

# 2019 PLANS AT A GLANCE

BENEFITS - SUMMARY OF PLAN CO-PAYS AND COINSURANCE	Platinum 90 HMO	Gold 80 HMO	Bronze 60 HMO	Minimum Coverage HMO <sup>2</sup>
<b>Annual Deductible<sup>1</sup></b> (individual/family)	\$0	\$0	\$6,300/\$12,600	\$7,900/\$15,800
<b>Annual Out of Pocket Maximum<sup>1</sup></b> (individual/family)	\$3,350/ \$6,700	\$7,200/ \$14,400	\$7,550/ \$15,100	\$7,900/ \$15,800
<b>Annual Pharmacy Deductible<sup>1</sup></b> (individual/family)	\$0	\$0	\$500/\$1,000	N/A
<b>OFFICE VISITS CO-PAY</b>				
<b>Preventive Care Services</b> including: prenatal visits, well-child care, family planning	\$0	\$0	\$0	\$0
<b>Primary Care Office Visits</b>	\$15	\$30	\$75 <sup>6</sup>	0% <sup>6</sup>
<b>Specialist Office Visits</b>	\$30	\$55	\$105 <sup>6</sup>	0%
<b>Mental Health and Substance Use Disorder Visits</b>	\$15	\$30	\$75 <sup>6</sup>	0% <sup>6</sup>
<b>URGENT &amp; EMERGENCY CARE</b>				
<b>Urgent Care Visit</b>	\$15	\$30	\$75 <sup>6</sup>	0% <sup>6</sup>
<b>Emergency Room<sup>3</sup></b>	\$150	\$325	100%	0%
<b>INPATIENT SERVICES</b>				
<b>Inpatient Hospitalization</b>	\$250/day <sup>4</sup>	\$600/day <sup>4</sup>	100%	0%
<b>Pregnancy (Labor and Delivery)</b>	\$250/day <sup>4</sup>	\$600/day <sup>4</sup>	100%	0%
<b>OUTPATIENT SERVICES</b>				
<b>Outpatient Surgery</b>	\$100	\$300	100%	0%
<b>Lab Services</b>	\$15	\$35	\$40	0%
<b>X-rays</b>	\$30	\$55	100%	0%
<b>Imaging (CT/PET Scans, MRIs)</b>	\$75	\$275	100%	0%

Benefit is available prior to meeting any deductible     Benefit is subject to annual deductible

*Benefit information continues on backside*

 **1.855.270.2327 (TTY 711)**

 **lacarecovered.org**

**FOOTNOTES:**   
**1** Annual deductible included in annual out-of-pocket maximum  
**2** Minimum Coverage HMO has an integrated medical and pharmacy deductible  
**3** Co-pay waived if member is admitted directly to the hospital

**4** Co-pay is per day up to 5 days  
**5** Applies to members up to the age of 19  
**6** Any combination of the first 3 visits prior to deductible

**7** Member is responsible for 100% up to \$500 per prescription after pharmacy deductible has been met

**8** Glasses (1 pair per year or contacts in lieu of glasses) subject to annual deductible  
 \* Subject to pharmacy deductible

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	Platinum 90 HMO	Gold 80 HMO	Bronze 60 HMO	Minimum Coverage HMO <sup>2</sup>
<b>PRESCRIPTION DRUGS</b>				
<b>Tier 1</b> (Most Generics)	\$5	\$15	100% <sup>7*</sup>	0%
<b>Tier 2</b> (Preferred Brand)	\$15	\$55	100% <sup>7*</sup>	0%
<b>Tier 3</b> (Non-Preferred Brand)	\$25	\$75	100% <sup>7*</sup>	0%
<b>Tier 4</b> (Specialty)	10% up to \$250/prescription	20% up to \$250/prescription	100% <sup>7*</sup>	0%
<b>PEDIATRIC VISION<sup>5</sup> (AGES 0-19)</b>				
<b>Vision exam and Glasses</b> (1 pair per year or contacts in lieu of glasses)	No charge	No charge	No charge	No charge <sup>8</sup>
<b>PEDIATRIC DENTAL<sup>5</sup> (AGES 0-19)</b>				
<b>Oral Exam, Preventive Cleaning, X-rays, Sealants per Tooth, Topical Fluoride Application and Space Maintainers</b> (fixed)	No charge	No charge	No charge	No charge

Benefit is available prior to meeting any deductible     Benefit is subject to annual deductible

Did you know that L.A. Care Covered *Direct*<sup>™</sup> offers no-cost Preventive Care and wellness services? Here are just a few of the services offered:

- Blood pressure and cholesterol screening
- Type 2 diabetes screening
- Vaccines, including the flu shot
- Depression screening
- Mammograms and Pap smear
- Tobacco and alcohol use (screening and counseling)
- Diet counseling
- Colorectal cancer screening
- Prenatal and well-baby visits

This “Plans at a Glance” document is intended to be a summary of benefits. Please review the L.A. Care Covered *Direct*<sup>™</sup> “Evidence of Coverage” document (or Member Handbook) for a detailed description of all benefits, limitations and exclusions.

#### Nondiscrimination and Accessibility Statement

L.A. Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

#### Getting Help in Other Languages

English: To request free interpreting services, information in your language or in another format, call L.A. Care at 1.855.270.2327 (TTY 711).

Spanish: Para solicitar servicios de interpretación gratuitos o información en su idioma o en otro formato, llame a L.A. Care al 1.855.270.2327 (TTY 711).

**L.A. Care Covered *Direct*<sup>™</sup> is the health plan that focuses exclusively on the health needs of all of L.A. County’s diverse residents. Free confidential assistance is available 24 hours a day, 7 days a week by calling 1.855.270.2327 (TTY 711). You may be eligible for financial assistance.**

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