart below for your costs for the services this plan covers
Are there services covered before you meet your deductible?	**No**	You will have to meet the deductible before the plan pays for any services
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?	**$7,800 person / $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 limits.
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) 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 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	$30	Not covered	None
	Specialist visit	$65	Not covered	None
	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 $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 More information about **prescription drug coverage** is available at www.lacare.org	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
	Tier 4 (Specialty drugs)	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
	Emergency room care	$350	$350	Co-pay waived if admitted

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		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	$250	$250	None
	Urgent care	$30	Not covered	None
If you have a hospital stay	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
If you need mental health, behavioral health, or substance abuse services	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 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	$600 per day up to 5 days	Not covered	Prior Authorization required
If you are pregnant	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
If you need help recovering or have other special health needs	Home health care	$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.

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		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
	Outpatient Rehabilitation services	$30	Not covered	Prior Authorization is required
	Outpatient Habilitation services	$30	Not covered	Prior Authorization is required
	Skilled nursing care	$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.
	Durable medical equipment	20%	Not covered	Prior Authorization is required
	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
	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** **$0**
- **Specialist *[cost sharing]*** **$65**
- **Hospital (facility) *[cost sharing]*** **$600**
  Per day up to 5 days
- **Other *[cost sharing]*** **$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*)

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,540**

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]*** **$600**
  Per day up to 5 days
- **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	$0
Copayments	$2,190
Coinsurance	$350
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,600**

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]*** **$600**
  Per day up to 5 days
- **Other *[cost sharing]*** **$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)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$910**

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