2017 PLANS AT A GLANCE

L.A. Care Covered™ Direct

BENEFITS - SUMMARY OF PLAN CO-PAYS AND COINSURANCE	Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Minimum Coverage HMO[2]
Annual Deductible[1] (individual/family)	$0	$0	$2,500/$5,000	$6,300/$12,600	$7,150/$14,300
Annual Out of Pocket Maximum[1] (individual/family)	$4,000/$8,000	$6,750/$13,500	$6,800/$13,600	$6,800/$13,600	$7,150/$14,300
Annual Pharmacy Deductible[1] (individual/family)	$0	$0	$250/$500	$500/$1,000	N/A
OFFICE VISITS CO-PAY					
Preventive Care Services including: prenatal visits, well-child care, family planning	$0	$0	$0	$0	$0
Primary Care Office Visits	$15	$30	$35	$75[6]	0%[6]
Specialist Office Visits	$40	$55	$70	$105[6]	0%
Mental Health and Substance Use Disorder Visits	$15	$30	$35	$75[6]	0%[6]
URGENT & EMERGENCY CARE					
Urgent Care Visit	$15	$30	$35	$75[6]	0%[6]
Emergency Room[3]	$150	$325	$350	100%	0%
INPATIENT SERVICES					
Inpatient Hospitalization	$250/day[4]	$600/day[4]	20%	100%	0%
Maternity	$250/day[4]	$600/day[4]	20%	100%	0%
OUTPATIENT SERVICES					
Outpatient Surgery	$250	$600	20%	100%	0%
Lab Services	$20	$35	$35	$40	0%
X-rays	$40	$55	$70	100%	0%
Imaging (CT/PET Scans, MRIs)	$150	$275	$300	100%	0%

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

Benefit information continues on backside

1.855.222.4239 (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 wHMO	Silver 70 HMO	Bronze 60 HMO	Minimum Coverage HMO[2]
PRESCRIPTION DRUGS					
Tier 1 (Most Generics)	$5	$15	$15	100%[7]*	0%
Tier 2 (Preferred Brand)	$15	$55	$55*	100%[7]*	0%
Tier 3 (Non-Preferred Brand)	$25	$75	$80*	100%[7]*	0%
Tier 4 (Specialty)	10% up to $250/prescription	20% up to $250/prescription	20% up to $250/prescription*	100%[7]*	0%
PEDIATRIC VISION[5]					
Vision exam and Glasses (1 pair per year or contacts in lieu of glasses)	No charge	No charge	No charge	No charge	No charge[8]
PEDIATRIC DENTAL[5]					
Oral Exam, Preventive Cleaning, X-rays, Sealants per Tooth, Topical Flouride Application and Space Maintainers (fixed)	No charge	No charge	No charge	No charge	No charge

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

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

Did you know that L.A. Care Covered *Direct*™ 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 smears
- Tobacco and alcohol use (screening and counseling)
- Diet counseling
- Colorectal cancer screening
- Prenatal and well-baby visits

L.A. Care Covered *Direct*™ 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 1.855.222.4239 (TTY 711).

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