Silver 87 HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2024 – 12/31/2024
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, call **1-855-270-2327** or visit us at **lacare.org**. 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** .

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0 individual / $0 family.** Per calendar year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins. 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. For example, this plan covers certain preventive without cost sharing and before you meet your deductible. See a list of covered preventive at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	**$3,000 individual / $6,000 family.**	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, balance billing 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 network 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.**	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

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	$15 copay / visit	Not covered	None
	Specialist visit	$25 copay / visit	Not covered	Referral is required *
	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, blood work)	$20 copay / test for laboratory tests. $40 copay / test for X-rays diagnostic imaging and ultrasounds.	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay / test	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 http://www.lacare.org/members/getting-care/pharmacy-services	Tier 1 - Most Generics	Retail - $5 copay / script Mail Order - $10 copay / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy.
	Tier 2 -Preferred brand drugs	Retail - $25 copay / script Mail Order - $50 copay / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy.
	Tier 3 - Non-preferred brand drugs	Retail - $45 copay / script Mail Order - $90 copay / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy.
	Tier 4 - Specialty drugs	15% coinsurance up to $150 copay per script	Not covered	Prior Authorization is Required. Mail order not available.

* For more information about limitations and exceptions, see the plan or policy document at **lacare.org**.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior Authorization is Required. *
	Physician / surgeon fees	20% coinsurance	Not covered	None
	Outpatient Visit	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay / visit No charge for physician fee	$150 / visit No charge for physician fee	Copay waived if admitted.
	Emergency medical transportation	$75 copay	$75	None
	Urgent care	$15 copay / visit	$15 /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Prior Authorization is Required.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay / office visit 20% coinsurance up to $15 copay for other outpatient services	Not covered	Prior Authorization is Required for Psychological Testing. *
	Inpatient services	20% coinsurance	Not covered	Prior Authorization is Required.
If you are pregnant	Office visits	No charge	Not covered	For prenatal care and preconception visits None
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$15 copay / visit	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. Prior Authorization is Required. *
	Rehabilitation services	$15 copay / visit	Not covered	Prior Authorization is Required. *
	Habilitation services	$15 copay / visit	Not covered	Prior Authorization is Required. *
	Skilled nursing care	20% coinsurance	Not covered	Up to a maximum of 100 days per Calendar Year per Member. Prior Authorization is Required.

* For more information about limitations and exceptions, see the plan or policy document at **lacare.org**.

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)	
	Durable medical equipment	15% coinsurance	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	Oral exam and preventive cleaning limited to 1 every 6 months. See your plan document for additional information about services.

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)
- 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
- Medical necessary routine foot care
- Services related to Abortion

Your Rights to Continue Coverage:

* For more information about limitations and exceptions, see the plan or policy document at **lacare.org**.

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care at **1 (888) HMO-2219 (1-888-466-2219)** or hmohelp.ca.gov; U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or www.cciio.cms.gov; Covered California at **1 (800) 300-1506** or coveredca.com; or contact L.A. Care Health Plan at **1- 855-270-2327**. We are available 24 hours a day, 7 days a week, including holidays. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about contact your rights, this notice, or assistance, contact L.A. Care Customer Service at **1- 855-270-2327**. We are available 24 hours a day, 7 days a week, including holidays. Additionally, you can contact the California DMHC at **1-888-466-2219** or visit **dmhc.ca.gov.**

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through Covered California or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

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Spanish (Español): Para obtener asistencia en Español, llame al **1- 855-270-2327**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1- 855-270-2327**

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **1- 855-270-2327**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1- 855-270-2327**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

* For more information about limitations and exceptions, see the plan or policy document at **lacare.org**.

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]*	**$25**
Hospital (facility) *[cost sharing]*	**20%**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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]*	**$25**
Hospital (facility) *[cost sharing]*	**20%**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

Mia's Simple Fracture

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**20%**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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