



# HEALTH BENEFITS GUIDE

2023



85 Years of Securing Your Tomorrows

# Health Benefits Guide 2023

<b>Open Enrollment:</b> October 17 – November 17, 2022	<b>Last Date to Make Changes:</b> November 17, 2022	<b>Benefit Changes Take Effect:</b> January 1, 2023
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## Top three things you should know about Open Enrollment:

- 1 Open Enrollment is your only opportunity to make coverage selections for yourself and your eligible dependents for 2023 (unless you experience a qualifying life event change or are a newly Retired Member).
- 2 Generally, your previous year’s benefit elections will automatically roll over to the following year, unless you make a change during Open Enrollment. Check your Open Enrollment Statement to review your previous year’s benefit elections.
- 3 Some Open Enrollment election actions require you to submit supporting documentation to complete the enrollment. A few common examples are enrolling a new dependent in coverage and showing proof of Medicare enrollment.

## New Retiree Enrollment

- 1 Review this Health Benefits Guide thoroughly to make the best health plan selection for your situation.
- 2 See Pages 9-12 regarding Medicare for when you become Medicare eligible.
- 3 Submit within 60 days of your retirement date all necessary and required enrollment paperwork for the health plan(s) you select to avoid delay in enrollment processing. Delays over 90 days in submitting retirement documents may result in disenrollment from LACERS health plans.

## Available Medical Plans for 2023

This chart is a summary. Please refer to Pages 19-48 for plan descriptions, comparison charts, and cost charts.

Retired Member and Survivor	Health Plans
Under Age 65	Anthem Blue Cross PPO (nationwide) Anthem Blue Cross HMO (CA only) Kaiser Permanente HMO (CA only)
Age 65+ with Medicare Part B only	Anthem Blue Cross PPO (nationwide) Anthem Blue Cross HMO (CA only) Kaiser Permanente Senior Advantage HMO (CA only)
Age 65+ with Medicare Parts A and B	Anthem Blue Cross Medicare Preferred (PPO) (nationwide) Kaiser Permanente Senior Advantage HMO (CA only) SCAN Health Plan Medicare Advantage HMO (CA only) UnitedHealthcare Medicare Advantage HMO (CA, AZ, and NV)
Outside of CA HMO service area, or Non-CA	LACERS Medical Premium Reimbursement Program
Reside Outside U.S. and Its Territories	Anthem Blue Cross Out-of-Country

## Available Dental Plans for 2023

Please refer to Pages 49-52 for plan descriptions, subsidy eligibility, comparison charts, and cost charts.

Delta Dental PPO (nationwide)	&	DeltaCare USA HMO (CA and NV)
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# Health Benefits Guide 2023

This guide provides information about the 2023 health plan options for current and new Retired Members and Survivors. Make an appointment with yourself and your family to review this material carefully before making your health and dental plan choices. For unfamiliar terms, please see the updated glossary in this guide.

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# About Your Health Benefits

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## 2023 Retired Member Health Benefits Guide

LACERS health benefits are for Retired Members and eligible Survivors. We encourage you to keep this Guide as a reference for the 2023 plan year. Use this Guide as your resource to:

- Familiarize yourself with your eligibility for benefits;
- Compare medical and dental plans;
- Help you with enrollment in LACERS-sponsored health plans; and
- Understand when and how you can change your and/or your eligible dependents' health plan coverage.

## Subscribe to the Official LACERS YouTube Channel

Can't attend a webinar and still want to learn about your LACERS benefits? Check out one of the many single-topic videos that cover all your burning questions from "What's the difference between service and service credit?" to "What survivor benefits are available to my family when I pass away?" Learn from the comfort of your home or on the go – it's never been more convenient! Make sure to subscribe to the LACERS YouTube channel to be the first to know when new videos are available. Just go to [youtube.com/lacersyoutube](https://youtube.com/lacersyoutube) for access to these resources.

## Take Advantage of Your MyLACERS Online Account

Keep track of your personal LACERS information such as your service and service credit, beneficiaries on file, and correspondence with LACERS staff through your secured online account at [mylacers.lacers.org](https://mylacers.lacers.org). Opening and maintaining a secured MyLACERS account provides you access to your confidential information that is less vulnerable to a hacking attempt. As a retiree, your MyLACERS account is also the easiest way to view, download, and print your Direct Deposit statements and 1099-R tax forms.

Don't have a MyLACERS account yet? Request a PIN be mailed to you by visiting [mylacers.lacers.org](https://mylacers.lacers.org) to get started.

## LACERS turns 85

In 1937, the Los Angeles City Charter established the Los Angeles City Employees' Retirement System (LACERS) as a retirement trust fund for the purpose of providing the civilian employees of the City of Los Angeles, a defined benefit retirement plan inclusive of service retirements, disability retirements, and survivor benefits. The retiree health insurance benefit was added in 1973.

As we celebrate 85 years in existence, we are proud that service to our Members remains first and foremost. We also remain committed to our mission of establishing trusting and lifelong relationships with all of our Members.

### LACERS

(800) 779-8328 • RTT (888) 349-3996 •

Fax (213) 473-7284

**Mailing address:** P.O. Box 512218,  
Los Angeles, CA 90051-0218

**Website:** [LACERS.org](https://LACERS.org)

**Email health plan questions:** [LACERS.health@lacers.org](mailto:LACERS.health@lacers.org)

**Email general questions:** [LACERS.services@lacers.org](mailto:LACERS.services@lacers.org)

**MyLACERS Portal:** [mylacers.lacers.org](https://mylacers.lacers.org)

# Your Detailed Enrollment Checklist

## Related Pages for Checklist

Dependent eligibility: pg 5	Open Enrollment and Qualifying Event: pg 6-8
Available medical plans: Inside cover, pg 18-22	Medical, Enhanced, and Vision benefits: pg 24-36
Monthly medical premiums/deductions: pg 37-48	Dental benefits: pg 49, 51
Monthly dental premiums/deductions: pg 52	

Step 1	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review your 2023 Open Enrollment Health Plan Statement (This is a <u>snapshot</u> of your coverage in LACERS' system as of August 31, 2022)             <ul style="list-style-type: none"> <li><input type="checkbox"/> Verify address(es) and phone number(s) are current</li> <li><input type="checkbox"/> Review your dependents' coverage and their eligibility for coverage (You must remove dependents from your coverage when they become ineligible, e.g., month following divorce/dissolution date.)</li> <li><input type="checkbox"/> Review your current coverage for 2023 premiums, subsidies, and deductions (New Retiree/Survivor or made plan changes: log into your MyLACERS account to view)</li> </ul> </li> </ul>
Step 2	<p><b>If enrolling in or changing your Medical and/or Dental plan</b>, review your plans' details in the 2023 Health Benefits Guide. This guide and all required forms, except the Senior (Medicare) forms, are available online at <a href="https://lacers.org/forms-info-sheets">lacers.org/forms-info-sheets</a>. Complete and submit required forms:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> LACERS Medical Enrollment form (one is Kaiser, one is for the other plans) and/or</li> <li><input type="checkbox"/> LACERS Dental Enrollment form</li> <li><input type="checkbox"/> <u>If covering existing dependents</u>, a new <i>Certification of Dependent and Survivor Status for Health Coverage</i> is required</li> <li><input type="checkbox"/> <u>If covering new dependents</u>, gather all necessary and required documents (e.g., birth and marriage certificate, domestic partner affidavit, Social Security Number, proof of Medicare), then complete and submit <i>Certification of Dependent and Survivor Status for Health Coverage</i></li> <li><input type="checkbox"/> If you and/or your eligible dependent(s) have Medicare, request a LACERS Senior Form for each person who has Medicare; Each Medicare enrollee must complete their own form</li> </ul> <p><b>If adding new dependents to your current Medical and/or Dental plan</b>,</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Gather all necessary, required documents for submission (e.g. birth certificate, marriage certificate, domestic partner affidavit, Social Security Number, proof of Medicare)</li> <li><input type="checkbox"/> Complete and submit <i>Certification of Dependent and Survivor Status for Health Coverage</i> (required)</li> <li><input type="checkbox"/> If the eligible dependent has Medicare, request a LACERS Senior Form (the form must be completed by the eligible dependent)</li> <li><input type="checkbox"/> Complete and submit <i>LACERS Family Account Change Form</i></li> </ul> <p><b>If cancelling your Medical and/or Dental plan or deleting a dependent</b>, please see page 7 of this Guide for the required forms</p>
Step 3	<ul style="list-style-type: none"> <li><input type="checkbox"/> Retain a copy of your forms as proof of enrollment. Enrolling in and/or changing your benefits cannot be done verbally.</li> <li><input type="checkbox"/> Submit your forms and required documents by the appropriate deadline to LACERS by:             <ul style="list-style-type: none"> <li>• Secure Document Upload: <a href="https://www.lacers.org/secure-document-upload">www.lacers.org/secure-document-upload</a>,</li> <li>• Email: <a href="mailto:LACERS.Health@lacers.org">LACERS.Health@lacers.org</a>,</li> <li>• Fax: (213) 473-7284, or</li> <li>• Mail to: LACERS, P.O. Box 512218, Los Angeles CA 90051-0218</li> </ul> </li> </ul>

# Important Notices

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## LACERS Health Benefits

This booklet is a reference guide to the retiree health benefits and health plan options offered by the Los Angeles City Employees' Retirement System (LACERS). The services to be provided shall be in accordance with agreements between the health plan carriers and LACERS. As the Program Administrator, the LACERS Board of Administration reserves the right, as provided in Chapter 11, Division 4 of the Los Angeles Administrative Code (LAAC) to terminate any plan benefits at the beginning of any plan year, or at any time, when, in the opinion of the Board, it is necessary for the administration of any individual plan or the medical and dental program.

You will find a plan's Evidence of Coverage on the LACERS website at [lacers.org/evidence-coverage](https://lacers.org/evidence-coverage). You may contact LACERS if you would like the appropriate Service Agreement or Certificate of Insurance for a LACERS-sponsored plan.

In the event of any discrepancies between this document and the various ordinances governing the receipt of health benefits or reimbursements, the legal text found in the ordinances shall govern at all times.

## Health Insurance Portability and Accountability Act (HIPAA)

Effective April 2003, HIPAA, a federal privacy rule for health information, placed strict limits on how your health information can be disclosed. Generally, health plans can only release your health information to you, your health care providers, or to those paying for your health care treatment unless you provide written permission stating otherwise.

If you ask LACERS to contact your health plan on your behalf, you must provide us with your written authorization to do so and allow the health plan to provide LACERS with your health information. Contact LACERS for your plan's authorization form at [LACERS.health@lacers.org](mailto:LACERS.health@lacers.org) or call LACERS Customer Service at (800) 779-8328 or RRT (800) 349-3996.

## Durable Power of Attorney

Should you become incapacitated and unable to make health benefits decisions, LACERS will require a Legal Authority document to allow an agent to act on your behalf.

- The *LACERS Special Durable Power of Attorney* form will only cover matters related to your LACERS' financial benefits. The form and instructions can be found at [lacers.org/forms-info-sheets](https://lacers.org/forms-info-sheets).
- The *California Uniform Statutory Form Power of Attorney* is sufficient for all your LACERS' retirement and health benefits decisions.

## Taxability of Your Health Benefits

All Retired Members enrolling dependents, and all eligible Survivors, must complete and submit a *Certification of Dependent or Survivor Status for Health Coverage Form*. This form may be found online at [lacers.org/forms-info-sheets](https://lacers.org/forms-info-sheets). If you do not have internet access, please call LACERS Customer Service at (800) 779-8328 or RRT (800) 349-3996.

Enrolling non-tax dependents may result in portions of your medical subsidy that is used to cover non-tax dependents to be reported to the IRS as taxable income. Please see Page 13 for Retired Members' medical subsidy and Page 15 for eligible Survivors' medical subsidy.



# Health Plan Enrollment Eligibility

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## Retired Member Eligibility

You are eligible to enroll in LACERS' health plans if you are a retired City employee who receives a monthly retirement allowance from LACERS.

### Eligible Dependents<sup>1</sup>

You may enroll your eligible dependent(s) in a LACERS health plan. An eligible dependent may be a:

- Spouse
- Domestic partner (your partnership must be registered with LACERS or your state)
- Dependent child who is:
  - Under age 26, except in circumstances where an adult child is eligible to enroll in an employee-sponsored plan, or
  - Unable to engage in gainful employment because of a mental or physical disability, in which the disability occurred before age 26
- Grandchild under age 26, if you or your spouse/domestic partner are the legal guardian(s) or have legal custody of the grandchild; or if the grandchild is the child of a dependent child as defined above

A “dependent child” includes:

- A child born to you
- A child legally adopted by you
- A step-child living with you in a parent-child relationship
- A child of whom you have legal custody or guardianship and provide principal financial support
- Your spouse's or domestic partner's child

## Dependent Eligibility Verification

To verify that your dependent is eligible to enroll in a LACERS health plan, you will be required to provide LACERS with supporting documents, such as:

- Copy of your certified marriage certificate
- Proof of domestic partnership
- Your child's birth certificate
- Proof of your child's disability, if applicable

## Domestic Partnership Eligibility

For your domestic partner and the children of your domestic partner to be eligible to enroll into a LACERS health plan with you, you must have one of the following:

- An *Affidavit of Domestic Partnership Form* on file with LACERS
- Proof of your legally-registered domestic partnership in the State of California
- Proof of a legal union of two persons validly formed in another jurisdiction that is substantially equivalent to a domestic partnership, regardless of whether it bears the name “Domestic Partnership.”

## Survivor Eligibility

An eligible Survivor to enroll in LACERS' health plans is a Surviving Spouse/Domestic Partner who receives a Continuance or a Survivorship allowance from LACERS. (Refer to Eligible Survivor Benefits on page 15)

Former spouses and former domestic partners of Retired Members are not eligible to enroll in LACERS' health plans.

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1. These definitions of dependent are relevant to eligibility for coverage. They may differ from dependent determinations for taxation purposes. For more information, please contact the Internal Revenue Service (IRS) and/or consult with a tax professional.

# Enrolling in a Health Plan

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## When to Enroll

Generally, you may enroll in a LACERS health plan:

- During your retirement process
- Within 60 days of your retirement effective date
- During LACERS' annual Open Enrollment period

## Open Enrollment Period

The **Open Enrollment Period** is when eligible Retired Members and Survivors **can enroll** in a LACERS health plan or **change** their current health plan. LACERS Annual Open Enrollment period is generally from October 15 to November 15. Requests made in the Open Enrollment Period will go into effect on the following January 1st.

If you are already enrolled in a health plan and do not want to make changes, no action is necessary and your health plan will remain in effect for the next plan year.

## Qualifying Events

A qualifying event triggers a special enrollment period for an individual or family to enroll in LACERS coverage outside of the regular annual Open Enrollment period. You may enroll or change plans within:

- 60 days of the Retiree turning age 55
- 90 days of the Retiree turning age 65 (based on Medicare eligibility)
- 30 days of relocation out of or into a LACERS HMO plan zip code service area
- 30 days of a LACERS HMO plan zip code service area becoming available or unavailable
- 30 days of being involuntarily terminated from a non-LACERS medical plan (LACERS requires proof of termination)
- 30 days from the date of family status change (such as marriage and birth or adoption of a child)

## Selecting a Health Plan and Enrolling

1. Review the premiums, subsidies, deductions, and benefit information provided in this Guide to understand the benefits each plan offers and any costs you may have.
2. Make a decision on your medical and/or dental plan selections.
3. If enrolling for the first time, obtain medical and/or dental enrollment forms from [LACERS.org](https://www.lacERS.org), by emailing LACERS Health Benefits directly at [LACERS.health@lacers.org](mailto:LACERS.health@lacers.org), or by calling (800) 779-8328. If you are already enrolled in a LACERS-sponsored medical/dental plan and wish to change plans and/or update dependents, see pages 7-8 then complete Steps 4 and 5.
4. Complete all applicable sections of the health plan enrollment forms.
5. Submit your completed forms and required documents back to LACERS as described on the forms.



# Health Plan Account Changes

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## When Your Health Plan Coverage Begins

- **For New Retirees:** The first of the month following your retirement effective date unless your retirement effective date is the first of the month, then coverage is effective that month; or
- **All other events:** The first of the month following the processing of your enrollment request

## Disenrolling from LACERS Health Plan

If you would like to disenroll from your LACERS health plan entirely, you must complete and submit a *LACERS Medical/Dental Plan Cancellation Form* available online at [LACERS.org](https://www.lacers.org). Your coverage will be terminated on the first day of the month after your form is processed by LACERS. A completed *LACERS Medical/Dental Plan Cancellation Form* **must be received by the 10th of the month** in order for the cancellation to be effective the first of the following month. If you and/or your dependent have Medicare (A&B or B only), the *Voluntary Senior Plan Disenrollment Form* is also required and due by the 10th of the month.

## Adding a New Dependent

If you have a family status change, such as a new marriage, a new domestic partnership, or the birth/adoption of a child, you may make changes to your health plan or enroll in another health plan without having to wait until the Open Enrollment period.

**You have 30 days from the date of your family status change to add a new dependent to your health plan.** To add a new dependent, you must complete and submit a *LACERS*

*Medical/Dental Plan Family Account Change Form* and a *Certification of Dependent or Survivor Status for Health Coverage Form*. Both forms are available online at [LACERS.org](https://www.lacers.org). Your dependent's health plan coverage will begin on the first day of the month after your form is processed. A completed *Family Account Change Form* **must be received by the 10th of the month** in order for the coverage to be effective the first of the following month. If your dependent(s) have Medicare (A&B or B only), Senior Plan Enrollment Form(s) are required and due by the 10th of the month.

If your dependent is Medicare-eligible, additional forms will be required to enroll in a LACERS medical plan. Contact LACERS Health Benefits Division for these forms.

## Deleting a Dependent

If you would like to delete a dependent, you must complete and submit a *LACERS Medical/Dental Plan Family Account Change Form*. Your dependent's coverage will be terminated on the first day of the month after your form is processed. A completed *Family Account Change Form* **must be received by the 10th of the month** in order for the cancellation to be effective the first of the following month. If your dependent(s) have Medicare (A&B or B only), a *Voluntary Senior Plan Disenrollment Form* is required and due by the 10th of the month.

Health plan enrollment forms are available from [LACERS.org](https://www.lacers.org), upon request by emailing [LACERS.health@lacers.org](mailto:LACERS.health@lacers.org), or by calling (800) 779-8328.

# Health Plan Account Changes (continued)

## Deleting an Ineligible Dependent

If an event makes your dependent ineligible for LACERS health plan coverage (e.g., divorce), you must delete a dependent from your LACERS health plan within 60 days. Please note that LACERS health subsidies may not be applied toward the coverage for ineligible dependents.

LACERS reserves the right to terminate your dependent's health plan coverage should we

discover your dependent is no longer eligible to participate in a LACERS health plan.

*If you do not notify LACERS within 60 days of your dependent becoming ineligible to participate in a LACERS health plan, this dependent may not be offered an opportunity to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and you may be responsible for paying any overpaid subsidy amounts to LACERS.*



# Medicare and LACERS Health Benefits

## When to Enroll in Medicare

Medicare is federal health insurance for people age 65 and older, and some people under 65 with certain disabilities or conditions. Generally, you are first eligible to sign up for Medicare 3 months before you turn age 65. Medicare is managed by Centers for Medicare & Medicaid Services (CMS) and Medicare enrollment eligibility is determined by Social Security Administration (SSA).

Parts of Medicare include:

- Part A (hospital insurance)
- Part B (medical insurance)
- Part D (prescription drug coverage)

You may find contact and website information for CMS and SSA on the back cover of this Guide.

If the Retired Member, dependent, or eligible Survivor does not enroll in Medicare by age 65 AND maintain their Medicare coverage, the LACERS medical plan premium subsidy will cease; additional premiums may be charged; and the existing LACERS medical plan coverage will be terminated for all covered individuals in the plan. Additionally, CMS may charge ongoing late enrollment penalties and LACERS may collect from the monthly retirement, continuance, or survivorship allowance all medical premium subsidies paid on your behalf during the period of medical premium subsidy ineligibility.

**For LACERS Members retiring at age 65 or older, and/or your dependent(s) are over age 65, Medicare allows you and/or those dependents to defer enrollment in Medicare Part B until you retire. This is known as Special Enrollment Period (SEP). You must complete additional forms (available at LACERS) when you retire and apply for Medicare.**

For additional information on Medicare after retirement at age 65 or older, please visit [LACERS.org/medicare](https://www.lacers.org/medicare).

### Medicare Enrollment Exception – Living Outside the U.S. and Its Territories

You may not need to enroll in Medicare if you reside permanently outside the U.S. and its territories. However, CMS may impose a lifetime penalty if A) you later decide to reside in the U.S. and its territories and have not enrolled in Medicare, and/or B) you allow your Medicare premium payments to lapse. Contact the SSA regarding Medicare rules, regulations, or penalties that may affect your medical plan coverage.

If you later decide to return to the U.S. and its territories to reside, continued Medicare enrollment should be discussed with the SSA in advance.

For a list of U.S. territories, refer to the Glossary on page 56.

## Medicare Part B Enrollment

Retirees, Survivors, and dependents are **required** to enroll in and maintain Medicare Part B to qualify for a LACERS medical plan premium subsidy and to enroll/remain enrolled in a LACERS medical plan (as provided in the Los Angeles Administrative Code (LAAC) §§ 4.1111(f) and 4.1126(e) and LACERS Board Rules (HBA 2.d)).

Retirees, Survivors, and dependents enrolled in a LACERS medical plan should apply for Medicare Part B enrollment (and, if at no cost, Medicare Part A) three months prior to their 65th birthday, or sooner, if eligible.

**Please note:** Retirees and dependents who do not use standardized legal names for all governmental systems (e.g. use different names for different systems, such as “Joe” in LACERS’ system but “Joseph” with SSA) may have difficulty when enrolling. This is especially possible when there is a mismatch in names when applying for Medicare and enrolling in a LACERS Medicare plan.



# Medicare and LACERS Health Benefits (continued)

Name mismatches can result in delays/denials in enrolling. Please be sure to provide only standardized names on enrollment documents.

## Medicare Part A Enrollment

Per LAAC §§ 4.1111(f) and 4.1126(e), if you qualify for Medicare Part A premium-free, you are **required** to enroll in Part A. If you are not entitled to Medicare Part A premium-free, you are **not required** to enroll in Medicare Part A.

You may receive Part A premium-free if you:

- Have 10 years of earnings history with Social Security outside of City employment; or
- Started with the City after April 1, 1986 (these City employees qualify for Part A by having paid FICA Medicare payroll taxes); or
- Through your spouse, if they are eligible for Part A premium-free, when they reach age 62.

Contact your local SSA office to determine if you are eligible for Medicare Part A premium-free. You may locate your local SSA at [secure.ssa.gov/ICON/](https://secure.ssa.gov/ICON/).

## Medicare Part D

Medicare Part D is already integrated into your LACERS medical plan. Do not enroll in Medicare Part D separate from your LACERS plan because enrolling or disenrolling in Medicare Part D on your own or through a non-LACERS group plan will cause your LACERS medical coverage to be terminated and will make you ineligible for a LACERS medical plan subsidy.

### Exception – Medical Premium Reimbursement Program

If you participate in LACERS' Medical Premium Reimbursement Program (MPRP) and your non-LACERS plan does not include Medicare Part D, you should enroll in supplemental Medicare Part D insurance in order to maintain creditable coverage.

## CMS One Medicare Plan Requirement

CMS allows only one Medicare Advantage plan or Medicare Part D Prescription Drug plan. If you enroll in a Medicare Advantage or a Medicare Part D Prescription Drug plan outside of your LACERS medical plan, you will lose your LACERS medical coverage, even if enrolled with the same insurance company but sponsored by a different organization (for example, the CalPERS Kaiser Permanente Senior Advantage HMO plan).

**If you pay Medicare premiums to CMS, consider the Medicare Easy Pay Program to avoid a lapse in coverage.** You can sign up via:

- Your Medicare online account
- The Authorization Agreement for Pre-authorized Payments form (SF-5510) and send it by mail to CMS

## Proof of Medicare Enrollment

Once enrolled in Medicare, provide a copy of your Medicare card or SSA Benefit Verification Letter to LACERS with the proper completed Senior Enrollment forms. You must maintain your Medicare enrollment by paying your monthly Medicare premiums and any surcharges, if assessed (see next page for IRMAA and LEP).

## Termination Due to Medicare Lapse

If you lapse on your Medicare Part B premiums and/or any surcharges and are terminated from your LACERS medical plan:

- You and your dependents' Medicare Part D will be canceled;
- Your LACERS medical subsidy will terminate;
- Your basic Medicare Part B premium reimbursement terminates;

# Medicare and LACERS Health Benefits (continued)

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- If enrolled in Kaiser Senior Advantage, you will be charged the full monthly Non-Medicare plan premium retroactive to the date Medicare coverage ended.

CMS may assess lifetime penalties when you re-enroll in Medicare Part B and Part D.

## Income-Related Monthly Adjustment Amount (IRMAA)

CMS assesses Income-Related Monthly Adjustment Amount (IRMAA) when the Medicare enrollee's Modified Adjusted Gross Income (MAGI) amount from two years prior (e.g. 2021 IRS tax return for 2023 IRMAA) exceeds a certain threshold. The IRMAA is a surcharge on top of the basic/standard Medicare Part B and D premium rates.

**It is the Medicare enrollee's responsibility to pay for any Medicare Part B and Part D IRMAAs assessed by CMS, even if the Medicare enrollee is not paying a Part D premium through enrollment in a LACERS senior medical plan.**

Partial payments of IRMAAs and/or allowing your Medicare premium payments to lapse will lead CMS to request LACERS medical plans to cancel your coverage. To regain your coverage, the Medicare enrollee needs to communicate with CMS and/or SSA and bring the balance to current.

**Note:** LACERS does not apply the medical subsidy towards, nor reimburses, any IRMAA costs.

For further IRMAA information, you may refer to [Medicare.gov/Your-Medicare-Costs/Part-B-Costs](https://www.Medicare.gov/Your-Medicare-Costs/Part-B-Costs)

## Medicare Part D Late Enrollment Penalty (LEP)

If you did not enroll in Medicare Part D through a LACERS group plan at the time you were first eligible or did not have creditable prescription drug coverage (i.e. coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage), the late

enrollment penalty (LEP) is an amount that may be added to your monthly premium. A Medicare enrollee may owe a LEP if they go without Part D or other creditable prescription drug coverage for any continuous period of 63 days or more after the end of their initial Medicare enrollment period.

CMS determines whether a Medicare enrollee is subject to the Part D LEP. Generally, LEP is added to the Medicare enrollee's monthly Part D premium for as long as they have Medicare drug coverage, even if the person changes their Medicare plan. The LEP amount changes each year. The cost of LEP depends on how long the person went without Part D or other creditable prescription drug coverage.

If you and/or your dependents are subject to LEP, CMS will notify your LACERS medical plan for collection. In turn, the medical plan will notify you as well as request LACERS to submit LEP payment. Because LACERS medical subsidy only covers the basic medical premium, the LEP amount must be taken from your retirement allowance.

To resolve Part D LEP issues, please contact CMS directly at 1-800-MEDICARE (1-800-633-4227).

## Medicare Part B Reimbursement

LACERS will reimburse the Retired Member for the **basic/standard** Medicare Part B premium if all the below requirements are met:

1. Enrolled in both Medicare Parts A and B; **AND**
2. Enrolled in a LACERS Senior Plan, or participating in the LACERS Medical Premium Reimbursement Program (MPRP); **AND**
3. Receiving a medical subsidy.

When you receive your LACERS Medicare packet, please complete your required Medicare documents as soon as possible to avoid delays in your reimbursement.

# Medicare and LACERS Health Benefits (continued)

For LACERS Members retiring at age 65 or older, the LAAC (§§ 4.1105, 4.1113, and 4.1123) states that qualified Retired Members enrolled in Medicare Parts A and B who are participating in a LACERS Senior medical plan or the MPRP may be entitled to reimbursement of their basic Part B premiums by LACERS. The Medicare Part B Reimbursement does not include the IRMAA portion of your premium.

Please note that LACERS does not reimburse Survivors nor dependents any part of their Medicare Part B premium.

A Retired Member enrolled as a dependent in a LACERS medical plan who meets the definition of an Eligible Retiree as provided in LAAC §§ 4.1113(b) and 4.1128(b) shall be eligible for the basic Medicare Part B premium reimbursement

and shall be subject to, and responsible for, complying with the Board Rules, Administrative Policies and Procedures, and contract provisions.

## **Exception – Out-of-Country Retirees**

If you are enrolled in the Anthem Blue Cross PPO Out-of-Country plan, you will not be eligible for Medicare Part B premium reimbursement.

## **Medicare Part D Low Income Subsidy**

You may be able to get extra help to pay for your prescription drug premiums and costs. Contact CMS, SSA, or your state's Medicaid office to see if you qualify for extra help. The contact information for CMS and SSA are provided on the back cover of this Guide. You may check the internet for contact information for your state's Medicaid office.





# LACERS Retired Member Medical Subsidy

## Retired Member Medical Subsidy Eligibility

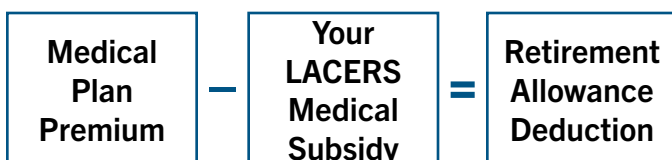
You may be eligible to receive a monthly medical plan premium subsidy from LACERS. The subsidy is a monthly dollar credit applied to the cost of the medical plan premium. The premium is the monthly cost of medical coverage for a LACERS Retired Member and any dependents.

**To be eligible for a medical subsidy, you must:**

- **Be at least age 55;**
- **Have a minimum of 10 full years of Service Credit (full-time employees), or a minimum of 10 full years of Service (part-time employees);**
- **Be enrolled in a LACERS-sponsored medical plan or be a participant in the MPRP.**

Example: If you are age 55+ and worked full-time or part-time for the City for 10 years and 11 months, you meet the minimum 10 whole years of Service or Service Credit. Alternatively, if you worked full-time or part-time for the City for 9 years and 11 months, you would NOT be eligible for a medical subsidy because the minimum 10 years of Service or Service Credit has not been met. Please refer to Page 58 for the definitions of Service and Service Credit, and refer to Page 60 for how subsidy is calculated.

Subsidy amounts are set annually by the LACERS Board of Administration or by ordinance, pursuant to the authority granted by the LAAC. Your subsidy amount is based on your whole years (minimum 10 years) of Service or Service Credit, age, and Medicare status.



Your subsidy may or may not cover the total cost of your monthly premium. If your subsidy is less than the monthly premium, the balance is deducted from your retirement allowance.

## Taxability of Your Medical Subsidy

Under the Internal Revenue Code, your LACERS medical subsidy is not taxable when used to pay for medical coverage for the following:

- Yourself
- Your spouse
- Your child who is under age 26
- Anyone you claim as a tax dependent on your federal income tax form

Any portion of your medical subsidy that is used to pay for coverage or provide medical benefits for any other individual who is not your tax dependent may be reported as taxable income to the IRS for federal tax purposes.

Your LACERS medical subsidy may be taxable if it is used to cover a child who is a child of a domestic partner. LACERS cannot determine for you if your dependents are eligible to be claimed for federal income tax purposes. Consult your tax advisor or the IRS for your specific situation.

When adding medical plan dependents, Retired Members must complete and submit a *Certification of Dependent or Survivor Status for Health Coverage Form*. This form is available at [LACERS.org](https://www.lacers.org) or by request by emailing [LACERS.Health@lacers.org](mailto:LACERS.Health@lacers.org) or calling (800) 779-8328. Retired Members enrolling dependents who fail to complete the *Certification of Dependent or Survivor Status for Health Coverage Form* may have the portion of their medical subsidy used to cover any persons other than themselves reported to the IRS as taxable income.

# LACERS Retired Member Medical Subsidy (continued)

Regardless of employment type, a minimum of 10 years of Service (part-time) or Service Credit (full-time) is required to be eligible for 40% of the maximum medical subsidy. Refer to Page 58 for the definitions of Service and Service Credit and Page 60 for Subsidy Eligibility Requirements.

## For Retired Members Who Are Under Age 65, or Age 65 or older with Medicare Part B only

**Full-time Employees** For each whole year of Service Credit, full-time employees receive 4% of the maximum medical subsidy.

**Part-time Employees** A minimum of 10 years of Service is required to be eligible to receive 40% of the maximum medical subsidy. For each year of Service Credit above ten years, you receive an additional 4% of the maximum medical subsidy. For more information on eligibility and how to calculate your medical subsidy, please see Page 60 of this Guide and/or contact LACERS.

Service/Service Credit	% of Maximum Subsidy	2023 Subsidy Amount
10*	40%	\$784.88
11	44%	\$863.37
12	48%	\$941.86
13	52%	\$1,020.34
14	56%	\$1,098.83
15	60%	\$1,177.32
16	64%	\$1,255.81
17	68%	\$1,334.30
18	72%	\$1,412.78
19	76%	\$1,491.27
20	80%	\$1,569.76
21	84%	\$1,648.25
22	88%	\$1,726.74
23	92%	\$1,805.22
24	96%	\$1,883.71
25+	100%	\$1,962.20

For those LACERS Members who retired on or after July 1, 2011, and did not make additional retirement contributions pursuant to LAAC 4.1003(c), please refer to the current plan year Health Benefits Guide Supplement for your subsidy information and monthly deduction charts. For more information, contact LACERS.

## For Retired Members Who Are age 65 or older with Medicare Parts A & B

For Retired Members who are enrolled in Medicare Parts A & B, eligible for medical subsidy, and enrolled in a senior medical plan, your maximum medical subsidy is based on your whole years of Service/Service Credit (beginning at 10 whole years) and the one-party premium of the LACERS Senior Plan in which you are enrolled.

Service Credit	% of Maximum Subsidy
10*-14	75% of one-party Monthly Premium
15-19	90% of one-party Monthly Premium
20+	100% of one-party Monthly Premium

**Note:** If you have Medicare Parts A & B, are enrolled in a LACERS Senior Plan, and are covering dependents, the amount of subsidy that will be available for your dependents will be the same as if you were enrolled in the corresponding Under-65 plan.

\* Refer to the Retired Member Medical Subsidy Eligibility on Page 13 and calculation chart on Page 60.

Any balance of subsidy not used for retiree coverage may be applied towards the cost of the dependent health plan coverage. Any unused subsidy cannot be received as cash compensation.

# Eligible Survivor Benefits

## Survivor Eligibility

An eligible Survivor is:

- The surviving spouse or domestic partner of a Retired Member who was married or in a domestic partnership:
  1. At the time of retirement,
  2. One year prior to retirement,
  3. At the time of death, **and**
  4. Is eligible for a Continuance allowance

**Or**

- The surviving spouse or domestic partner of a LACERS Member who died prior to retirement, who was married or in a domestic partnership at the time of death, **and** is eligible for a Survivorship allowance.

At the time of death of a LACERS Member or a Retired Member, an eligible Survivor may continue receiving medical and/or dental coverage if the eligible Survivor:

1. Was covered as a dependent at the time of the LACERS Member's or Retired Member's death,
2. Is receiving a LACERS Continuance or Survivorship allowance that is sufficient to cover any monthly health premium payroll deduction; **and**
3. Re-enrolls in the same medical and/or dental plan within 60 days of the LACERS Member's or Retired Member's death.

If you do not submit your Continuance (Survivor Benefits Unit) documents and/or your Health Enrollment forms timely, you will not be eligible for coverage until the next Open Enrollment period.

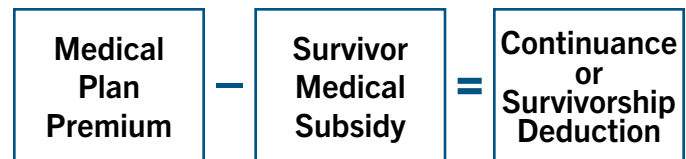
If the eligible Survivor was not covered by a LACERS health plan at the time of the LACERS Member's or Retired Member's death but is receiving a Continuance or Survivorship allowance from LACERS, the eligible Survivor may enroll in a LACERS health plan during the annual Open Enrollment period.

## Eligible Survivor Medical Subsidy

An eligible Survivor may be eligible to receive a monthly medical plan premium subsidy from LACERS. A subsidy is a monthly dollar credit applied to the cost of the medical plan premium. The premium is the monthly cost of medical coverage for a Survivor and any dependents.

The eligible Survivor medical subsidy is based on:

1. The LACERS Member's or Retired Member's years of Service or Service Credit (minimum of 10 years; see Page 14, How Retired Member Medical Subsidy is Calculated)
2. When the deceased LACERS Member would have turned age 55\*
3. The Survivor's eligibility for Medicare



Your medical subsidy will be taxable if you are an eligible Surviving Domestic Partner.

When adding medical plan dependents, eligible Survivors must complete the *Certification of Dependent or Survivor Status for Health Coverage Form*, even though they do not receive a medical subsidy for their dependents. Eligible Survivors who fail to complete the *Certification of Dependent or Survivor Status for Health Coverage Form* may have the entire medical subsidy reported to the IRS as taxable income. This form is available at [LACERS.org](http://LACERS.org) or by calling (800) 779-8328.

\* If the LACERS Member dies prior to becoming eligible for a medical subsidy (e.g., while working for the City), the Survivor will be eligible to receive a medical subsidy on the date when the Member would have turned age 55.

# Eligible Survivor Benefits (continued)

## Eligible Survivor Dental Subsidy

Survivors are not eligible for dental subsidy. However, they may enroll in a LACERS dental plan and have the monthly premium deducted from their Continuance or Survivorship allowance. See Page 49 for Dental Benefits Information.

## How the Eligible Survivor Medical Subsidy is Calculated

### For Eligible Survivors Who Are Under Age 65, or Age 65 or older with Medicare Part B only

For each whole year of the LACERS Member’s or Retired Member’s Service and Service Credit beginning at 10 whole years, an eligible Survivor receives an additional 4% of the maximum Survivor medical subsidy. The maximum Survivor medical subsidy is equivalent to the lowest-cost standard one-party Non-Medicare (under age 65) monthly premium. For the eligible Survivor to receive the maximum monthly medical subsidy amount, the LACERS Member or Retired Member must have had at least 25 whole years of Service Credit.

**The medical subsidy may only be applied toward the eligible Survivor participating in a LACERS medical plan or the MPRP (see Page 23 for MPRP information).**

**Any unused subsidy cannot be received as cash compensation nor used to cover the cost of the health plan for a dependent. Eligible Survivors must pay the full cost of their dependents’ premiums through deductions from their monthly Continuance or Survivorship allowances.**

Service/Service Credit	% of Maximum Subsidy	2023 Subsidy Amount
10*	40%	\$375.64
11	44%	\$413.20
12	48%	\$450.76
13	52%	\$488.33
14	56%	\$525.89
15	60%	\$563.45
16	64%	\$601.02
17	68%	\$638.58
18	72%	\$676.14
19	76%	\$713.71
20	80%	\$751.27
21	84%	\$788.84
22	88%	\$826.40
23	92%	\$863.96
24	96%	\$901.53
25+	100%	\$939.09

\* For the eligible Survivor to qualify for a medical subsidy, the LACERS Member or Retired Member must have at least 10 years of Service/Service Credit. Refer to the Retired Member Medical Subsidy Eligibility on Page 13 and Page 60 for how subsidy is calculated by employment type.



# Eligible Survivor Benefits (continued)

## For Eligible Survivors Who Are age 65 or older with Medicare Parts A and B

For eligible Survivors who are Medicare enrollees with Medicare Parts A and B and are eligible for a medical subsidy, your maximum medical subsidy is based on each whole year of the Member's Service Credit (beginning at 10 whole years) and the one-party monthly premium of the LACERS Senior Plan. To receive the maximum medical subsidy amount, the LACERS Member or Retired Member must have had at least 20 whole years of Service and Service Credit. Refer to Retired Member Medical Subsidy Eligibility on Page 13 regarding Service and Service Credit.

The Survivor medical subsidy may not be used to cover costs of dependents; eligible Survivors must pay the full cost of their dependents' premiums through deductions from the monthly Continuance or Survivorship allowances.

Service Credit	% of Maximum Subsidy
10*-14	75% of one-party Monthly Premium
15-19	90% of one-party Monthly Premium
20+	100% of one-party Monthly Premium

Survivors are not eligible to receive Medicare Part B premium reimbursements.

\* For the eligible Survivor to qualify for a medical subsidy, the LACERS Member or Retired Member must have at least 10 years of Service/Service Credit. Refer to the Retired Member Medical Subsidy Eligibility on Page 13 and Page 60 for how subsidy is calculated by employment type.



# LACERS Health Benefit Options

## Medical Plan Choices

	PPO <sup>6</sup> (U.S. and Its Territories <sup>1</sup> )	HMO <sup>6</sup> (CA Only) <sup>2</sup>	Outside of U.S. and Its Territories
<b>Under age 65</b>	Anthem Blue Cross PPO	<ul style="list-style-type: none"> <li>• Anthem Blue Cross HMO</li> <li>• Kaiser Permanente HMO</li> </ul>	Anthem Blue Cross PPO Out-of-Country Plan <sup>4,5</sup>
<b>Age 65 or older with Medicare Part B Only</b>	Anthem Blue Cross PPO	<ul style="list-style-type: none"> <li>• Anthem Blue Cross HMO</li> <li>• Kaiser Permanente Senior Advantage HMO</li> </ul>	
<b>Age 65 or older with Medicare Parts A and B</b>	Anthem Blue Cross Medicare Preferred (PPO)	<ul style="list-style-type: none"> <li>• Kaiser Permanente Senior Advantage HMO</li> <li>• SCAN Health Plan<sup>3</sup></li> <li>• UnitedHealthcare Medicare Advantage HMO (CA, AZ, and NV)</li> </ul>	
<b>Dual Care Household, where at least one subscriber is age 65 or older with Medicare Parts A and B, and the other subscriber(s) is either under age 65, or at least age 65 with Medicare Part B only</b>	Anthem Blue Cross PPO + Anthem Blue Cross Medicare Preferred (PPO)	<ul style="list-style-type: none"> <li>• Kaiser Permanente HMO + Kaiser Permanente Senior Advantage HMO</li> <li>• Anthem Blue Cross HMO + SCAN Health Plan<sup>3</sup></li> <li>• Anthem Blue Cross HMO + UnitedHealthcare Medicare Advantage HMO</li> </ul>	

## Medical Premium Reimbursement Program (MPRP)

If you reside outside of a LACERS HMO zip code service area or outside of California, and you have coverage through a federally qualified HMO or state-regulated non-LACERS medical plan, you may be eligible to participate in the MPRP. Please refer to Page 23 for MPRP information.

## Dental Plan Choices

- Delta Dental PPO
- DeltaCare USA HMO (CA and NV)

1. See Glossary for list of U.S. territories.
2. Available in authorized California zip code service areas only, except UnitedHealthcare Medicare Advantage HMO. Contact the medical plan of interest to verify that your zip code is a covered area. Medical plan contact information is located on the back cover of this Guide.
3. Available in the following counties in California: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Napa, Sonoma, Stanislaus, and Ventura.
4. The Anthem Blue Cross PPO non-Medicare (under age 65) premium rates and deductions apply outside the U.S.
5. Medicare Part B premiums are not reimbursed while residing outside the U.S.
6. If you will be traveling/visiting outside your service area or out of the country, please contact your plan directly for how Emergency Services are provided.



# LACERS Medical Plans

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## Preferred Provider Organization (PPO)

When you choose a LACERS PPO plan, you have the flexibility of receiving all covered services from the physician or facility of your choice, as long as your insurance is accepted.

With a PPO plan, you have the option to choose from a list of in-network physicians and hospitals, or any out-of-network physicians and certified hospitals anywhere in the U.S. and its territories.

Your benefit coverage will depend on whether you choose an in-network physician/hospital or an out-of-network physician/hospital. You may receive more benefit coverage and reduce your costs if you use an in-network physician/hospital.

## Health Maintenance Organization (HMO)

When you choose a LACERS HMO medical plan, you receive all your covered services from a network of hospitals, pharmacies, and physician groups that are contracted by the plan. You must live within the plan's authorized zip code service area and use its plan-authorized physicians and hospitals (unless emergency care is required).

You choose your Primary Medical Group or a Primary Care Physician (PCP) from a list of doctors in the plan's network to coordinate your care.

Your PCP will:

- Provide care
- Coordinate with a specialist, if needed
- Obtain approval for a hospital stay
- Arrange any necessary pre-certification
- Administer preventive measures and screenings
- Recommend wellness programs and provide health information

**For Retirees and Survivors Who Are Under Age 65 Residing in the U.S. and Its Territories**

## Anthem Blue Cross HMO (CA Only)

You must choose a PCP for yourself and your enrolled dependents from a network of participating HMO physicians at the time you enroll. You may review a list of participating physicians by contacting Anthem Blue Cross or visiting their website. See the back cover of this guide for contact information. You may choose a different PCP for each person enrolled in your plan.

**Reminder:** Anthem Blue Cross HMO enrollees must submit an arbitration form. Contact LACERS for the Anthem Blue Cross HMO arbitration form.

## Kaiser Permanente HMO (CA Only)

Kaiser Permanente (Kaiser) HMO requires you to use Kaiser plan physicians and Kaiser hospitals (unless emergency care is required).

You do not need to choose a PCP when you enroll, but you will receive additional information on how to select one once your enrollment is processed.

## Anthem Blue Cross PPO (U.S. and Its Territories)

The Anthem Blue Cross PPO plan gives you the choice of receiving services from an in-network physician/hospital or an out-of-network physician/hospital. Keep in mind that using an in-network physician/hospital may give you more benefit coverage at a reduced cost compared to an out-of-network physician/hospital.

# LACERS Medical Plans (continued)

## For Retirees and Survivors Who Are Age 65 or Older Residing in the U.S. and Its Territories

LACERS offers Senior Plans for Medicare-eligible Retirees and Survivors who reside in the United States and its territories.

For Retirees and Survivors enrolled in Medicare Part B only, LACERS offers:

- Anthem Blue Cross HMO (CA only) and Blue Cross MedicareRx Prescription Drug Plan (PDP) with SeniorRx Plus
- Anthem Blue Cross PPO and Blue Cross MedicareRx (PDP) with SeniorRx Plus
- Kaiser Permanente Senior Advantage HMO (CA only)

For Retirees and Survivors enrolled in Medicare Parts A and B, LACERS offers three Medicare Advantage HMO plans and one Medicare PPO plan:

- Anthem Blue Cross Medicare Preferred (PPO) Plan and Blue Cross MedicareRx (PDP) with Senior Plus
- Kaiser Permanente Senior Advantage HMO (CA only)
- SCAN Health Plan Medicare Advantage HMO (CA only)
- UnitedHealthcare Medicare Advantage HMO (CA, AZ, NV)

## Medicare Advantage HMO Plans

A separate Senior Enrollment plan form is required for each Medicare eligible enrollee.

### **Kaiser Permanente Senior Advantage HMO (CA only), SCAN Health Plan (CA only), UnitedHealthcare Medicare Advantage HMO (CA, NV, AZ)**

A Medicare Advantage plan is an HMO medical plan with a Medicare contract. Instead of receiving benefits from Medicare, you receive benefits

directly from the Medicare Advantage HMO plan. The physicians and hospitals under these plans are Medicare-approved. In some cases, a Medicare Advantage HMO plan provides more benefits than traditional Medicare Parts A and B.

You coordinate your care through a Primary Care Physician (PCP) whom you choose from a network of participating physicians.

Medicare Advantage HMO plans are available in authorized zip code service areas only. Contact the medical plan to verify that your zip code is a LACERS Group service-covered area.

## Medicare Preferred (PPO) Plan

A separate Senior Enrollment plan form is required for each Medicare eligible enrollee.

### **Anthem Blue Cross Medicare Preferred (PPO) Plan**

Those enrolled in this plan must be enrolled in Medicare Parts A & B. This is a national program and covers Retired Members in the U.S. and its territories. The Anthem Medicare Preferred (PPO) is a single integrated program approved by Medicare that provides all health care services previously covered by original Medicare and supplemented by a Medicare Supplement Plan. The Anthem plan must follow Medicare rules and provide all benefits provided by Medicare. Members can go to any doctor or hospital that accepts Medicare.



# LACERS Medical Plans (continued)

## For Dual Care Households (Residing in the U.S. and Its Territories)

For households where at least one person (Retired Member, Survivor, or dependent) is covered by both Medicare Parts A and B and another person is either under age 65 or at least age 65 with Medicare Part B only, LACERS offers four medical plan combinations:

- Anthem Blue Cross Medicare Preferred (PPO) Plan + Anthem Blue Cross (Anthem) PPO (U.S. and Its Territories)
- Kaiser Permanente Senior Advantage HMO + Kaiser Permanente HMO (CA only)
- SCAN Health Plan Medicare Advantage HMO + Anthem Blue Cross HMO (CA only)
- UnitedHealthcare Medicare Advantage HMO + Anthem Blue Cross HMO (CA only)

### Care Management Programs

If you have chronic health issues, LACERS medical plans (except Anthem Blue Cross PPO Out-of-Country) offer care management and disease management programs. Many of these programs have been recognized by national organizations for excellence and effectiveness. For more information, contact your health plan provider.





# LACERS Medical Plans (continued)

For Retirees and Survivors Residing Outside the U.S. and Its Territories

## Anthem Blue Cross PPO Out-of-Country

The Anthem Blue Cross PPO Out-of-Country medical plan is the only LACERS medical plan available if you reside permanently outside the U.S.<sup>1</sup>

<b>Key Features</b>	<ul style="list-style-type: none"> <li>• Paid by reimbursement only</li> <li>• Claim forms are required</li> <li>• Claims may take up to 30 days to be processed upon receipt by Anthem</li> </ul>
<b>Medical Services</b>	<ul style="list-style-type: none"> <li>• Must meet U.S. standards of care<sup>2</sup></li> </ul>
<b>Prescription Drugs</b>	<ul style="list-style-type: none"> <li>• \$10 copay per 30-day supply (<i>All Anthem Blue Cross approved drugs</i>)</li> <li>• Copay will not apply toward your calendar year deductible</li> </ul>
<b>Medically Necessary Hearing Aids</b>	<ul style="list-style-type: none"> <li>• No deductible</li> <li>• Up to \$2,000 per ear every 36 months</li> </ul>
<b>Key Plan Benefits</b>	<ul style="list-style-type: none"> <li>• \$500 deductible/person</li> <li>• 70% reimbursement of UCR<sup>3</sup> charges</li> <li>• Up to \$10,000 out-of-pocket maximum per calendar year, 100% reimbursement thereafter</li> <li>• Up to \$2,000,000 lifetime maximum</li> </ul>

1. Anthem Blue View Vision and Delta Dental PPO are also available outside the U.S.
2. As defined by the American Medical Association ([www.ama-assn.org](http://www.ama-assn.org)).
3. UCR = Usual and Customary Rates as defined by Anthem Blue Cross.

## Premium and Deduction Amounts

The premium and deduction amounts for the LACERS Anthem Blue Cross PPO Out-of-Country Plan are the same as the LACERS non-Medicare (under age 65) Anthem Blue Cross PPO plan, regardless of the age or Medicare status of the Retiree and Survivor residing outside the U.S. and its territories.

**Note:** Anthem Blue Cross Out-of-Country premium and deduction amounts are more costly than LACERS Anthem Blue Cross Medicare Preferred (PPO) plan because Medicare does not subsidize the cost of services received outside the U.S.

## Living Abroad and Medicare

If you live or travel outside the U.S., Medicare does not cover you. This is because the program provides protection against the cost of hospital and medical expenses you incur while in the U.S. and its territories.

You do not need to enroll in Medicare if you reside permanently outside the U.S. and its territories. However, if you later decide to reside in the U.S. and you are over age 65, you are required to enroll in Medicare in order to enroll in a LACERS medical plan. CMS may impose a lifetime penalty for lapsed Medicare coverage and require you to wait for their Open Enrollment period to enroll in Medicare.

Anthem Blue Cross PPO Out-of-Country prescription drug coverage provides creditable coverage equivalent to Medicare Part D benefits, so you will not be penalized by Medicare for not having Medicare Part D while out of the country.

Because you will not be enrolled in a Medicare plan, LACERS will not reimburse your Medicare Part B premiums while you are enrolled in the Anthem Blue Cross PPO Out-of-Country plan.

Contact the SSA regarding Medicare rules, regulations or penalties that may affect your medical plan coverage should you return to the U.S. to reside.

# Medical Premium Reimbursement Program (MPRP)

## Medical Premium Reimbursement Program

LACERS MPRP is available to Retirees and eligible Survivors if all of the following are met:

1. Based on your home address on file with LACERS, reside more than three months out of the year:
  - Outside of California and within the U.S. & its territories; or
  - Within California but outside the authorized zip code service areas of a LACERS HMO or Medicare Advantage HMO Plan.
2. Have at least 10 years of Service.
3. Are at least age 55 or older.
4. Are not enrolled in a LACERS medical plan.
5. Your non-LACERS medical insurance policy is a federally-qualified or state-regulated medical insurance plan.
6. You are not receiving a federal subsidy or tax credit through a health insurance exchange.

Under this program, LACERS may reimburse up to your monthly medical subsidy for medical premiums you pay to a federally-qualified HMO or state-regulated non-LACERS medical plan. You may be reimbursed for vision insurance and Medicare Part D premiums if they are not part of your non-LACERS medical plan. Dental coverage, health savings accounts premiums which are tax-free or taken as a tax adjustment, and long-term care plans do not qualify for reimbursement. Premium reimbursements are paid on a quarterly basis upon submission of MPRP claim forms and proof of premium payments.

If you currently are enrolled in a LACERS medical plan, you must cancel your coverage by the 10th day of the final month of your coverage in order to participate in the MPRP. Acceptance into this program is not guaranteed and if you cancel your LACERS medical plan, you cannot re-enroll until the annual Open Enrollment period or when you have a qualifying event (See Page 6, Qualifying Events).

If you are not enrolled in a LACERS medical plan, you may enroll in the MPRP at any time. Contact LACERS for an MPRP Information Packet and the reimbursement schedule.

In 2012, a provision of the Patient Protection and Affordable Care Act took effect requiring medical insurance plans to have annual medical care and quality improvement costs represent at least 80% (for individual plans) or 85% (for fully-insured group plans) of the annual premium cost. The medical plans must rebate any shortfall below these thresholds to subscribers.

Any MPRP participant who receives a rebate of any portion of the Member’s or eligible Survivor’s medical plan premium for which the MPRP participant has been reimbursed by LACERS shall report the rebate to LACERS and provide supporting documentation. Should LACERS become aware of a rebate made to the MPRP participant for premiums reimbursed under the MPRP, and should the MPRP participant refuse to reimburse LACERS for its portion of the rebate as calculated in Board Rule HBA 5.f, the portion of the rebate due to LACERS shall be included in the MPRP participant’s taxable income reported to the IRS and the State of California (if applicable).

2023 MPRP Maximum Reimbursement		
Medicare Status	Retired Member Subsidy	Survivor Subsidy
Under 65 or Part B only	\$1,962.20	\$939.09
Medicare Parts A & B	\$494.67	\$494.67
Medicare Parts A & B and covering an Under 65 or Part B Only dependent	\$1,148.55	N/A

# Medical Plan Comparison Charts

## Retired Members, Dependents and Survivors under Age 65

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
<b>Calendar Year Deductible</b>				
Individual	\$750		Not applicable	Not applicable
Family	\$1,500; at least one family member must satisfy the \$750 per individual deductible			
<b>Annual Out-of-Pocket Maximum</b>				
Individual	Deductible excluded \$5,000		\$500	\$500
Family	Not applicable		\$1,500	\$1,500
<b>Lifetime Maximum</b>				
	Unlimited		Unlimited	Unlimited
<b>Preventive Care</b>				
Routine Physical Examination	No charge (may include lab & X-ray)		\$20 copay	\$20 copay
Pap Smear, Pelvic & Breast Annual Exam	No charge	Anthem pays 70% UCR <sup>1</sup> after deductible	No charge after \$20 office visit copay	No charge after \$20 office visit copay
Mammography	Anthem pays 100% after deductible			
<b>Physician Services</b>				
Office Visit	\$20 copay	Anthem pays 70% UCR <sup>1</sup> after deductible	\$20 copay	\$20 copay
Specialist Care				
Inpatient Surgery	Anthem pays 90% after deductible		No charge	No charge
Outpatient Surgery		\$20 copay		
Telehealth/Virtual Visits	\$20 copay	Anthem pays 70% UCR <sup>1</sup> after deductible	\$0 copay	\$0 copay
<b>Inpatient Hospital Room &amp; Board</b>				
	Anthem pays 90% after deductible	Anthem pays 80% UCR <sup>1</sup> after deductible	No charge	No charge

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. Limitations, copayments, and restrictions may apply.



# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors under Age 65

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
<b>Other Health Services</b>				
Allergy Tests & Treatments	Anthem pays 90% after deductible	Anthem pays 70% UCR <sup>1</sup> after deductible	\$20 copay	No charge after \$20 office visit copay
Lab & X-ray			No charge	No charge
Physical & Speech Therapy			\$20 copay	\$20 copay
Dialysis & ESRD Services			No charge	No charge <sup>2</sup>
Skilled Nursing Facility ( <i>limit 100 days/calendar year</i> )				
Home Health Care	Anthem pays 90% after deductible; limit up to 60 visits/calendar year	Anthem pays 70% UCR <sup>1</sup> after deductible; limit up to 60 visits/calendar year	No charge; limit up to 100 visits/calendar year	No charge <sup>2</sup>
Hospice Services	Anthem pays 80% after deductible; contact Anthem Blue Cross member services for details		No charge; limits apply	No charge
Ambulance	Anthem pays 90% after deductible	Anthem pays 70% UCR <sup>1</sup> after deductible	No charge	No charge <sup>3</sup>
Durable Medical Equipment				No charge; formulary applies
Chiropractic Services ( <i>limit 30 visits/calendar year</i> )	\$20 copay		\$20 copay	\$15 copay
Acupuncture Services ( <i>limit 30 visits/calendar year</i> )	\$20 copay		\$20 copay	\$15 copay
<b>Emergency Services</b>				
Emergency Room Visit	Anthem pays 90% after deductible	Anthem pays 90% after deductible	\$100 copay; waived if admitted	\$100 copay; waived if admitted <sup>8</sup>
Urgent Care Visit			\$20 copay	\$20 copay

# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors under Age 65

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
<b>Mental Health (MH)<sup>2</sup>/Chemical Dependency (CD)<sup>2</sup></b>				
Inpatient	Anthem pays 90% after deductible (MH/CD)	Anthem pays 80% UCR <sup>1</sup> after deductible (MH/CD)	No charge (MH/CD)	No charge; unlimited (MH); In acute medical facility (CD)
Outpatient	\$20 copay	Anthem pays 70% UCR <sup>1</sup> after deductible	\$20 office visit copay (MD & CD); No Charge Facility (MD & CD)	\$20 copay (MH/CD); \$10 (MH), \$5 (CD) copay for group; unlimited
<b>Hearing Services</b>				
Hearing Exam	Covered under your Routine Physical Examination Benefit		\$20 copay	\$20 copay
Medically Necessary Hearing Aid (every 3 calendar years)	No deductible: up to \$2,000 per ear every 36 months		Up to \$2,000 per ear every 36 months	\$2,000 limit per ear every 36 months
<b>Retail Prescription Drugs<sup>5</sup></b>				
	<i>Up to 30-day supply<sup>6</sup></i>		<i>Up to 30-day supply<sup>6</sup></i>	<i>Up to 30-day supply<sup>7</sup></i>
Generic	\$10 copay	Anthem pays 80%; deductible does not apply	\$10 copay	\$15 copay
Brand	\$30 copay		\$30 copay	\$35 copay
Non-formulary	\$50 copay		\$50 copay	Not applicable
<b>Mail Order<sup>4</sup> Prescription Drugs</b>				
	<i>Up to 90-day supply<sup>6</sup></i>		<i>Up to 90-day supply<sup>6</sup></i>	<i>Up to 100-day supply<sup>7</sup></i>
Generic	\$20 copay	Not covered	\$20 copay	\$30 copay
Brand	\$60 copay		\$60 copay	\$70 copay
Non-formulary	\$100 copay		\$100 copay	Not applicable

1. UCR = Usual & Customary Rates.

2. Please review your Evidence of Coverage for plan details.

3. No charge per trip when defined as an emergency.

4. You must order your prescriptions through your medical plan's Mail Order vendor. The vendor's contact information is available from your medical plan.

5. For certain injectable drugs (except insulin), a different copayment may be required. Contact your medical plan for details.

6. \$0 copay for select generics. **Note:** Specialty Drugs (Generic and Brand) 20% coinsurance with maximum copay of \$100.

7. Specialty Drugs (Generic and Brand) Copay of \$100. Most specialty drugs only come as a 30-day supply from a plan pharmacy.

8. If admitted for observation, copay is not waived.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. Limitations, copayments, and restrictions may apply.

# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors Age 65 or Older with Medicare Part B Only

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
<b>Calendar Year Deductible</b>				
Individual/Family	Medicare Part B deductible		Not applicable	Not applicable
<b>Annual Out-of-Pocket Maximum</b>				
	Deductible excluded			
Individual	\$5,000		\$500	\$500
Family	Not applicable		\$1,500	Not applicable
<b>Lifetime Maximum</b>				
	Unlimited		Unlimited	Unlimited
<b>Preventive Care</b>				
Routine Physical Examination	No charge (may include lab & X-ray)		\$20 copay	No charge
Annual Pap Smear, Pelvic & Breast Exam	Anthem pays 20% after deductible		No charge after \$20 office visit copay	No charge
Mammography				No charge
<b>Physician Services</b>				
Office Visit	Anthem pays 20% after deductible		\$20 copay	\$15 copay
Specialist Care				
Inpatient Surgery			No charge	No charge
Outpatient Surgery				\$15 copay
Telehealth/Virtual Visits	Anthem pays 20% after deductible	Anthem pays 70% UCR <sup>1</sup> after deductible	\$0 copay	\$0 copay
<b>Inpatient Hospital Room &amp; Board</b>				
	Anthem pays 90% after deductible	Anthem pays 80% UCR <sup>1</sup> after deductible	No charge	No charge

# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors Age 65 or Older with Medicare Part B Only

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
<b>Other Health Services</b>				
Allergy Tests & Treatments	Anthem pays 100%		\$20 copay	No charge after \$15 office visit copay
Lab & X-ray			No charge	No charge
Physical & Speech Therapy	Anthem pays 20% after deductible		\$20 copay	\$15 copay
Dialysis & ESRD Services				
Skilled Nursing Facility (limit 100 days/calendar year)	Anthem pays 90% after deductible	Anthem pays 70% UCR <sup>1</sup> after deductible	No charge	No charge
Home Health Care	Anthem pays 20% after deductible		No charge; limit up to 100 visits/calendar year	No charge when prescribed by Plan physician (limited to service area)
Hospice Services	Contact Anthem Blue Cross Member services – Benefits are case specific		No charge; limits apply	No charge
Ambulance	Anthem pays 20% after deductible		No charge	No charge when defined as an emergency
Durable Medical Equipment				No charge; formulary applies
Transportation to medical appointments/pharmacy	Not applicable		Not applicable	24 one-way trips per calendar year; limits apply
Chiropractic Services (limit 30 visits/calendar year)	Medicare authorized visits: \$10 copay	Medicare authorized visits: Anthem Pays 70% UCR <sup>1</sup> after deductible	\$20 copay	\$15 copay
Acupuncture Services (limit 30 visits/calendar year)	Medicare authorized visits: \$10 copay	Medicare authorized visits: Anthem Pays 70% UCR <sup>1</sup> after deductible	\$20 copay	\$15 copay
<b>Emergency Services</b>				
Emergency Room Visit	Anthem pays 20% after deductible if admitted – 90% for hospital services, Anthem pays 20% after deductible <sup>2</sup> for professional services		\$100 copay; waived if admitted	\$50 copay; waived if admitted <sup>6</sup>
Urgent Care Visit	Anthem pays 20% after deductible		\$20 copay	\$15 copay

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. Limitations, copayments, and restrictions may apply.



# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors Age 65 or Older with Medicare Part B Only

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
<b>Mental Health (MH)<sup>2</sup>/Chemical Dependency (CD)<sup>2</sup></b>				
Inpatient	Anthem pays 90% after deductible (MH/CD)	Anthem pays 80% UCR <sup>1</sup> after deductible (MH/CD)	No charge (MH/CD)	No charge per admission as covered by Medicare (MH/CD)
Outpatient	Anthem pays 50% after deductible (MH/CD)	Anthem pays 50% after deductible (MH/CD)	\$20 office visit copay (MD & CD); No Charge Facility (MD & CD)	\$15 copay; \$7 copay (MH), \$5 copay (CD) for group visits; unlimited
<b>Hearing Services</b>				
Hearing Exam	Covered under your Routine Physical Examination Benefit		\$20 copay	\$15 copay
Medically Necessary Hearing Aid (every 3 calendar years)	No deductible: up to \$2,000 per ear every 36 months		up to \$2,000 per ear every 36 months	\$2,000 limit per ear every 36 months
<b>Retail Prescription Drugs<sup>4</sup></b>	<i>Up to 30-day supply<sup>4,5</sup></i>		<i>Up to 30-day supply<sup>4,5</sup></i>	<i>Up to 100-day supply</i>
Generic	\$0 copay for select generics/ \$5 copay generics	See Evidence of Coverage	\$5 copay	Generic- \$15 Brand- \$15
Preferred Brand	\$25 copay		\$25 copay	
Non-Preferred Brands/ Non-Formulary	\$50 copay		\$50 copay	Not applicable
<b>Mail Order<sup>3,4</sup> Prescription Drugs</b>			<i>Up to 90-day supply<sup>3,4,5</sup></i>	<i>Up to 100-day supply</i>
Generic	\$0 copay for select generics/ \$10 copay generics <sup>7</sup>	Not covered	\$0 copay for select generics/\$10 copay <sup>7</sup>	Generic- \$15 Brand- \$15
Preferred Brand	\$50 copay		\$50 copay	
Non-Preferred Brands/ Non-Formulary	\$100 copay		\$100 copay	Not applicable

1. UCR = Usual & Customary Rates.
2. Please review your Evidence of Coverage for plan details.
3. You must order your prescriptions through your medical plan's Mail Order vendor. The vendor's contact information is available from your medical plan. The Anthem Part D Mail Order contact information is available in your Evidence of Coverage.
4. For certain injectable drugs (except insulin), a different copayment may be required. Contact your medical plan for details.
5. \$0 copay for select generics. For Anthem diabetic supplies, a different copay may be required. Please see your Evidence of Coverage.
6. If admitted for observation, copay is not waived.
7. Up to 100-day supply for select generics.

# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors Age 65 or Older with Medicare Parts A & B

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
<b>Calendar Year Deductible</b>				
Individual/Family	Not applicable	Not applicable	Not applicable	Not applicable
<b>Out-of-Pocket Maximum</b>				
	Out-of-Pocket Maximum - Deductible Excluded			
Individual	\$0	\$500	\$3,400	\$6,700
Family	Not applicable	Not applicable	Not applicable	Not applicable
<b>Lifetime Maximum</b>				
	Unlimited	Unlimited	Unlimited	Unlimited
<b>Preventive Care</b>				
Routine Physical Examination	No charge	No charge	No charge	\$0 copay in CA, NV & AZ
Annual Pap Smear, Pelvic & Breast Exam	No charge	No charge	No charge	No charge
Mammography				
<b>Physician Services</b>				
Office Visit	No charge <sup>1</sup>	\$15 copay	\$10 copay	\$15 copay
Specialist Care				
Inpatient Surgery		No charge	No charge	No charge
Outpatient Surgery				
Telehealth/Virtual Visits				
<b>Inpatient Hospital Room &amp; Board</b>				
	No charge	No charge	No charge	No charge

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. Limitations, copayments, and restrictions may apply.

# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors Age 65 or Older with Medicare Parts A & B

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
<b>Other Health Services</b>				
Allergy Tests & Treatments	No charge for Medicare-covered allergy testing	No charge after \$15 office visit copay	No charge	No charge after \$15 office visit copay
Lab & X-ray	No charge for Medicare-covered services <sup>1</sup>	No charge		No charge
Physical & Speech Therapy		\$15 copay		No charge after \$15 office visit copay
Dialysis and ESRD Services				
Skilled Nursing Facility	No charge in Medicare-covered, inpatient plan facility; limit 100 days each benefit period <sup>1</sup>	No charge; limit 100 days/calendar year	No charge; limit 100 days/calendar year	No charge; limit 100 days/calendar year
Home Health Care	No charge when certified and ordered by Plan doctor	No charge when prescribed by Plan physician (limited to service area)	No charge	No charge
Hospice Services	No charge in Medicare-certified hospice <sup>1</sup>	No charge	No charge	Per Medicare guidelines
Ambulance	No charge for Medicare-covered services <sup>1</sup>	No charge when defined as emergency	No charge	No charge
Durable Medical Equipment	No charge for Medicare-covered equipment <sup>1</sup>	No charge; formulary applies		\$0 copay
Chiropractic Services	No charge for Medicare-covered visits/Non-Medicare, 30 visits/year, costs may apply <sup>1</sup>	\$15 copay; limit 30 visits/year	\$10 copay; limit 20 visits/calendar year	\$15 copay; limit 30 visits/year (CA), limit 12 visits/year (NV & AZ)
Acupuncture Services	No charge for Medicare-covered visits, limit 20/Non-Medicare, 30 visits/year, costs may apply <sup>1</sup>	\$15 copay; limit 30 visits/year	\$10 copay; limit 20 visits/calendar year	\$15 copay; limit 30 visits/year (CA), limit 12 visits/year (NV & AZ)

# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors Age 65 or Older with Medicare Parts A & B

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Emergency Room Visit	No charge in U.S. and while traveling	\$50 copay; waived if admitted <sup>6</sup>	\$50 copay; waived if admitted	\$50 copay; waived if admitted
Urgent Care Visit		\$15 copay	\$10 copay	\$15 copay
Transportation	12 one-way trips per calendar year; limits apply, advance notice required <sup>1</sup>	24 one-way trips per calendar year; limits apply, advance notice required <sup>1</sup>	Unlimited rides; 75-mile maximum radius; \$0 copay <sup>1</sup>	Up to 30 one-way trips per year to medical appointment/pharmacy, up to 50 miles away <sup>1</sup>
Home Delivered Meals	Up to 56 meals per year, no charge <sup>1</sup>	Up to 84 meals, three meals/day for a four-week period, one instance/year <sup>1</sup>	Unlimited, no charge <sup>1</sup>	Three meals/day for four-week period following discharge, when referred by case manager <sup>1</sup>
<b>Mental Health (MH)<sup>1</sup>/Chemical Dependency (CD)<sup>1</sup></b>				
Inpatient	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge (MH/CD); unlimited
Outpatient	No charge for Medicare-covered therapy/hospitalization	\$15 copay; \$7 copay (MH), \$5 copay (CD) group visits; unlimited	No charge; unlimited (MH/CD)	\$15 copay; unlimited visits
<b>Hearing Services</b>				
Hearing Exam	No charge <sup>1</sup>	\$15 copay	\$10 copay	No charge
Medically Necessary Hearing Aid	No deductible; up to \$2,000 per ear every 36 months	\$2,000 allowance per ear every 36 months	\$4,000 limit; for one or two hearing aids every two years	No deductible; limits: CA: \$2,000 per ear every 3 years, NV & AZ: \$500 every 2 years

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. Limitations, copayments, and restrictions may apply.



# Medical Plan Comparison Charts (continued)

## Retired Members, Dependents and Survivors Age 65 or Older with Medicare Parts A & B

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
<b>Retail Prescription Drugs<sup>3</sup></b>	Up to 30-day supply	Up to 100-day supply	Up to 100-day supply	Up to 30-day supply
Generic <sup>5</sup>	\$0 copay for select generics/\$5 copay generics	Generic- \$15 Brand- \$15	\$5-\$10 copay	Tier I generic \$10/unit <sup>4</sup>
Preferred Brand <sup>5</sup>	\$25 copay		\$20 copay	Tier II brand \$20/unit <sup>4</sup>
Non-Preferred Brands/ Non-Formulary <sup>5</sup>	\$50 copay	Not applicable	Non-Preferred Brands \$20 copay; Non-Formulary not covered	Tier III & IV \$50/unit <sup>4</sup>
<b>Mail Order Prescription Drugs<sup>2,3</sup></b>	Up to 90-day supply	Up to 100-day supply	Up to 100-day supply	Up to 90-day supply <sup>4</sup>
Generic	\$0 copay for select generics/\$10 copay generics	Generic- \$15 Brand- \$15	\$10-\$20 copay	Tier I generic \$20
Preferred Brand	\$50 copay		\$40 copay	Tier II brand \$40
Non-Preferred Brands/ Non-Formulary	\$100 copay	Not applicable	Non-Preferred Brands \$40 copay; Non-Formulary not covered	Tier III & IV \$100

1. Review your Evidence of Coverage for plan details.
2. All Mail Order prescriptions must be ordered through your medical plan's mail order vendor or participating pharmacy directory. Contact your medical plan for mail order vendor contact information. The Anthem Part D Mail Order information is available in your Evidence of Coverage.
3. For certain injectable drugs (except insulin) a different copayment may be required. Contact your medical plan for details.
4. Tier I – primarily Generics. Tier II – Preferred Brand & Higher Cost Generics. Tier III – Non-preferred. Tier IV – Specialty. Contact your medical plan for details.
5. For Anthem diabetic supplies, a different copay may be required. Please see your Evidence of Coverage.
6. If admitted for observation, copay is not waived.

# SCAN Health Plan and Anthem Medicare Preferred (PPO) Subscribers

## Enhanced Social Services Programs

These services depend on individual need, as determined by the respective plans. Information provided herein is a brief summary and not a comprehensive description of available benefits. Review your Evidence of Coverage for plan details and more available benefits.

Benefit	SCAN Health Plan Independent Living Power (ILP) <sup>1</sup>	Anthem Blue Cross Medicare Preferred (PPO)
<b>Service Areas</b>	Available in CA - Los Angeles, Orange, Riverside, San Diego counties only	Throughout the U.S.
<b>Personal Emergency Response System</b>	<ul style="list-style-type: none"> <li>• Includes installation &amp; monthly monitoring</li> <li>• \$0 copay</li> </ul>	<ul style="list-style-type: none"> <li>• One in-home system and monthly monitoring</li> <li>• No charge</li> </ul>
<b>Transportation to Provider Visits</b>	<ul style="list-style-type: none"> <li>• Unlimited taxi rides per year</li> <li>• No charge<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• 12 one-way trips per year to medical visits, pharmacy, SilverSneakers, etc. within service area; 60 mile limit</li> <li>• Advanced scheduling required</li> <li>• No charge</li> </ul>
<b>Caregiver Relief</b> <i>(Alternative Caregiver Provides Services When The Regular Caregiver Is Not Available)</i>	<ul style="list-style-type: none"> <li>• In-home visits when regular caregiver cannot be there</li> <li>• Services include companionship, assistance with bathing, dressing, and light meal preparation.</li> <li>• Adult day care – physical, social or intellectual exercises and stimulation for seniors</li> <li>• \$15 per visit<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• At state-licensed adult day center, up to one eight-hour day per week at a state-licensed adult day care               <ul style="list-style-type: none"> <li>– Prior plan approval required</li> <li>– Direct member reimbursement, up to \$80 per visit</li> </ul> </li> <li>• In Home Support; Up to 30 hours per year of assistance with daily living activities</li> </ul>
<b>Personal Care and Homemaker Service</b>	<ul style="list-style-type: none"> <li>• Services include light housekeeping, laundry and meal preparation, grocery shopping, companionship, assistance with bathing and dressing</li> <li>• \$15 per visit<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Services include light housekeeping (<i>cleaning, laundry, dishes, etc.</i>), help with dressing, eating, bathing/showering, and transferring/mobility help in home; Up to 124 hours/year, 4 hours/day max</li> <li>• Prior plan approval required</li> <li>• Direct member reimbursement, up to \$100 per visit</li> </ul>
<b>Home Delivered Meals</b>	<ul style="list-style-type: none"> <li>• Unlimited</li> <li>• No charge<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Healthy Meals Program; Up to 56 meals per year, no charge</li> <li>• Healthy Pantry; available to qualifying members</li> </ul>
<b>Bathroom Safety/ Assistive Equipment</b>	<ul style="list-style-type: none"> <li>• \$0 copay</li> </ul>	<ul style="list-style-type: none"> <li>• Up to \$200 every year for items allowed by Medicare</li> </ul>

1. \$650 allowance per month for all ILP services combined

# LACERS Vision Plans

## Kaiser Permanente

If you are enrolled in a LACERS Kaiser Permanente medical plan, you receive vision benefits directly from Kaiser Permanente.

Medicare Status	Exam Copay
<b>Under age 65 and not enrolled in Medicare</b>	\$20
<b>If you have Medicare Part B Only</b>	\$15
<b>If you have Medicare Parts A &amp; B</b>	\$15

## Kaiser Permanente Vision Benefit

In addition, you may receive a benefit of up to \$150 every 24 months toward eyeglass frames and lenses, or contact lenses.

Vision services provided outside the Kaiser Permanente network are not covered.

## Anthem Blue View Vision

Anthem Blue View Vision for vision coverage is available to those enrolled in a LACERS medical plan other than Kaiser Permanente.

When you see a Blue View Vision doctor, you'll get the most out of your Anthem Blue View Vision benefit and have lower out-of-pocket costs.

For details, contact Anthem Blue View Vision at (866) 723-0515 or visit [www.anthem.com/ca](http://www.anthem.com/ca).

If you receive care from an out-of-network provider, send your claims to:

**Out of Network Claims Department  
Anthem Blue View Vision**

**Mail: Attn: OON Claims, P.O. Box 8504  
Mason, OH 45040-7111**

**Fax: (866) 293-7373**

**Email: [oonclaims@eyewearspecialoffers.com](mailto:oonclaims@eyewearspecialoffers.com)**

See Vision Plan Comparison Chart on page 36.



# Vision Plan Comparison Chart

Vision Benefits	Anthem Blue View Vision (Non-Kaiser Permanente plan members)		Kaiser Permanente
	In-Network Provider	Out-of-Network Provider (Maximum Reimbursement)	
<b>Exam</b>	Every 12 months <sup>1</sup>		\$20 Kaiser Permanente HMO, \$15 Kaiser Permanente Senior Advantage
	\$20 copay	Up to \$49	
<b>Lenses and Options</b>	Every 12 months <sup>1,3</sup>		Every 24 months
Single Vision	Paid in full <sup>2</sup>	Up to \$45	
Bifocal		Up to \$65	
Trifocal		Up to \$85	
Lenticular		Up to \$125	
Tint/photochromic		Up to \$5	
Scratch coating		Not covered	
Polycarbonate		Not covered	
Progressive	\$30 additional copay	Up to \$85	
<b>Frame Allowance</b>	Every 24 months <sup>1</sup>		Up to \$150 for all frames, lenses or contacts
One pair	\$150 allowance, then 20% off any remaining balance	Up to \$70	
<b>Contact Lenses Allowance</b>	Every 12 months <sup>1,2,4</sup> (Instead of glasses)		
Elective conventional <i>or</i>	Up to \$120, then 15% off any remaining balance	Up to \$105	
Elective disposable <i>or</i>	Up to \$120, no additional discount	Up to \$105	
Medically Necessary	Paid in full <sup>5</sup>	Up to \$210	

1. Based on your last date of service.
2. Patients choosing contacts will be next eligible for lenses in 12 months.
3. You may also choose to receive 40% off additional complete pairs of glasses or 20% off when purchasing additional lenses or frames separately, and 20% off sunglasses and lens options from any in network Anthem Blue View Vision provider.
4. Your plan includes Anthem Blue View Vision doctor professional services for contact lens fitting when buying contact lenses.
5. Medically necessary contact lenses are covered in full when Anthem Blue View Vision benefit criteria are met and verified by an Anthem Blue View Vision network doctor for eye conditions that would prohibit the use of glasses.



# Medical Plan Premiums (Includes Vision Benefits)

	PPO	HMO/Senior Plans				
	U.S.	CA			NV	AZ
	Anthem Blue Cross (PPO) & Medicare Preferred (PPO) Plan	Kaiser Permanente HMO/ Sr. Advantage <sup>1</sup>	SCAN Health Plan & Anthem Blue Cross HMO <sup>3</sup>	United-Healthcare HMO & Anthem Blue Cross HMO <sup>3</sup>	UnitedHealthcare HMO	
Retiree/ Survivor Only	Monthly Premiums					
Under 65 or over 65 w/Medicare Part B only <sup>1</sup>	\$1,464.23	\$939.09	\$1,169.74	\$1,169.74	N/A	N/A
65 or older w/Medicare Parts A & B	\$494.67	\$262.47	\$268.95	\$287.80	\$258.54	\$359.80
Retiree/ Survivor & 1 Dependent	Monthly Premiums					
Both under 65 or both 65 or older w/Medicare Part B only	\$2,923.43	\$1,878.18	\$2,334.45	\$2,334.45	N/A	N/A
Retired Member under 65 and Dependent 65 or older w/Medicare Parts A & B	\$1,953.87	\$1,148.55	\$1,433.66	\$1,452.51	N/A	N/A
Retired Member 65 or older w/Medicare Parts A & B and Dependent under 65	\$1,953.87	\$1,148.55	\$1,433.66	\$1,452.51	N/A	N/A
Retired Member & Dependent both 65 or older, both w/Medicare Parts A & B	\$984.31	\$524.94	\$532.87	\$570.57	\$512.05	\$714.57

**Note:** Premium rates include Vision benefits. All of the above rates are effective from January 1, 2023 through December 31, 2023.

- Those enrolled in Kaiser Senior Advantage who have only Part B of Medicare are charged the same premiums as those who have both Parts A and B of Medicare.
- Family = 2 or more dependents.
- Dual Care Households - The person with Medicare Parts A & B would be enrolled in SCAN or UnitedHealthcare while the other person who is under 65 or has Medicare Part B Only is enrolled in Anthem Blue Cross HMO.

# Medical Plan Premiums (Includes Vision Benefits)

	PPO	HMO/Senior Plans				
	U.S.	CA			NV	AZ
	Anthem Blue Cross (PPO) & Medicare Preferred (PPO) Plan	Kaiser Permanente HMO/ Sr. Advantage <sup>1</sup>	SCAN Health Plan & Anthem Blue Cross HMO <sup>3</sup>	UnitedHealthcare HMO & Anthem Blue Cross HMO <sup>3</sup>	United-Healthcare HMO	
Retiree/ Survivor & Family <sup>2</sup>	Monthly Premiums					
Retired Member & Family under 65 or 65 or older w/Medicare Part B only <sup>1</sup>	\$3,443.13	\$2,441.63	\$3,041.23	\$3,041.23	N/A	N/A
Retired Member under 65, 1 Dependent 65 or older w/Medicare Parts A & B and at least 1 Dependent w/o Medicare	\$2,473.57	\$1,712.00	\$2,140.44	\$2,159.29	N/A	N/A
Retired Member 65 or older w/Medicare Parts A & B and Family w/o Medicare	\$2,473.57	\$1,712.00	\$2,140.44	\$2,159.29	N/A	N/A
Retired Member & 1 Dependent 65 or older both w/Medicare Parts A & B, and at least 1 Dependent w/o Medicare	\$1,504.01	\$1,036.98	\$1,239.65	\$1,277.35	N/A	N/A

**Note:** Premium rates include Vision benefits. All of the above rates are effective from January 1, 2023 through December 31, 2023.

1. Those enrolled in Kaiser Senior Advantage who have only Part B of Medicare are charged the same premiums as those who have both Parts A and B of Medicare.
2. Family = 2 or more dependents.
3. Dual Care Households - The person with Medicare Parts A & B would be enrolled in SCAN or UnitedHealthcare while the other person who is under 65 or has Medicare Part B Only is enrolled in Anthem Blue Cross HMO.

## Medical Monthly Allowance Deductions (Retired Members)

### Retired Member

These are the amounts of monthly deductions charged to the Retired Member. The premium amount has been reduced by the appropriate subsidy amount based on the Retired Member's whole years of Service Credit, and the remaining balance is deducted from the Retired Member's monthly retirement allowance.

For the purposes of this Guide, these deduction charts are based on years of Service Credit of full-time employment. Refer to Page 13 for Retired Member medical subsidy eligibility, Page 14 for Retired Member Medical Subsidy charts, and Page 60 for detail on how subsidy is calculated.

For those LACERS Members who retired on or after July 1, 2011, and who have not made additional retirement contributions pursuant to Los Angeles Administrative Code § 4.1003(c), please refer to the 2023 Health Benefits Guide Supplement for your subsidy information and monthly deduction charts. For more information, contact LACERS.

### Retired Member Only not in Medicare or with Medicare Part B Only

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
Monthly Premiums	\$1,464.23	\$939.09	\$1,169.74
Service/Service Credit	Monthly Allowance Deduction		
10*	\$679.35	\$154.21	\$384.86
11	\$600.86	\$75.72	\$306.37
12	\$522.37	\$0.00	\$227.88
13	\$443.89	\$0.00	\$149.40
14	\$365.40	\$0.00	\$70.91
15	\$286.91	\$0.00	\$0.00
16	\$208.42	\$0.00	\$0.00
17	\$129.93	\$0.00	\$0.00
18	\$51.45	\$0.00	\$0.00
19	\$0.00	\$0.00	\$0.00
20	\$0.00	\$0.00	\$0.00
21	\$0.00	\$0.00	\$0.00
22	\$0.00	\$0.00	\$0.00
23	\$0.00	\$0.00	\$0.00
24	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$0.00	\$0.00

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.

## Medical Monthly Allowance Deductions (Retired Members) (continued)

### Retired Member Only with Medicare Parts A & B

	PPO (U.S.)	HMO/Senior Plans				
	Anthem Blue Cross Medicare Preferred (PPO) Plan	CA – Kaiser Permanente Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	\$494.67	\$262.47	\$268.95	\$287.80	\$359.80	\$258.54
Service/ Service Credit	Monthly Allowance Deduction					
10* to 14	\$123.67	\$65.62	\$67.24	\$71.95	\$89.95	\$64.63
15 to 19	\$49.47	\$26.25	\$26.89	\$28.78	\$35.98	\$25.85
20 to 24	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.



## Medical Monthly Allowance Deductions (Retired Members) (continued)

### Retired Member and Dependent not in Medicare or with Medicare Part B Only

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
Monthly Premiums	<b>\$2,923.43</b>	<b>\$1,878.18</b>	<b>\$2,334.45</b>
Service/ Service Credit	Monthly Allowance Deduction		
10*	\$2,138.55	\$1,093.30	\$1,549.57
11	\$2,060.06	\$1,014.81	\$1,471.08
12	\$1,981.57	\$936.32	\$1,392.59
13	\$1,903.09	\$857.84	\$1,314.11
14	\$1,824.60	\$779.35	\$1,235.62
15	\$1,746.11	\$700.86	\$1,157.13
16	\$1,667.62	\$622.37	\$1,078.64
17	\$1,589.13	\$543.88	\$1,000.15
18	\$1,510.65	\$465.40	\$921.67
19	\$1,432.16	\$386.91	\$843.18
20	\$1,353.67	\$308.42	\$764.69
21	\$1,275.18	\$229.93	\$686.20
22	\$1,196.69	\$151.44	\$607.71
23	\$1,118.21	\$72.96	\$529.23
24	\$1,039.72	\$0.00	\$450.74
25+	\$961.23	\$0.00	\$372.25

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.

## Medical Monthly Allowance Deductions (Retired Members) (continued)

### Retired Member not in Medicare and Dependent with Medicare Parts A & B (Dual Care)

	PPO (U.S.)	HMO/Senior Plan (CA)		
	Anthem Blue Cross Medicare Preferred (PPO) Plan	Kaiser Permanente Sr. Advantage	SCAN Health Plan / Anthem Blue Cross HMO	UnitedHealthcare HMO / Anthem Blue Cross HMO
Monthly Premiums	<b>\$1,953.87</b>	<b>\$1,148.55</b>	<b>\$1,433.66</b>	<b>\$1,452.51</b>
Service/ Service Credit	Monthly Allowance Deduction			
10*	\$1,168.99	\$363.67	\$648.78	\$667.63
11	\$1,090.50	\$285.18	\$570.29	\$589.14
12	\$1,012.01	\$206.69	\$491.80	\$510.65
13	\$933.53	\$128.21	\$413.32	\$432.17
14	\$855.04	\$49.72	\$334.83	\$353.68
15	\$776.55	\$0.00	\$256.34	\$275.19
16	\$698.06	\$0.00	\$177.85	\$196.70
17	\$619.57	\$0.00	\$99.36	\$118.21
18	\$541.09	\$0.00	\$20.88	\$39.73
19	\$462.60	\$0.00	\$0.00	\$0.00
20	\$384.11	\$0.00	\$0.00	\$0.00
21	\$305.62	\$0.00	\$0.00	\$0.00
22	\$227.13	\$0.00	\$0.00	\$0.00
23	\$148.65	\$0.00	\$0.00	\$0.00
24	\$70.16	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$0.00	\$0.00	\$0.00

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.

## Medical Monthly Allowance Deductions (Retired Members) (continued)

### Retired Member with Medicare Parts A & B and Dependent not in Medicare (Dual Care)

	PPO (U.S.)	HMO/Senior Plan (CA)		
	Anthem Blue Cross Medicare Preferred (PPO) Plan / Anthem Blue Cross PPO	Kaiser Permanente Sr. Advantage / Kaiser HMO	SCAN Health Plan / Anthem Blue Cross HMO	UnitedHealthcare HMO / Anthem Blue Cross HMO
Monthly Premiums	\$1,953.87	\$1,148.55	\$1,433.66	\$1,452.51
Service/ Service Credit	Monthly Allowance Deduction			
10*	\$1,582.87	\$951.70	\$1,231.95	\$1,236.66
11	\$1,582.87	\$951.70	\$1,231.95	\$1,236.66
12	\$1,582.87	\$948.93	\$1,231.95	\$1,236.66
13	\$1,582.87	\$870.45	\$1,231.95	\$1,236.66
14	\$1,582.87	\$791.96	\$1,231.95	\$1,236.66
15	\$1,508.67	\$674.10	\$1,184.02	\$1,185.91
16	\$1,508.67	\$595.61	\$1,105.53	\$1,107.42
17	\$1,508.67	\$517.12	\$1,027.04	\$1,028.93
18	\$1,508.67	\$438.64	\$948.56	\$950.45
19	\$1,481.63	\$360.15	\$870.07	\$871.96
20	\$1,353.67	\$255.41	\$764.69	\$764.69
21	\$1,275.18	\$176.92	\$686.20	\$686.20
22	\$1,196.69	\$98.43	\$607.71	\$607.71
23	\$1,118.21	\$19.95	\$529.23	\$529.23
24	\$1,039.72	\$0.00	\$450.74	\$450.74
25+	\$961.23	\$0.00	\$372.25	\$372.25

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.

## Medical Monthly Allowance Deductions (Retired Members) (continued)

### Retired Member and Dependent with Medicare Parts A & B

	PPO (U.S.)	HMO/Senior Plans				
	Anthem Blue Cross Medicare Preferred (PPO) Plan	CA – Kaiser Permanente Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
<b>Monthly Premiums</b>	<b>\$984.31</b>	<b>\$524.94</b>	<b>\$532.87</b>	<b>\$570.57</b>	<b>\$714.57</b>	<b>\$512.05</b>
<b>Service/ Service Credit</b>	<b>Monthly Allowance Deduction</b>					
10*	\$613.31	\$328.09	\$331.16	\$354.72	\$444.72	\$318.14
11	\$613.31	\$328.09	\$331.16	\$354.72	\$444.72	\$318.14
12	\$613.31	\$325.32	\$331.16	\$354.72	\$444.72	\$318.14
13	\$613.31	\$246.84	\$331.16	\$354.72	\$444.72	\$318.14
14	\$613.31	\$168.35	\$331.16	\$354.72	\$444.72	\$318.14
15	\$539.11	\$50.49	\$283.23	\$303.97	\$383.17	\$271.78
16	\$539.11	\$26.25	\$204.74	\$225.48	\$304.68	\$193.29
17	\$539.11	\$26.25	\$126.25	\$146.99	\$226.19	\$114.80
18	\$539.11	\$26.25	\$47.77	\$68.51	\$147.71	\$36.32
19	\$512.07	\$26.25	\$26.89	\$28.78	\$69.22	\$25.85
20	\$384.11	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
21	\$305.62	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
22	\$227.13	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
23	\$148.65	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
24	\$70.16	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.

## Medical Monthly Allowance Deductions (Retired Members) (continued)

### Retired Member with Medicare Parts A & B and Family not in Medicare (Dual Care)

	PPO (U.S.)	HMO/Senior Plan (CA)		
	Anthem Blue Cross Medicare Preferred (PPO) Plan / Anthem Blue Cross PPO	Kaiser Permanente Sr. Advantage / Kaiser HMO	Scan Health Plan / Anthem Blue Cross HMO	UnitedHealthcare HMO / Anthem Blue Cross HMO
<b>Monthly Premiums</b>	<b>\$2,473.57</b>	<b>\$1,712.00</b>	<b>\$2,140.44</b>	<b>\$2,159.29</b>
<b>Service/ Service Credit</b>	<b>Monthly Allowance Deduction</b>			
10*	\$2,102.57	\$1,515.15	\$1,938.73	\$1,943.44
11	\$2,102.57	\$1,515.15	\$1,938.73	\$1,943.44
12	\$2,102.57	\$1,512.38	\$1,938.73	\$1,943.44
13	\$2,102.57	\$1,433.90	\$1,938.73	\$1,943.44
14	\$2,102.57	\$1,355.41	\$1,938.73	\$1,943.44
15	\$2,028.37	\$1,237.55	\$1,890.80	\$1,892.69
16	\$2,028.37	\$1,159.06	\$1,812.31	\$1,814.20
17	\$2,028.37	\$1,080.57	\$1,733.82	\$1,735.71
18	\$2,028.37	\$1,002.09	\$1,655.34	\$1,657.23
19	\$2,001.33	\$923.60	\$1,576.85	\$1,578.74
20	\$1,873.37	\$818.86	\$1,471.47	\$1,471.47
21	\$1,794.88	\$740.37	\$1,392.98	\$1,392.98
22	\$1,716.39	\$661.88	\$1,314.49	\$1,314.49
23	\$1,637.91	\$583.40	\$1,236.01	\$1,236.01
24	\$1,559.42	\$504.91	\$1,157.52	\$1,157.52
25+	\$1,480.93	\$426.42	\$1,079.03	\$1,079.03

For those LACERS Members who retired on or after July 1, 2011, and who have not made additional retirement contributions pursuant to Los Angeles Administrative Code § 4.1003(c), please refer to the 2023 Health Benefits Guide Supplement for your subsidy information and monthly deduction charts. For more information, contact LACERS.

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.



## Medical Monthly Allowance Deductions (Retired Members) (continued)

### Retired Member and Family not in Medicare or with Medicare Part B Only

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
Monthly Premiums	\$3,443.13	\$2,441.63	\$3,041.23
Service/ Service Credit	Monthly Allowance Deduction		
10*	\$2,658.25	\$1,656.75	\$2,256.35
11	\$2,579.76	\$1,578.26	\$2,177.86
12	\$2,501.27	\$1,499.77	\$2,099.37
13	\$2,422.79	\$1,421.29	\$2,020.89
14	\$2,344.30	\$1,342.80	\$1,942.40
15	\$2,265.81	\$1,264.31	\$1,863.91
16	\$2,187.32	\$1,185.82	\$1,785.42
17	\$2,108.83	\$1,107.33	\$1,706.93
18	\$2,030.35	\$1,028.85	\$1,628.45
19	\$1,951.86	\$950.36	\$1,549.96
20	\$1,873.37	\$871.87	\$1,471.47
21	\$1,794.88	\$793.38	\$1,392.98
22	\$1,716.39	\$714.89	\$1,314.49
23	\$1,637.91	\$636.41	\$1,236.01
24	\$1,559.42	\$557.92	\$1,157.52
25+	\$1,480.93	\$479.43	\$1,079.03

\* Refer to Page 13 for Retired Member Medical Subsidy Eligibility and Page 60 for how subsidy is calculated by employment type.

# Medical Monthly Allowance Deductions (Eligible Survivors)

## Survivor

These are the amounts of monthly deductions charged to the Survivor. The premium amount has been reduced by the appropriate subsidy amount based on the Retired Member's or LACERS Members' whole years of Service Credit and the balance is paid by deductions taken from the Survivor's monthly retirement allowance. You may find further information on Pages 15, Eligible Survivor Benefits.

## Eligible Survivor not in Medicare or with Medicare Part B Only

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
<b>Monthly Premiums</b>	<b>\$1,464.23</b>	<b>\$939.09</b>	<b>\$1,169.74</b>
<b>Service/ Service Credit</b>	<b>Monthly Allowance Deduction</b>		
10*	\$1,088.59	\$563.45	\$794.10
11	\$1,051.03	\$525.89	\$756.54
12	\$1,013.47	\$488.33	\$718.98
13	\$975.90	\$450.76	\$681.41
14	\$938.34	\$413.20	\$643.85
15	\$900.78	\$375.64	\$606.29
16	\$863.21	\$338.07	\$568.72
17	\$825.65	\$300.51	\$531.16
18	\$788.09	\$262.95	\$493.60
19	\$750.52	\$225.38	\$456.03
20	\$712.96	\$187.82	\$418.47
21	\$675.39	\$150.25	\$380.90
22	\$637.83	\$112.69	\$343.34
23	\$600.27	\$75.13	\$305.78
24	\$562.70	\$37.56	\$268.21
25+	\$525.14	\$0.00	\$230.65

**Note:** In order for an eligible Survivor to qualify for a subsidy, the associated Member must have had at least 10 years of Service and have been at least age 55. The premium amount has been reduced by the appropriate subsidy amount based on the Member's whole years of Service Credit. These are the amounts of monthly deductions charged to the eligible Survivor. Refer to Page 15 for Eligible Survivor Medical Subsidy.

\* Refer to Retired Member Medical Subsidy Eligibility on Page 14 and Page 60 for how subsidy is calculated by employment type.

## Medical Monthly Allowance Deductions (Eligible Survivors) (continued)

### Eligible Survivor with Medicare Parts A & B

	PPO (U.S.)	HMO/Senior Plans				
	Anthem Blue Cross Medicare Preferred (PPO) Plan	CA – Kaiser Permanente Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	\$494.67	\$262.47	\$268.95	\$287.80	\$359.80	\$258.54
Service/ Service Credit	Monthly Allowance Deduction					
10* to 14	\$123.67	\$65.62	\$67.24	\$71.95	\$89.95	\$64.63
15 to 19	\$49.47	\$26.25	\$26.89	\$28.78	\$35.98	\$25.85
20+	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

**Note:** In order for an eligible Survivor to qualify for a subsidy, the associated Member must have had at least 10 years of Service and have been at least age 55. The premium amount has been reduced by the appropriate subsidy amount based on the Member's whole years of Service Credit. These are the amounts of monthly deductions charged to the eligible Survivor. Refer to Page 15 for Eligible Survivor Medical Subsidy.

\* Refer to Retired Member Medical Subsidy Eligibility on Page 14 and Page 60 for how subsidy is calculated by employment type.

# LACERS Dental Plans

LACERS offers two dental plans: Delta Dental PPO<sup>SM</sup> and DeltaCare USA<sup>®</sup> DHMO.

Regardless of dental plan choice, LACERS advises the practice of contacting your plan’s Member Services prior to receiving major dental treatment to ensure that the treatments/services are covered under the plan.

Double coverage is not allowed for Members and Survivors already enrolled as a subscriber or dependent on another plan.

## Delta Dental PPO<sup>SM</sup>

You may visit any licensed dentist under this plan, but you will maximize plan value by taking advantage of the large Delta Dental PPO network. PPO network dentists have agreed to reduced contracted rates and cannot bill you for additional fees. If you cannot find a PPO dentist, the next best option is to visit a Delta Dental Premier<sup>®</sup> dentist. The costs may be slightly higher compared to a PPO dentist, but lower compared to a non-Delta Dental dentist.

Under this plan, after meeting your deductible, you pay a certain percentage (known as coinsurance) of each covered service. You are also responsible for any non-covered services and any amount over your annual maximum. If you go to a non-Delta Dental dentist, you have no cost protections and will be responsible for paying any amount your dentist charges above your allowance for any services you received (referred to as “balance billing”).

## DeltaCare<sup>®</sup> USA DHMO

With the DeltaCare USA DHMO Plan, you select a primary dentist from the DeltaCare USA network. For each covered service, you pay a pre-determined copay. For specific benefit information, contact DeltaCare USA for a schedule of benefits (see back cover for contact information).

Availability	Delta Dental PPO	DeltaCare USA DHMO
<b>U.S. and Its Territories</b>	✓	
<b>California and Nevada</b>	✓	✓ <sup>1</sup>
<b>Outside the U.S.</b>	✓	

1. Only available in select parts of Nevada. For a current list of DeltaCare USA dentists, visit the website at [deltadentalins.com](http://deltadentalins.com) or call Customer Services at (800) 422-4234.



# LACERS Dental Subsidy

## Dental Subsidy Eligibility

The maximum dental subsidy is based on the maximum dental subsidy provided to Active Members by the City of Los Angeles. Your monthly dental subsidy amount is based on whole years of Service Credit and applied toward the monthly cost of your dental premiums.

To be eligible for a LACERS dental subsidy, you must:

- Be at least age 55
- Have a minimum of 10 whole years of Service Credit
- Be enrolled in a LACERS-sponsored dental plan

To receive the maximum dental subsidy, you must have at least 25 years of Service Credit. Otherwise, your subsidy is 4% of the maximum subsidy for each whole year of Service Credit earned. See Page 60 for how subsidy is calculated.

**Dental subsidies are not provided for dependents or eligible Survivors.** However, you may enroll dependents in a LACERS dental plan and have their premium costs deducted from your retirement allowance. Eligible Survivors may have their dental premiums deducted from their Continuance or Survivorship allowances.

## 2023 Dental Subsidy

Service/Service Credit	% of Maximum	Delta Dental PPO Subsidy Amount	DeltaCare USA DHMO Subsidy Amount
10*	40%	\$17.52	\$6.04
11	44%	\$19.28	\$6.64
12	48%	\$21.03	\$7.25
13	52%	\$22.78	\$7.85
14	56%	\$24.53	\$8.46
15	60%	\$26.29	\$9.06
16	64%	\$28.04	\$9.66
17	68%	\$29.79	\$10.27
18	72%	\$31.54	\$10.87
19	76%	\$33.30	\$11.48
20	80%	\$35.05	\$12.08
21	84%	\$36.80	\$12.68
22	88%	\$38.55	\$13.29
23	92%	\$40.31	\$13.89
24	96%	\$42.06	\$14.50
25+	100%	\$43.81	\$15.10

\* Refer to Dental Subsidy Eligibility on Page 49 and Page 60 for how subsidy is calculated by employment type.



# Dental Plan Comparison Chart

Dental Benefits	DeltaCare® USA DHMO	Delta Dental PPO <sup>1,2</sup>	
		PPO <sup>3,5</sup>	Non-PPO <sup>4,5,6</sup>
Calendar year deductible <sup>7</sup>	None	\$25/person \$75/family	
Annual Maximum Benefit	None	\$2,500/person <sup>2</sup>	\$1,750/person <sup>2</sup>
<b>Preventive Care</b>			
Two cleanings/year Bite-wing <sup>12</sup> x-rays and Exam	100%	100% 100%	80% 80%
Four periodontal cleanings/year	100%	100%	80%
<b>Basic Services</b>			
Fillings; Extractions; Root canal; Repair crowns	100%, after \$0-\$20 copay/procedure	80%	70%
<b>Major Services</b>			
Crowns	\$40-\$75 copay/procedure <sup>8</sup>	80% <sup>9</sup>	70% <sup>9</sup>
Dentures	\$15-\$60 copay	50%	50%
Implants	Not covered	50%	50%
<b>Orthodontia</b>			
Children <sup>10</sup>	\$1,000 copay + retention/startup fees <sup>11</sup>	50%	50%
Other covered persons	\$1,350 copay + retention/startup fees <sup>11</sup>	Adults not covered	Adults not covered
Lifetime Maximum	Not applicable	\$1,500 per child	\$1,500 per child

- For those Retired Members residing in Texas, Montana, Mississippi, and Louisiana, the Non-PPO coinsurance amount for the preventive service will be 100% of the allowed amount, the Non-PPO coinsurance amount for the basic service will be 80% of the allowed amount and crowns are considered a basic service.
- If you use both PPO and Non-PPO dentists, your total annual maximum benefit will never be more than the Annual Maximum Benefit.
- Services conducted by a Delta Dental PPO<sup>SM</sup> contracted provider are reimbursed at the PPO schedule of benefits and subject to the PPO Fee Schedule.
- Services conducted by a Delta Dental Premier<sup>®</sup> contracted provider are reimbursed at the Non-PPO schedule, and subject to the Premier Fee Schedule.
- Dental contracted providers accept either the PPO or Premier contracted fee as payment in full. Patients cannot be balance billed for any amounts exceeding the contracted fee.
- Services conducted by a non-Delta Dental contracted provider are reimbursed at the Non-PPO schedule of benefits. Patients are responsible for all amounts exceeding the plan allowance.
- Delta Dental PPO deductible applies to Diagnostic & Preventive, Basic and Major Services. **Note:** Routine cleanings and periodontal cleanings are not subject to the yearly deductible.
- Plus the cost of precious/semi-precious metal and porcelain.
- Crowns are considered a Basic service under the Delta Dental PPO plan.
- DeltaCare USA DHMO children under age 19; Delta Dental PPO children under age 26.
- Copay covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$25 may apply.
- Delta Dental PPO: Bite-wing x-rays for adults are once in a calendar year.

# Dental Plan Premiums and Deductions

## Dental Plan Premium Rates

Coverage Level	Delta Dental PPO	DeltaCare USA DHMO
Retired Member	\$51.16	\$15.10
Retired Member + 1	\$101.45	\$28.19
Retired Member + Family <sup>1</sup>	\$146.56	\$32.59

1. A family consists of two or more dependents.

## Dental Monthly Allowance Deductions

	Retired Member Only		Retired Member & One Dependent		Retired Member & Family	
	Delta Dental PPO	DeltaCare USA DHMO	Delta Dental PPO	DeltaCare USA DHMO	Delta Dental PPO	DeltaCare USA DHMO
<b>Monthly Premiums</b>	<b>\$51.16</b>	<b>\$15.10</b>	<b>\$101.45</b>	<b>\$28.19</b>	<b>\$146.56</b>	<b>\$32.59</b>
<b>Service/Service Credit</b>	<b>Monthly Allowance Deduction</b>					
10*	\$33.64	\$9.06	\$83.93	\$22.15	\$129.04	\$26.55
11	\$31.88	\$8.46	\$82.17	\$21.55	\$127.28	\$25.95
12	\$30.13	\$7.85	\$80.42	\$20.94	\$125.53	\$25.34
13	\$28.38	\$7.25	\$78.67	\$20.34	\$123.78	\$24.74
14	\$26.63	\$6.64	\$76.92	\$19.73	\$122.03	\$24.13
15	\$24.87	\$6.04	\$75.16	\$19.13	\$120.27	\$23.53
16	\$23.12	\$5.44	\$73.41	\$18.53	\$118.52	\$22.93
17	\$21.37	\$4.83	\$71.66	\$17.92	\$116.77	\$22.32
18	\$19.62	\$4.23	\$69.91	\$17.32	\$115.02	\$21.72
19	\$17.86	\$3.62	\$68.15	\$16.71	\$113.26	\$21.11
20	\$16.11	\$3.02	\$66.40	\$16.11	\$111.51	\$20.51
21	\$14.36	\$2.42	\$64.65	\$15.51	\$109.76	\$19.91
22	\$12.61	\$1.81	\$62.90	\$14.90	\$108.01	\$19.30
23	\$10.85	\$1.21	\$61.14	\$14.30	\$106.25	\$18.70
24	\$9.10	\$0.60	\$59.39	\$13.69	\$104.50	\$18.09
25+	\$7.35	\$0.00	\$57.64	\$13.09	\$102.75	\$17.49

\* Refer to Dental Subsidy Eligibility on Page 49 and Page 60 for how subsidy is calculated by employment type.

# LACERS Well

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## What is LACERS Well?

LACERS Well is an innovative program designed to help our Members attain the best retirement possible.

## More About LACERS Well

- LACERS Well is free to Retired Members and Survivors, their spouses/domestic partners, and their eligible dependents.
- The program is proudly supported by LACERS health plans: Anthem Blue Cross, Kaiser Permanente, UnitedHealthcare, SCAN, Blue View Vision, and Delta Dental.
- LACERS Well safeguards your personal information at all times.

For more information: visit [lacers.org/lacerswell](https://lacers.org/lacerswell), contact LACERS at (800) 779-8328, or send an email to [LacersWell@lacers.org](mailto:LacersWell@lacers.org).

## Foundation for LACERS Well program

LACERS Well has built the foundation of the program on the five elements of well-being described below to support our mission.

Well-being isn't about being wealthy, a certain weight, or in a relationship. Often we will achieve these goals, but still find that something is missing. At times, well-being might seem like it's unattainable. But, research shows that you can achieve it when your life is comprised of **five basic elements**:

- Purpose in life (engage in activities that support your passions);
- Social engagement or connection with others (isolation can negatively impact your health);
- Security of your finances (it's not how much you have, but how you manage what you do have);
- Quality of your health (your health impacts your attitude, motivation, finances, and ability to pursue interests); and
- Contributions you make to your communities (giving to others has been shown to improve one's happiness).

You might have experienced these elements in your life, but they don't always occur at the same time or maybe they exist in only a limited capacity. However, for the most part, these elements are within our control and we have the ability to enhance them to improve our sense of well-being.

*Source: Well-being: The Five Essential Elements by Tom Rath and Jim Harter*

# COBRA

## COBRA

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) that allows your dependents to continue their coverage, at their own expense, for up to 36 months after they have been terminated from your LACERS health plans for the following qualifying events:

- Legal separation
- Divorce
- Termination of domestic partnership
- Marriage of dependent child
- Dependent child reaches age limit shown on plan
- Death of Retired Member (dependent not eligible for Continuance or Survivorship allowance)

You, as a Retired Member or Survivor, must inform LACERS within 60 days of the COBRA-qualifying event, otherwise your dependents will lose their rights to continue their coverage. LACERS will notify your dependents of their rights to continue coverage and payment procedures.

Your dependents will have:

- 60 days from when notified by LACERS to elect to continue coverage.
- 45 days after election to continue coverage to make the first direct payment to the medical and/or dental insurance carrier.

Your dependents will have coverage up to a maximum of 36 months or until one of the following occurs:

- LACERS no longer offers medical or dental coverage;
- The monthly premium is not paid within the 30-day grace period;
- Your dependents enroll as employees in another group plan;
- Your spouse/domestic partner remarries or enters into a new domestic partnership and is covered under another plan; or
- Your spouse/domestic partner becomes eligible for Medicare.





# Settling Disputes and Arbitration

## Settling Disputes

LACERS Anthem Blue Cross HMO, Anthem Blue Cross Medicare Preferred (PPO), Anthem Blue Cross PPO, Anthem Blue View Vision, Kaiser Permanente HMO and Senior Advantage, SCAN Health Plan, and UnitedHealthcare medical and the Delta Dental PPO and DeltaCare USA HMO dental plans are licensed under the California Knox-Keene Care Service Plan Act of 1975, which is administered by the State of California's Department of Managed Health Care (DMHC). According to each of LACERS health plans' Evidence of Coverage, if you wish to file a complaint against your health plan with the DMHC, you may do so **ONLY AFTER** you have contacted your health plan and used the plan's grievance process. However, you may immediately file a complaint with the DMHC in an emergency. You may also file a complaint with the DMHC if the health plan has not satisfactorily resolved your grievance within 60 days of filing. See back cover for contact information.



## Arbitration

Anthem Blue Cross HMO, Kaiser Permanente HMO and Senior Advantage, SCAN Health Plan, and UnitedHealthcare medical plans, and the DeltaCare USA HMO dental plan use binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. Any medical malpractice dispute regarding health services, whether those services were unnecessary, unauthorized, or improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by California law and not by a lawsuit or a court process, except as California law provides for judicial review of arbitration proceedings.

By enrolling in a LACERS health plan, Retired Members and Survivors may be giving up their right to have any dispute resolved by litigation in court, except for claims within the jurisdiction of the small claims court, and instead may be accepting the use of binding arbitration relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, dependent, enrollee or otherwise (whether a minor or adult) or the heirs-at-law or personal representatives of any such individual(s), as the case may be and the medical plan (including any of their agents, successors or predecessors in interest, employees or providers).



# Glossary

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**Anthem Blue Cross Medicare Preferred (PPO) Plan:** A Medicare Advantage PPO plan offered by Anthem Blue Cross and available to Retired Members, Survivors, and eligible dependents with Medicare Parts A and B.

**Carrier:** A health insurance organization (medical or dental) that LACERS has contracted with to provide health insurance to Retired Members.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency that administers the Medicare program. CMS works in partnership with the state to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

**Claim:** A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered

**CMS:** See Centers for Medicare & Medicaid Services.

**COBRA:** See Consolidated Omnibus Budget Reconciliation Act of 1986.

**Co-Insurance:** The percentage of the approved cost of a medical/dental service that you have to pay after meeting the deductible. When seeking out-of-network care, you may have to pay any amount charged above the approved cost of the service as well.

**Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA):** COBRA provides certain former employees, Retired Members, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at the group premium rate plus an administrative fee.

**Continuance:** A lifetime monthly benefit provided to a qualified beneficiary as a result of the death of a Retired Member.

**Copayment (Copay):** The predetermined (flat)

fee that an individual pays for certain health care services.

**Deductible:** The amount an individual must pay for health care expenses before insurance covers costs. PPO health plans usually have calendar-year deductible amounts.

**Deduction:** An amount taken from a Retired Member's or eligible Survivor's monthly retirement allowance to cover the difference between the plan premium and the available eligible subsidy.

**Dependent:** A spouse/domestic partner, and/or eligible child(ren) or grandchild(ren) enrolled in the Retired Member's and Survivor's LACERS health plan.

**Dual Care:** A LACERS medical insurance option available to Retired Members and Survivors whose households consist of at least one enrollee (Retired Member, Survivor, or dependent) has both Medicare Parts A and B and at least one enrollee does not have Medicare Parts A nor B.

**Eligible Surviving Spouse/Domestic Partner (Survivor):** The surviving spouse/domestic partner of a Retired Member or of a LACERS Member who died prior to retirement, and is eligible for a survivorship benefit from the plan.

**Formulary:** A listing of prescription medications or durable medical equipment that are covered by a medical plan.

**Generic Drug:** Chemically equivalent copy of a brand-name drug whose patent is expired. Generic drugs typically are less expensive and sold under the common name for the drug, not the brand name.

**Health Maintenance Organization (HMO):** A prepaid medical group practice plan that provides a comprehensive predetermined medical care benefit package. HMOs are both insurers and providers of health care.

# Glossary (continued)

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**LACERS Member:** (For the purpose of this Guide) Any active Member who is a Civilian employee or one of the few specific Sworn classifications to the City of Los Angeles, including employees on leave without pay status, excluding employees of the Department of Water and Power.

**Maximum Out-of-Pocket Payment:** The largest amount of money a person will pay annually in addition to premium payments and their insurance plan's deductible. The out-of-pocket payment is usually the sum of co-insurance payments made by an enrollee.

**Medical Premium Reimbursement Program (MPRP):** A LACERS program that reimburses Retired Members and eligible Survivors who have non-LACERS medical plans for their plan premiums up to the amount of their subsidy eligibility. MPRP participants must live outside California or reside outside of a LACERS HMO zip code service area.

**Member:** A LACERS Retired Member or an eligible Survivor.

**Network:** A defined group of providers who have contracted with a health insurance company to supply a full range of primary, acute health care services.

**PCP:** See Primary Care Physician.

**Power of Attorney (POA):** Power to act for another; the legal authority to act for another person in legal and business matters.

**PPO:** See Preferred Provider Organization.

**Preferred Provider Organization (PPO):** A group of hospitals and physicians that contract on a fee-for-service basis with insurance companies or third-party administrators to provide comprehensive medical coverage. Using in-network services allows more of an individual's costs to be covered. An individual can go out-of-network to receive care, but usually at a higher cost.

**Premium:** The monthly cost of insurance coverage.

**Primary Care Physician (PCP):** A health care provider in a managed care plan responsible for coordinating all care for an individual patient, including providing direct care services and referring the patient to a specialist and hospital care.

**Reasonable and Customary (R & C) Fee:** Average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the maximum amount of money they will approve for a specific test or procedure. When out-of-network fees are higher than the R & C amount, the individual receiving the service is responsible for paying the difference.

**Reimbursement:** A repayment of an eligible payment a person made directly for a benefit claim for service(s) rendered.

**Reimbursement - Anthem Medicare Preferred (PPO) Enhanced Benefits:** A repayment by Anthem Medicare Preferred (PPO) to a plan member who directly paid for eligible claims for Caregiver Relief, and Personal Care and Homemaker Service. See Page 34 for Anthem Medicare Preferred (PPO) Enhanced Social Services Program.

## Glossary (continued)

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**Reimbursement - Medical Premium Reimbursement Program (MPRP):** A repayment of medical insurance premium, up to the Retired Member's or eligible Survivor's medical subsidy, to a Retired Member or Survivor for their non-LACERS sponsored medical insurance plan, of which the Retired Member or Survivor made direct payments to their non-LACERS sponsored health plan. Refer to Page 23 for MPRP information.

**Reimbursement - Medicare Part B Premium:** A repayment of the basic/standard Medicare Part B premium (which you either paid directly to CMS or was deducted from your Social Security check) to eligible Retired Members who are receiving a medical subsidy; enrolled in both Medicare Parts A and B; and enrolled in a LACERS medical plan or participating in LACERS' MPRP. Neither Survivors nor dependents are eligible to receive Medicare Part B premium reimbursement.

**Retired Member:** (For the purpose of this Guide) Any retired Member of LACERS who was a Civilian employee of the City of Los Angeles, excluding employees of the Department of Water and Power, and is receiving either a service, vested, or disability pension.

**Senior Plan:** A medical insurance plan that coordinates with Medicare.

**Service:** Service is the number of years of City Service an employee has and is used to determine eligibility for a medical and/or dental plan premium subsidy.

**Service Credit:** Service Credit is a component in the calculation of your LACERS Retirement Allowance and, if applicable, LACERS benefit calculation. Service Credit is based on actual hours worked: full-time employees receive 0.03835 years of Service Credit per pay period, and part-time employees' are prorated for each pay period based on the actual hours worked divided by 80 hours.

**Subsidy:** A benefit for eligible LACERS Retired Members and their eligible Surviving Spouses/Domestic Partners that assists with the cost of health insurance. It is applied toward the cost of the Retired Member's or eligible Survivor's monthly premium. Both Retired Members and eligible Survivors may qualify to receive LACERS medical subsidy. (See Pages 13 for medical subsidy.) Only Retired Members may be eligible for dental subsidies (NOT i.e. neither dependents nor eligible Survivors are eligible for LACERS dental subsidy).

**Survivor:** Surviving spouse or domestic partner of a LACERS Member or a Retired Member who is eligible for a Continuance or Survivorship benefit from LACERS.

**Survivorship:** A lifetime monthly benefit provided to a qualified beneficiary as the result of the death of a Member prior to retirement.

**UCR:** Usual and Customary Rates. See Reasonable and Customary (R & C) Fee.

**U.S. Territories:** American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands

# Appendix: Related Ordinances

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For your convenience, excerpts of the Los Angeles Administrative Code (LAAC) and LACERS Board Manual (LACERS BM) that were mentioned in this Guide may be found below. These excerpts are current at the time of the printing of this publication. The full text may be found online.

**LAAC § 4.1003(c) *Additional Contributions [Tier 1 Provisions]*.** In addition to the contributions required pursuant to Subsection (a) or (b) herein, as applicable, certain members shall make additional normal contributions to the Retirement Fund as provided herein. In consideration for such additional contributions, these members shall receive the benefit set forth in Section 4.1111(c) of Article 2 of Chapter 11 of Division 4 of this Code. The City Administrative Officer shall notify the Retirement System and the Controller of the specific Memoranda of Understanding (MOUs) which require members to contribute as provided herein. . . .

**LAAC § 4.1111(f) *Medicare Enrollment and Assignment [Tier 1 Provisions]*.** Retirees who are eligible to enroll in Medicare Part B must do so in order to qualify to receive the subsidy provided in Subsections (d) and (e) of this section. The Board may require retirees to enroll in and assign to LACERS any coverage that is provided by Medicare in order to qualify to receive the subsidy provided in this section, except that retirees who are not entitled to premium free Part A of Medicare are not required to enroll in Part A.

**LAAC § 4.1113(b) *Eligible Retiree [Tier 1 Provisions]*.** In order to participate in the Medicare Part B Basic Premium Reimbursement Program, a retiree must be eligible to receive a medical plan premium subsidy, enrolled in Medicare Parts A and B, and either enrolled in a Medicare supplemental or coordinated plan administered by the Board or be a participant in the Medical Premium Reimbursement Program. Only retired employees may participate in this program.

**LAAC § 4.1126(e) *Medicare Enrollment and Assignment [Tier 3 Provisions]*.** Retirees who are eligible to enroll in Medicare Part B must do so in order to qualify to receive the subsidy provided in Subsections (c) and (d) of this section. The Board may require retirees to enroll in and assign to LACERS any coverage that is provided by Medicare in order to qualify to receive the subsidy provided in this section, except that retirees who are not entitled to premium free Part A of Medicare are not required to enroll in Part A.

**LAAC § 4.1128(b) *Eligible Retiree [Tier 3 Provisions]*.** In order to participate in the Medicare Part B Basic Premium Reimbursement Program, a retiree must be eligible to receive a medical plan premium subsidy, enrolled in Medicare Parts A and B, and either enrolled in a Medicare supplemental or coordinated plan administered by the Board or be a participant in the Medical Premium Reimbursement Program. Only retirees may participate in this program.

**LACERS BM § HBA 2.d:** At age 65 (or sooner if eligible for Medicare insurance), Eligible Primary Subscribers and their Medicare eligible dependents must enroll in a LACERS Medicare plan. (LAAC 4.1111(f))

**LACERS BM § HBA 5.f:** Any Eligible Primary Subscriber who receives a payment as a refund or rebate of any portion of his/her health plan premium for which the Eligible Primary Subscriber has been reimbursed by LACERS under the MPRP shall report the payment to LACERS and provide supporting documentation. LACERS will determine if any portion of the payment is due to LACERS. Should an Eligible Primary Subscriber refuse to reimburse LACERS the payment, the amount due to LACERS shall be included in the Eligible Primary Subscriber's taxable income as reported to the IRS and the State of California.

# Appendix: Subsidy Eligibility Requirements for LACERS Members

Became LACERS Member On or Before April 22, 1990

Member Type	Subsidy Eligibility*			Subsidy Calculation
	Age	City Service	Health Service Credit	10 Years Minimum = 40% Health Subsidy, 4% for each full year after 10 years
Full-time	55+	≥ 10 Years	≥ 10	Service Credit × 4%
Part-time	55+	≥ 10 Years	1-10	First 10 years of <b>Service</b> × 4% for 40%, then each additional whole year of <b>Service</b> × 4%

Became LACERS Member After April 23, 1990, including Tier 3 Part-Time effective February 21, 2016

Member Type	Subsidy Eligibility*			Subsidy Calculation
	Age	City Service	Health Service Credit	10 Years Minimum = 40% Health Subsidy, 4% for each full year after 10 years
Full-time	55+	≥ 10 Years	≥ 10	Service Credit × 4%
Part-time	55+	≥ 10 Years	1-10	First 10 years of <b>Service</b> × 4% for 40%, then each additional whole year of <b>Service Credit</b> × 4%

\* Service/Service Credit in Determining Health Subsidy

## Included in Determining Health Subsidy

- Los Angeles County Employees Retirement Association (LACERA) reciprocity – Included, if eligible (minimum of 10 years combined) and elected
- Back contributions and Government Service Buybacks
- City Service/Service Credit decreases, resulting from Separate Accounts due to Community Property rules, do not affect health service credit as that is not a community property right. Members retain their health subsidy eligibility.

## Not Included in Determining Health Subsidy

- Non-LACERA (i.e. CalPERS) reciprocity
- Public Service Buyback
- Water and Power Employees' Retirement Plan Service after January 1, 2014, due to suspension of reciprocity

## Visual of Part-Time Subsidy Calculation

Whole Years of Service		% of Maximum Subsidy	2023 Subsidy Amount
10		40%	See medical subsidy chart on Page 14; See dental subsidy chart on Page 50
11 to 25+	*On/before 04/22/1990: based on <u>Service</u>	4% for each full additional year	
	*After 04/22/1990: based on <u>Service Credit</u>		





# Health Plan and Other Important Contact Information

Resources	Phone Numbers and Websites	Resources	Phone Numbers and Websites
Anthem Blue Cross HMO	(866) 940-8303 TTY 711 <a href="http://anthem.com/ca">anthem.com/ca</a>	Kaiser Permanente HMO	(800) 464-4000 TTY 711 <a href="http://my.kp.org/lacers">my.kp.org/lacers</a>
Anthem Blue Cross Medicare Preferred (PPO) Plan	Medical: (833) 848-8730 PDP (Rx): (833) 360-3662 TTY 711 <a href="http://anthem.com/ca/lacerswellness">anthem.com/ca/lacerswellness</a>	Kaiser Permanente HMO Senior Advantage	(800) 443-0815 TTY 711 <a href="http://my.kp.org/lacers">my.kp.org/lacers</a>
Anthem Blue Cross Medicare RX (PDP) with SeniorRx Plus	(833) 285-4636 TTY 711 <a href="http://anthem.com/ca/lacerswellness">anthem.com/ca/lacerswellness</a>	LACERS Well	<a href="http://lacers.org/lacers-well">lacers.org/lacers-well</a>
Anthem Blue Cross PPO	(866) 940-8303 TTY 711 <a href="http://anthem.com/ca">anthem.com/ca</a>	LACERS	(800) 779-8328 RTT (888) 349-3996 <a href="http://LACERS.org">LACERS.org</a>
Anthem Blue View Vision	(866) 723-0515 TTY 711 <a href="http://anthem.com/ca">anthem.com/ca</a>	Centers for Medicare & Medicaid Services (CMS)	(800) MEDICARE (800) 633-4227 TTY (877) 486-2048 <a href="http://medicare.gov">medicare.gov</a>
California Department of Managed Health Care	(888) 466-2219 TDD (877) 688-9891 <a href="http://dmhc.ca.gov">dmhc.ca.gov</a>	SCAN Health Plan	(800) 559-3500 CA TTY 711 <a href="http://scanhealthplan.com/lacers">scanhealthplan.com/lacers</a>
DeltaCare® USA HMO	(800) 422-4234 TTY 711 <a href="http://deltadentalins.com">deltadentalins.com</a>	Social Security Administration	(800) 772-1213 TTY (800) 325-0778 <a href="http://ssa.gov">ssa.gov</a>
Delta Dental PPO	(800) 765-6003 TTY 711 <a href="http://deltadentalins.com">deltadentalins.com</a>	UnitedHealthcare Medicare Advantage HMO	(800) 457-8506 CA, AZ, NV TTY 711 CA, AZ, NV <a href="http://uhcretiree.com">uhcretiree.com</a>

## LACERS

(800) 779-8328 • RTT (888) 349-3996 •  
Fax (213) 473-7284

**Mailing address:** P.O. Box 512218,  
Los Angeles, CA 90051-0218

**Website:** [LACERS.org](http://LACERS.org)

**Email health plan questions:** [LACERS.health@lacers.org](mailto:LACERS.health@lacers.org)

**Email general questions:** [LACERS.services@lacers.org](mailto:LACERS.services@lacers.org)

**MyLACERS Portal:** [mylacers.lacers.org](http://mylacers.lacers.org)