2024 HEALTH BENEFITS GUIDE

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

2024 Health Benefits Guide

Open Enrollment:	Last Date to Make Changes:	Benefit Changes Take Effect:
October 16 - November 16, 2023	November 16, 2023	January 1, 2024

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 2024 (unless you experience a qualifying life event change or are a newly Retired Member).
2	Your 2023 benefit elections will continue in 2024 unless you make a change during Open Enrollment. Review your Open Enrollment Statement for your previous year's benefit elections. If you want to make changes, you can find online enrollment forms at: lacers.org/post/health-benefit-forms
3	Some Open Enrollment election actions require you to submit supporting documentation to complete the enrollment. A few common examples include 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 9-13 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 or survivor documents may result in disenrollment from LACERS health plans.**

Available Medical Plans for 2024 (Summary Chart)

Please refer to Pages 20-51 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 & B	Anthem Blue Cross Medicare Preferred (PPO) (nationwide) **NEW** Anthem Blue Cross Life & Health Medicare Plan (Medicare Supplement) (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 2024 (Summary Chart)

Please refer to Pages 52-55 for plan descriptions, comparison charts, and cost charts. Members and Survivors enrolled as a dependent on the other's plan for double coverage is not allowed.

Delta Dental PPO (nationwide)	&	DeltaCare USA HMO (CA and NV)

This guide provides information about the 2024 health plan options for current and new Retired Members and Survivors. Make a plan and time for yourself and your family to review this material carefully before making your medical and dental plan choices. For unfamiliar terms, please see the Glossary on Page 59.

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About Your Health Benefits

2024 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 2024 plan year. Use this Guide as your resource to:

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

New Medical Plan Added for the 2024 Plan Year

The Anthem Blue Cross Life and Health Medicare Plan, a Medicare Supplement plan, is available for Members and Survivors who have Medicare Parts A & B. If you are interested in enrolling in this plan, review this Guide for the benefits, premiums, and possible cost to you. See Pages 34-36 for benefits comparison, 40-41 for premiums, and 43, 45-48, 51 for allowance deductions. You will need to submit a disenrollment of current plan to select this plan for the 2024 plan year.

Subscribe to the Official LACERS YouTube Channel

Can't attend a Health 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 are LACERS Medicare requirements?" to "How do I enroll in LACERS retiree health benefits?" Learn from the comfort of your home or on the go – it's never been more convenient! Make sure to subscribe to the Official LACERS YouTube channel to be the first to know when new videos are available. Just go to **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 health benefit, beneficiaries on file, and correspondence with LACERS staff through your secured online account at **https://mylacers.lacers.org**. Opening and maintaining a secured MyLACERS account provides you access to your confidential information and 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 **https://mylacers.lacers.org** to get started.

Income-Related Monthly Adjustment Amount (IRMAA)

The Centers for Medicare and Medicaid Services (CMS) assesses Income-Related Monthly Adjustment Amount (IRMAA) when a Medicare enrollee's Modified Adjusted Gross Income (MAGI) amount from two years prior (e.g., 2022 IRS tax return for 2024 IRMAA) exceeds a certain threshold. For more information, see Page 13.

LACERS
(800) 779-8328 • RTT (888) 349-3996 • Fax (213) 473-7284
Mailing address: P.O. Box 512218, Los Angeles, CA 90051-0218
Visit us at: 977 N. Broadway, Los Angeles, CA 90012-1728
Website: LACERS.org • **MyLACERS Portal:** https://mylacers.lacers.org
General questions: LACERS.services@lacers.org • **Health plan questions:** LACERS.health@lacers.org

Your Detailed Enrollment Checklist

Important: Members and Survivors enrolled as a Dependent on the other's plan for double coverage is not allowed.

Step 1	**Review your 2024 Open Enrollment Health Plan Statement** (This is a snapshot of your coverage in LACERS' system as of August 21, 2023.) ❑ Verify address and phone number are current ❑ Review your dependents' eligibility for coverage. (You must remove dependents from your coverage when they become ineligible, e.g., month following divorce/dissolution date.) ❑ Review your current plans' 2024 premiums, subsidies, and deductions. (New Retiree/Survivor or made recent plan changes: log into your MyLACERS account to view your current coverage)	Pgs 25-55 for Medical, Enhanced, and Vision, Dental benefits; and monthly medical/dental premiums and deductions
Step 2	**If enrolling as a new retiree or changing your Medical and/or Dental plan,** review your plans' details in this guide. All required forms for subscribers under 65 are available online at **lacers.org/post/health-benefit-forms**. Subscribers aged 65+, please call LACERS to request forms. Once forms are gathered, complete and submit: ❑ LACERS Medical Enrollment form (Two options: Kaiser form, or Other Plans form) ❑ LACERS Dental Enrollment form ❑ If covering existing dependents, a **new** *Certification of Dependent and Survivor Status for Health Coverage* is required ❑ If covering new dependents, gather all necessary and required documents (e.g., birth and marriage certificate, domestic partner affidavit, copy of Social Security Cards or redacted tax document showing dependents' name and Social Security Number, proof of Medicare) then complete and submit *Certification of Dependent and Survivor Status for Health Coverage* ❑ If you or your eligible dependent(s) have Medicare, call or email LACERS Health to request a LACERS Senior Form for each person who has Medicare. Each Medicare enrollee must complete their own form and a *Medicare Information Acknowledgment form*. **If adding new dependents to your current Medical and/or Dental plan,** ❑ Submit a *Certification of Dependents and Survivor Status for Health Coverage form*, a birth certificate for children and grandchildren dependents, a marriage certificate or domestic affidavit for spouse/domestic partner, copy of Social Security Cards or redacted tax document showing dependents' name and Social Security Number, and proof of Medicare, if applicable. ❑ If you or your eligible dependent(s) have Medicare, call or email LACERS Health to request a LACERS Senior Form (a separate form must be completed by the Medicare enrollee) and a *Medicare Information Acknowledgment form*. ❑ Complete and submit *LACERS Family Account Change Form*	Pgs 5-8 for eligibility and changes Pgs 9-13 for LACERS Medicare requirements Pgs 19-23 for available medical plans, and 52 & 54 for dental benefits Pgs 25-39 for Medical, Enhanced, and Vision benefits Pgs 40-51 and 55 for monthly medical/dental premiums and deductions
Step 3	Retain a copy of your forms as proof of enrollment. Submit your forms and required documents by the appropriate deadline to LACERS by: • Secure Document Upload: **lacers.org/secure-document-upload**, • Drop off at LACERS: 977 N. Broadway, Los Angeles, CA 90012-1728 • Email / Fax: **LACERS.Health@lacers.org** / (213) 473-7284 • Mail to: P.O. Box 512218, Los Angeles, CA 90051-0218	

Important Notices

LACERS Health Benefits

This booklet is a reference guide for 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.

Evidences of Coverage (EOC) will be posted to the LACERS website at lacers.org/evidence-coverage when they become available. 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 or call LACERS Member Service Center at (800) 779-8328 / RTT (888) 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.
- 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. If you do not have internet access, please call LACERS Member Service Center at (800) 779-8328 / RTT (888) 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 14 for Retired Members' medical subsidy and Page 16 for eligible Survivors' medical subsidy.

Federal Income-Related Monthly Adjustment Amount (IRMAA)

For IRMAA information, please see Page 13.

Enrollment Eligibility, Changes, Terminations

Member and Survivor Eligibility

You are eligible to enroll in LACERS' health plans if you are a:

a. Retired City employee who receives a monthly retirement allowance from LACERS, or

b. Surviving Spouse/Domestic Partner who receives a Continuance or a Survivorship allowance from LACERS.

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

Eligible Dependents[1]

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

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.

Dependent Eligibility Verification

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

- Copy of your certified marriage certificate
- Proof of domestic partnership
- Your child's birth certificate
- Copy of Social Security Card, or proof of Social Security Number, for each dependent
- Proof of your child's disability, if applicable

If your supporting documents for your dependent is not in English, please visit an agency listed at lacers.org/submit-your-required-documents that provide certified translation services.

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, one of the following must be provided:

- 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"

When to Enroll

Generally, you may enroll in a LACERS health plan:

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

Health Enrollment forms not submitted within the 60-day window will result in your and your dependents, if applicable, having no coverage until the following year's Open Enrollment. In addition, although your Health enrollment forms were received timely, if your retirement documents are not complete and/or submitted within 90 days, your coverage may be terminated and you will not be eligible for coverage until the next 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 starts a special enrollment period for an individual or family to enroll in LACERS coverage outside of the regular annual Open Enrollment period. Members experiencing a qualifying event are strongly encouraged to speak to a LACERS Health Advocate to receive counseling on their health options.

A Dependent who is not currently enrolled in the Member's medical plan and turns age 65 is **not** a Qualifying Event to be added to the Retired Member's plan; the Dependent must meet the involuntary termination* event to be added.

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 (LACERS requires Change of Address form to be submitted)
- 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/domestic partnership and birth or adoption of a child)

* An involuntary termination can be caused by loss of Employer coverage as an Employee or dependent; no longer qualifies for current coverage due to age, e.g., age 65; expiration of COBRA benefits; or, change in current plan's service area.

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 online at lacers.org/post/health-benefit-forms, by emailing LACERS Health Benefits at LACERS.health@lacers.org, or by calling LACERS Customer Service at (800) 779-8328. If you are already enrolled in a LACERS-sponsored medical/dental plan and wish to change plans and/or update dependents, continue reading the next few subtopics then complete Steps 4 and 5.
4. Complete all applicable sections of the health plan enrollment forms and gather all necessary, required supporting documents.
5. Submit completed forms and required documents back to LACERS as indicated on Step 3 in Your Detailed Enrollment Checklist on Page 3.

When Health Plan Coverage Begins

- **For New Retirees:** The first of the month following your retirement effective date **or**, if retirement effective date is the first of the month, then coverage begins at the same time
- **All other events:** The first of the month following the processing of your enrollment request

Medical insurance cards take 7-10 business days to be mailed from desired plan, starting from the plan's effective date.

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/post/health-benefit-forms. Required documents to submit include marriage certificate, birth certificate, and a copy of Social Security Card or redacted tax document showing dependents' name and Social Security Number.

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.

Health plan enrollment forms are available at lacers.org/post/health-benefit-forms, upon request by emailing LACERS.health@lacers.org, or by calling LACERS at (800) 779-8328.

Deleting/Removing a Dependent

Carefully consider deleting a dependent because you will not be able to re-enroll the dependent until the next Open Enrollment period.

If you would like to delete a dependent, you must complete and submit a *LACERS Medical/Dental Plan Family Account Change Form*. You will need to indicate whether the removal is for the medical and/or dental plan.

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**.

Deleting/Removing an Ineligible Dependent

If an event makes your dependent ineligible for LACERS health plan coverage (e.g., divorce, overaged), you must delete a dependent from your LACERS health plan within 60 days.

LACERS health subsidies may not be applied toward the coverage of ineligible dependents. If your dependent is overaged and disabled, you must provide disabled certification as proof of dependent's disability to prevent termination of overaged dependent.

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, including any Medicare non-compliance reason, e.g., lapse of Part B or enrolled in another plan. Termination due to Medicare non-compliance is not a COBRA event. Refer to Pages 12 regarding termination of coverage due to Medicare reasons, and Page 57 for COBRA.

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 (as provided in LACERS Board Rules, HBA 7).

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*. 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**.

Termination of Medical Coverage

For information on terminations based on the following reasons, refer to Page 12 in the LACERS Medicare Requirement section.

- Due to Centers for Medicare and Medicaid Services (CMS) One Medicare Plan Requirement
- Due to Medicare Lapse
- Due to Medicare Non-Compliance

LACERS Medicare Requirements

Form 1095-B is requested from the carriers or Medicare, not LACERS.
Form 1095-C is supplied by the employer, not LACERS.

When to Enroll in Medicare

Medicare is federal health insurance for people aged 65 and older, and some people under 65 with certain disabilities or conditions. Generally, you first become 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 who retired prior to aging 65, LACERS will mail out a Medicare packet with senior enrollment form(s) and Medicare information three months prior to your or your dependent's 65th birthday. This packet contains information about Medicare and how to timely enroll in a qualified LACERS-sponsored Medicare medical plan. It is the Member's responsibility to ensure the packet is received at the home address; these packets are not mailed to correspondence addresses. When you receive your LACERS Medicare packet, please complete your required Medicare documents as soon as possible to avoid delays.

For LACERS Members retiring at age 65 or older, and/or your dependent(s) are over age 65, please contact LACERS. Medicare allows you and/or your 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.

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 59.

Medicare Part B (Required)

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.

You may change or correct your name with the federal and/or state agencies. Please contact the agencies for further instructions.

You may change or correct your name with LACERS by providing a written request with wet signature (not an electronic signature) to change your name and submit a photo of your passport, driver's license, or state-issued ID.

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

Medicare Part A (Required, If Eligible)

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.You may also qualify even if you are divorced or your spouse is deceased.

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/.

Medicare Part D (Included in LACERS Medical Plans)

Medicare Part D is already integrated into your LACERS medical plan. If you enroll in Medicare Part D separate from your LACERS plan, whether it is enrolling or disenrolling in Medicare Part D on your own or through a non-LACERS group plan, your LACERS medical coverage will terminate 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 to maintain creditable coverage. For more information about MPRP, refer to Page 24.

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 (800) MEDICARE, or (800) 633-4227.

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.

CMS Single Medicare Plan Requirement

CMS only allows you to enroll in a single Medicare Advantage plan or Medicare Part D Prescription Drug plan. Enrolling in a LACERS sponsored plan fulfills this requirement and will tie your Medicare benefits to your LACERS plan. If you later enroll in a plan outside of LACERS, you will lose your LACERS medical coverage because CMS will tie your Medicare benefits to the new plan.

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. If you submit a SSA Benefit Verification Letter, the letter must have the Medicare Benefits Identification (MBI) along with the effective dates of Parts A and B. You must maintain your Medicare enrollment by paying your monthly Medicare premiums and any surcharges, if assessed (see Pages 11 for LEP and Page 13 for IRMAA).

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 at medicare.gov
- Contact CMS for the Authorization Agreement for Pre-Authorized Payment form and submit to CMS

Termination of Your LACERS Medical Coverage Due to Medicare Lapse

If you lapse on your Medicare Part B premiums and/or any surcharges (see Page 13 for IRMAA) and are terminated from your LACERS medical plan:

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

Termination of Your LACERS Medical Coverage Due to Medicare Non-Compliance

If you or your dependents fail to maintain Medicare entitlement or fail to adhere to the CMS single Medicare plan requirement, you and your dependent may lose the LACERS medical plan coverage and medical subsidy. Your LACERS medical plan coverage will be canceled if any of the following occur:

- Medicare Part B lapse (see prior topic above)
- Non-payment of Part D Income-Related Monthly Adjustment Amount (IRMAA)
- Enrollment in a non-LACERS medical plan or Part D plan
- Relocation out of a LACERS HMO plan zip code service area and qualifying event deadline has passed

If enrolled in Kaiser Senior Advantage, you will be disenrolled from Kaiser Senior Advantage and temporarily enrolled in Kaiser HMO non-Medicare plan. The full monthly Kaiser non-Medicare plan premium will be charged retroactive to the date of disenrollment from Kaiser Senior Advantage.

Medicare Part B Reimbursement

Exceptions – Persons not eligible for Medicare Part B Reimbursement

You will not be eligible for Medicare Part B premium reimbursement if you are:

- Enrolled in the Anthem Blue Cross PPO Out-of-Country plan
- A Survivor or dependent
- Are non-compliant with Medicare (see Page 12)

LACERS Retired Members will be reimbursed for the **basic/standard** Medicare Part B premium (non-Income-Related Monthly Adjustment Amount (IRMAA) portion) 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.

According to the LAAC (§§ 4.1105, 4.1113, and 4.1123), qualified Retired Members enrolled in Medicare Parts A & B who are participating in a LACERS Senior medical plan or the MPRP may be entitled to coverage of their basic Part B premiums by LACERS. The Medicare Part B Reimbursement does not include any penalties or the IRMAA portion of your premium. (Please also see the IRMAA topic on Page 13.)

LACERS only covers Part B premiums that are paid by the Retired Member for their Part B coverage. LACERS does not cover Part B premiums that are paid by some other entity, e.g., the State.

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.

This reimbursement is processed the later of either the senior medical plan's effective date or your Medicare Parts A & B effective date. The basic/standard Part B reimbursement will be reflected as a credit on the retirement allowance each month that Medicare Parts A, B, and D and LACERS medical plan enrollment are maintained. Retired Members participating in the MPRP who maintain their Medicare Parts A, B, and D and non-LACERS plan are reimbursed quarterly.

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., 2022 IRS tax return for 2024 IRMAA) exceeds a certain threshold. The IRMAA is a surcharge on top of the basic/standard Medicare Part B and D premium rates.

Although you are enrolled in Medicare Part D through your LACERS Medical Plan, the Medicare Part D IRMAA is a separate surcharge that is payable by you, not LACERS. Paying Part D IRMAA does not enroll you in a non-LACERS Medicare Part D plan.

It is the Medicare enrollee's responsibility to pay any CMS-assessed IRMAAs on their Medicare Part B and D, even if the Medicare enrollee is not paying a Part D premium through enrollment in a LACERS senior medical plan. **(See Medicare Part D on Page 10.)**

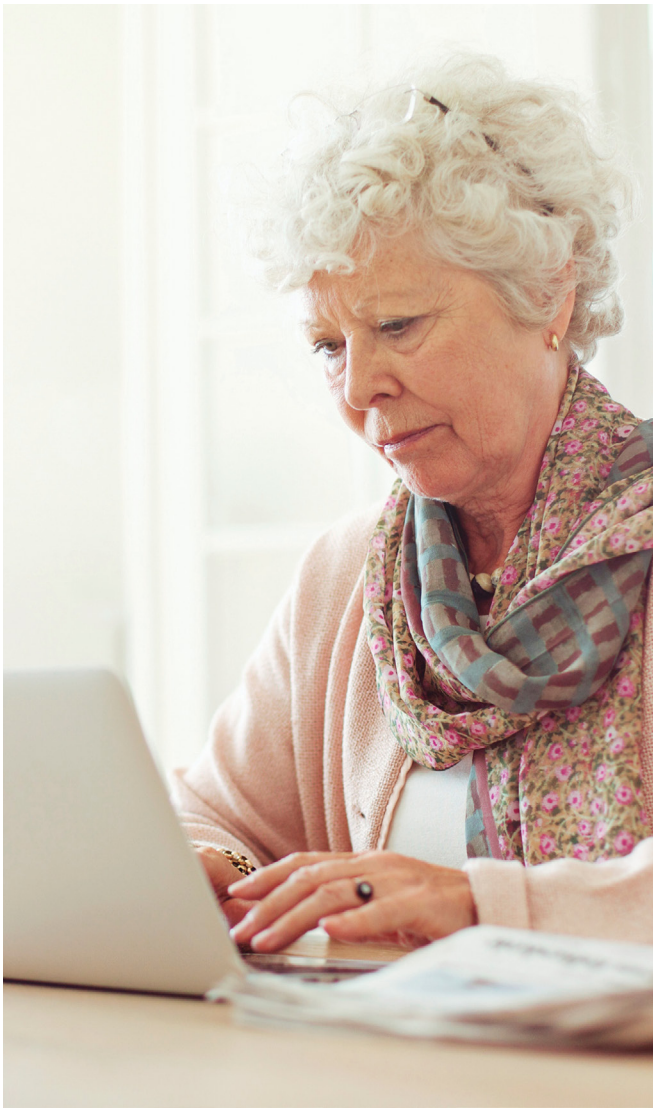
Non-payment and partial payments of IRMAAs and/or allowing your Medicare premium payments to lapse will lead CMS to request your LACERS medical plan to cancel your coverage.

Reinstatement is not automatic. Reinstatement is not guaranteed. Although CMS may reinstate your Medicare Part B and/or D coverage, the reinstatement does not automatically reinstate the LACERS medical coverage. You must contact LACERS for reinstatement requirements. See back of Guide for LACERS contact information.

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

For further IRMAA information, you may refer to medicare.gov/basics/costs/medicare-costs

To request to lower an IRMAA, please visit Social Security or their webpage ssa.gov/medicare/lower-irmaa



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

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), and**
- **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 the Glossary on Page 59 for the definitions of Service and Service Credit, and refer to Page 63 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.

Medical Plan Premium	-	Your LACERS Medical Subsidy	=	Retirement Allowance Deduction

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/post/health-benefit-forms or by request by emailing 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.

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.

Full-time employees need 10 years of Service Credit, while part-time employees need 10 years of City Service to be eligible for 40% of the maximum medical subsidy. Refer to the Glossary on Page 59 for the definitions of Service and Service Credit and Page 63 for Subsidy Eligibility Requirements.

How Your Medical Subsidy is Calculated

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 63 of this Guide and/or contact LACERS.

Service/ Service Credit*	% of Maximum Subsidy	2024 Subsidy Amount
10	40%	$875.03
11	44%	$962.54
12	48%	$1,050.04
13	52%	$1,137.54
14	56%	$1,225.04
15	60%	$1,312.55
16	64%	$1,400.05
17	68%	$1,487.55
18	72%	$1,575.06
19	76%	$1,662.56
20	80%	$1,750.06
21	84%	$1,837.57
22	88%	$1,925.07
23	92%	$2,012.57
24	96%	$2,100.08
25+	100%	$2,187.58

As an example, see Page 42 for how the subsidy is applied to the premium.

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/ 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 14 and calculation chart on Page 63.

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.

Health enrollment forms not submitted within the 60-day window will result in the Survivor's medical and/or dental coverage termination on last day of Retiree's death month. Continuance documents (Survivor Benefits Unit) not submitted within 90 days will result in your coverage termination and you will not be eligible for coverage until the next Open Enrollment period. Where both situations occur, 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 Pages 14-15)
2. When the deceased LACERS Member would have turned age 55*
3. The Survivor's eligibility for Medicare

Medical Plan Premium	-	Survivor Medical Subsidy	=	Continuance or Survivorship Deduction

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

The medical subsidy may only be applied toward the eligible Survivor participating in a LACERS medical plan or the Medical Premium Reimbursement Program (MPRP) (see Page 24 for MPRP information).

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/post/health-benefit-forms 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.

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.

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	2024 Subsidy Amount
10	40%	$420.71
11	44%	$462.78
12	48%	$504.85
13	52%	$546.93
14	56%	$589.00
15	60%	$631.07
16	64%	$673.14
17	68%	$715.21
18	72%	$757.28
19	76%	$799.35
20	80%	$841.42
21	84%	$883.50
22	88%	$925.57
23	92%	$967.64
24	96%	$1,009.71
25+	100%	$1,051.78

* 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 14 and Page 63 for how subsidy is calculated by employment type.

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

For eligible Survivors who are Medicare enrollees with Medicare Parts A & 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 14 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/ 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

As an example, see Page 50 for how the subsidy is applied to the 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 14 and Page 63 for how subsidy is calculated by employment type.

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 52 and 54 for Dental Benefits Information.

LACERS Health Benefit Options

Medical Plan Choices*

	PPO[6] (U.S. and Its Territories[1])	HMO[6] (CA Only)[2]	Outside of U.S. and Its Territories
Under age 65	• Anthem Blue Cross (Anthem) PPO	• Anthem Blue Cross (Anthem) HMO • Kaiser Permanente (Kaiser) HMO	Anthem Blue Cross PPO Out-of-Country Plan[4,5]
Age 65 or older with Medicare Part B Only	• Anthem PPO	• Anthem HMO • Kaiser Senior Advantage HMO	
Age 65 or older with Medicare Parts A & B	• Anthem Medicare Preferred (PPO) • Anthem Life & Health Medicare Plan (Medicare Supplement)	• Kaiser Senior Advantage HMO • SCAN Health Plan[3] • UnitedHealthcare (UHC) Medicare Advantage HMO *(CA, AZ, and NV)*	
Dual Care Household, where at least one subscriber is age 65+ with Medicare Parts A & B, and the other person(s) is either under age 65 or at least age 65 with Medicare Part B only	• Anthem PPO + Anthem Medicare Preferred (PPO) • Anthem PPO + Anthem Life & Health Medicare Plan (Medicare Supplement)	• Kaiser HMO + Kaiser Senior Advantage HMO • Anthem HMO + SCAN Health Plan[3] • Anthem HMO + UHC (CA) Medicare Advantage HMO	

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 24 for MPRP information.

Dental Plan Choices

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

* See Page 64 for official plan names

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, Fresno, Los Angeles, Madera, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, 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.

Medical insurance cards take 7-10 business days to be mailed from desired plan, starting from effective date.

LACERS Medical Plans

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 (Anthem) 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 HMO enrollees must submit an arbitration form. Contact LACERS for the Anthem 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 PPO plan, also known as *Prudent Buyer* in California and *PPO (non-California Resident)* in non-California states, 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.

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 HMO (CA only) and Blue Cross MedicareRx Prescription Drug Plan (PDP) with SeniorRx Plus
- Anthem PPO (also known as *Prudent Buyer* in CA, and *PPO (non-California Resident)* in non-CA states) and Blue Cross MedicareRx (PDP) with SeniorRx Plus
- Kaiser Senior Advantage HMO (CA only)

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

- Anthem Medicare Preferred (PPO) Plan and Blue Cross MedicareRx (PDP) with Senior Plus
- Anthem Life & Health Medicare Plan (Medicare Supplement) and Blue Cross Medicare Rx (PDP) with Senior Plus
- Kaiser 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 & 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 is also known as *Anthem Blue Cross Passive PPO Medicare* 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 Medicare Preferred Plan must follow Medicare rules and provide all benefits provided by Medicare. Members can go to any doctor or hospital that accepts Medicare.

Medicare Supplement Plan

Anthem Blue Cross Life & Health Medicare Plan

Members enrolled in the Anthem Life & Health Medicare Plan must be enrolled in Medicare Parts A & B. The Anthem Life & Health Medicare Plan fully supplements Medicare Parts A & B.

Under the Anthem Life & Health Medicare Supplement Plan, any portion of your medical expenses that are **authorized** but paid for by Medicare will be covered. Medicare pays 80% of most medical services and Anthem pays the remaining 20% after the deductible has been reached. The plan also covers certain benefits, such as hearing aids, that are not covered by Medicare.

You have the option to choose from a list of in-network physicians, providers, and hospitals, or any out-of-network physicians, providers, and certified hospitals that accept Medicare (assignment) anywhere in the U.S. and Its Territories.

Your benefit coverage may be less if you use an out-of-network physician, provider, or hospital.

Please be aware that Members and/or dependents enrolled in the Medicare Supplement plan **are not eligible** for the Enhanced Social Services Programs listed on Page 37.

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 & B and and others are either under age 65 or at least age 65 with Medicare Part B only, LACERS offers four medical plan combinations:

- Anthem Medicare Preferred (PPO) Plan + Anthem PPO (U.S. and Its Territories) (also known as *Prudent Buyer* in CA, and *PPO (non-California Resident)* in non-CA states)
- Anthem Life & Health Medicare Plan (Medicare Supplement) + Anthem PPO (U.S. and Its Territories)
- Kaiser Senior Advantage HMO + Kaiser HMO (CA only)
- SCAN Health Plan Medicare Advantage HMO + Anthem HMO (CA only)
- UnitedHealthcare Medicare Advantage HMO + Anthem 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.

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.[1]

Key Features	• Paid by reimbursement only • Claim forms are required • Claims may take up to 30 days to be processed upon receipt by Anthem
Medical Services	• Must meet U.S. standards of care[2]
Prescription Drugs	• $10 copay per 30-day supply *(All Anthem Blue Cross approved drugs)* • Copay will not apply toward your calendar year deductible
Medically Necessary Hearing Aids	• No deductible • Up to $2,000 per ear every 36 months
Key Plan Benefits	• $500 deductible/person • 70% reimbursement of UCR[3] charges • Up to $10,000 out-of-pocket maximum per calendar year, 100% reimbursement thereafter • Up to $2,000,000 lifetime maximum

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).
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 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 PPO Out-of-Country premium and deduction amounts are more costly than LACERS Anthem 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 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 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.

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.

As a Member enrolled in MPRP, if you enroll in a medical plan through a state or federal healthcare exchange, you will be ineligible to receive a federal subsidy toward your premium cost.

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).

2024 MPRP Maximum Reimbursement

Medicare Status	Retired Member Subsidy	Survivor Subsidy
Under 65 or Part B only	$2,187.58	$1,051.78
Medicare Parts A & B	$549.16	$549.16
Medicare Parts A & B and covering an Under 65 or Part B Only dependent	$1,288.44	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		
Calendar Year Deductible				
Individual	$750		Not applicable	Not applicable
Family	$1,500; at least one family member must satisfy the $750 per individual deductible			
Annual Out-of-Pocket Maximum	Deductible excluded			
Individual	$5,000		$500	$500
Family	Not applicable		$1,500	$1,500
Lifetime Maximum				
	Unlimited		Unlimited	Unlimited
Preventive Care				
Routine Physical Examination	No charge (may include lab & X-ray)		$20 copay	$20 copay
Pap Smear, Pelvic & Breast Annual Exam	No charge	Routine preventative mammogram and any other routine services is payable at 100% for out-of-network providers at UCR. Deductible does not apply.	No charge after $20 office visit copay	No charge after $20 office visit copay
Mammography	Preventative Mammogram is payable at 100% for in-network deductible. Deductible does not apply.			
Physician Services				
Office Visit	$20 copay	Anthem pays 70% UCR[1] 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[1] after deductible	$0 copay	$0 copay

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

Retired Members, Dependents, and Survivors under Age 65 (continued)

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
Inpatient Hospital Room & Board				
	Anthem pays 90% after deductible	Anthem pays 80% UCR[1] after deductible	No charge	No charge
Other Health Services				
Allergy Tests & Treatments	Anthem pays 90% after deductible	Anthem pays 70% UCR[1] after deductible	$20 copay	No charge after $20 office visit copay
Lab & X-ray			No charge	No charge
Physical & Speech Therapy			$20 copay; for Physical & Speech Therapy: limit of 60 days combined per illness/per injury	$20 copay
Dialysis & ESRD Services				
Skilled Nursing Facility *(limit 100 days/calendar year)*			No charge	No charge[2]
Home Health Care	Anthem pays 90% after deductible; limit up to 60 visits/calendar year	Anthem pays 70% UCR[1] after deductible; limit up to 60 visits/calendar year	No charge; limit up to 100 visits/calendar year	No charge[2]
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[1] after deductible	No charge	No charge[3]
Durable Medical Equipment				No charge; formulary applies
Chiropractic Services *(limit 30 visits/calendar year)*	$20 copay		$20 copay; the chiro rider benefit is subject towards $15 copay with limit up to 30 visits	$15 copay; combined 30 visits per 12-month period[2]
Acupuncture Services *(limit 30 visits/calendar year)*	$20 copay; payable at 90% after deductible. Visit Max Anthem will pay is $20		$20 copay	
Emergency Services				
Emergency Room Visit	Anthem pays 90% after deductible	Anthem pays 90% after deductible	$100 copay; waived if admitted	$100 copay; waived if admitted[8]

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

Retired Members, Dependents, and Survivors under Age 65 (continued)

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
Urgent Care Visit	100% subject towards $20 copay	Covered 70% of UCR after deductible	$20 copay	$20 copay
Mental Health (MH)[2]/Chemical Dependency (CD)[2]				
Inpatient	Anthem pays 90% after deductible (MH/CD)	Anthem pays 80% UCR[1] after deductible (MH/CD)	No charge (MH/CD)	No charge; unlimited (MH); In acute medical facility (CD)
Outpatient	$20 copay	Anthem pays 70% UCR[1] 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
Hearing Services				
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
Retail Prescription Drugs[5]	*Up to 30-day supply[6]*		*Up to 30-day supply[6]*	*Up to 30-day supply[7]*
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
Mail Order[4] Prescription Drugs	*Up to 90-day supply[6]*		*Up to 90-day supply[6]*	*Up to 100-day supply[7]*
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. See plan's Evidence of Coverage for limitations and details.

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		
Calendar Year Deductible				
Individual/Family	Medicare Part B deductible		Not applicable	Not applicable
Annual Out-of-Pocket Maximum	Deductible excluded			
Individual	$5,000		$500	$500
Family	Not applicable		$1,500	Not applicable
Lifetime Maximum Preventive Care	Unlimited		Unlimited	Unlimited
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
Physician Services				
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[1] after deductible	$0 copay	$0 copay
Inpatient Hospital Room & Board				
	Anthem pays 90% after deductible	Anthem pays 80% UCR[1] after deductible	No charge	No charge
Other Health Services				
Allergy Tests & Treatments	Anthem pays 100%		$20 copay	No charge after $15 office visit copay
Lab & X-ray			No charge	No charge

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

Retired Members, Dependents, and Survivors Age 65 or Older with Medicare Part B Only (continued)

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
Physical & Speech Therapy	Anthem pays 20% after deductible		$20 copay; for Physical & Speech Therapy: limit of 60 days combined per illness/per injury	$15 copay
Dialysis & ESRD Services				
Skilled Nursing Facility *(limit 100 days/calendar year)*	Anthem pays 90% after deductible	Anthem pays 70% UCR[1] 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[1] after deductible	$20 copay; the chiro rider benefit is subject towards $15 copay with limit up to 30 visits	$15 copay; combined 30 visits per 12-month period[2]
Acupuncture Services *(limit 30 visits/calendar year)*	Medicare authorized visits: $10 copay	Medicare authorized visits: Anthem pays 70% UCR[1] after deductible	$20 copay	
Emergency Services				
Emergency Room Visit	Anthem pays 20% after deductible if admitted – 90% for hospital services, Anthem pays 20% after deductible[2] for professional services		$100 copay; waived if admitted	$50 copay; waived if admitted[6]
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. See plan's Evidence of Coverage for limitations and details.

Retired Members, Dependents, and Survivors Age 65 or Older with Medicare Part B Only (continued)

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
Mental Health (MH)[2]/Chemical Dependency (CD)[2]				
Inpatient	Anthem pays 90% after deductible (MH/CD)	Anthem pays 80% UCR[1] 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
Hearing Services				
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
Retail Prescription Drugs[4]	*Up to 30-day supply[4,5]*		*Up to 30-day supply[4,5]*	*Up to 100-day supply*
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
Mail Order[3,4] Prescription Drugs			*Up to 90-day supply[3,4,5]*	*Up to 100-day supply*
Generic	$0 copay for select generics/ $10 copay generics[7]	Not covered	$0 copay for select generics/$10 copay[7]	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.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

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

Summary of Benefits	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Calendar Year Deductible			
Individual/Family	Not applicable	Not applicable	Not applicable
Out-of-Pocket Maximum	Out-of-Pocket Maximum - Deductible Excluded		
Individual	$500	$3,400	$6,700
Family	Not applicable	Not applicable	Not applicable
Lifetime Maximum			
	Unlimited	Unlimited	Unlimited
Preventive Care			
Routine Physical Examination	No charge	No charge	$0 copay in CA, NV & AZ
Annual Pap Smear, Pelvic & Breast Exam	No charge	No charge	No charge
Mammography			
Physician Services			
Office Visit	$15 copay	$10 copay	$15 copay
Specialist Care			
Inpatient Surgery	No charge	No charge	No charge
Outpatient Surgery	$15 copay		
Telehealth/ Virtual Visits	$0 copay	No charge	$0 copay
Inpatient Hospital Room & Board			
	No charge	No charge	No charge
Other Health Services			
Allergy Tests & Treatments	No charge after $15 office visit copay	No charge	No charge after $15 office visit copay
Lab & X-ray	No charge		No charge
Physical & Speech Therapy	$15 copay		No charge after $15 office visit copay
Dialysis and ESRD Services			

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

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

Summary of Benefits	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Skilled Nursing Facility	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 prescribed by Plan physician (limited to service area)	No charge	No charge
Hospice Services	No charge	No charge	Per Medicare guidelines
Ambulance	No charge when defined as emergency	No charge	No charge
Durable Medical Equipment	No charge; formulary applies		$0 copay
Chiropractic Services	$15 copay; combined 30 visits per 12-month period[1]	$10 copay; limit 20 visits/calendar year	$15 copay; limit 30 visits/year (CA), limit 12 visits/year (NV & AZ)
Acupuncture Services		$10 copay; limit 20 visits/calendar year	$15 copay; limit 30 visits/year (CA), limit 12 visits/year (NV & AZ)
Emergency Room Visit	$50 copay; waived if admitted[6]	$50 copay; waived if admitted	$50 copay; waived if admitted
Urgent Care Visit	$15 copay	$10 copay	$15 copay
Transportation	24 one-way trips per calendar year; limits apply, advance notice required[1]	Unlimited rides; 75-mile maximum radius; $0 copay[1]	Up to 30 one-way trips per year to medical appointment/pharmacy, up to 50 miles away[1]
Home Delivered Meals	Up to 84 meals, three meals/day for a four-week period, one instance/year[1]	Unlimited, no charge[1]	Three meals/day for four-week period following discharge, when referred by case manager[1]
Mental Health (MH)[1]/Chemical Dependency (CD)[1]			
Inpatient	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	$15 copay; $7 copay (MH), $5 copay (CD) group visits; unlimited	No charge; unlimited (MH/CD)	$15 copay; unlimited visits

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

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

Summary of Benefits	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Hearing Services			
Hearing Exam	$15 copay	$10 copay	No charge
Medically Necessary Hearing Aid	$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
Retail Prescription Drugs[3]	Up to 100-day supply	Up to 100-day supply	Up to 30-day supply
Generic[5]	Generic- $15 Brand- $15	$5-$10 copay	Tier I generic $10/unit[4]
Preferred Brand[5]		$20 copay	Tier II brand $20/unit[4]
Non-Preferred Brands/ Non-Formulary[5]	Not applicable	Non-Preferred Brands $20 copay; Non-Formulary not covered	Tier III & IV $50/unit[4]
Mail Order Prescription Drugs[2,3]	Up to 100-day supply	Up to 100-day supply	Up to 90-day supply[4]
Generic	Generic- $15 Brand- $15	$10-$20 copay	Tier I generic $20
Preferred Brand		$40 copay	Tier II brand $40
Non-Preferred Brands/ Non-Formulary	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.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

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

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Anthem Blue Cross Life & Health Medicare Plan (Medicare Supp.)
Calendar Year Deductible		
Individual/Family	Not applicable	Medicare Part B deductible
Out-of-Pocket Maximum	Out-of-Pocket Maximum - Deductible Excluded	
Individual	$0	Not applicable
Family	Not applicable	
Lifetime Maximum		
	Unlimited	Unlimited
Preventive Care		
Routine Physical Examination	No charge	No charge (may include lab & X-ray)
Annual Pap Smear, Pelvic & Breast Exam	No charge	Anthem pays 20% after deductible[1]
Mammography		
Physician Services		
Office Visit	No charge[1]	Anthem pays 20% after deductible[1]
Specialist Care		
Inpatient Surgery		
Outpatient Surgery		
Telehealth/Virtual Visits		
Inpatient Hospital Room & Board		
	No charge	Plan pays Medicare Part A deductible & current per-day deductible from 61st - 90th day
Other Health Services		
Allergy Tests & Treatments	No charge for Medicare-covered allergy testing	Anthem pays 20% after deductible
Lab & X-ray	No charge for Medicare-covered services[1]	Anthem pays 20% after deductible[1]
Physical & Speech Therapy		
Dialysis and ESRD Services		

Anthem Blue Cross Life and Health Medicare Supplement Plan: Any portion of your medical expenses that are authorized but not paid for by Medicare will be covered. Medicare pays 80% of most medical services and Anthem pays the remaining 20% after the deductible has been reached.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

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

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Anthem Blue Cross Life & Health Medicare Plan (Medicare Supp.)
Skilled Nursing Facility	No charge in Medicare-covered, inpatient plan facility; limit 100 days each benefit period[1]	If approved by Medicare, pays per-day deductible from 21st - 100th day
Home Health Care	No charge when certified and ordered by Plan doctor	Anthem pays 20% after deductible
Hospice Services	No charge in Medicare-certified hospice[1]	Medicare pays all hospice claims
Ambulance	No charge for Medicare-covered services[1]	Anthem pays 20% after deductible
Durable Medical Equipment	No charge for Medicare-covered equipment[1]	Anthem pays 20% after deductible
Chiropractic Services	No charge for Medicare-covered visits/Non-Medicare, 30 visits/year, costs may apply[1]	In-Network $10 copay; 30 visits/year; Out-of-Network 70% UCR after deductible
Acupuncture Services	No charge for Medicare-covered visits, limit 20/Non-Medicare, 30 visits/year, costs may apply[1]	In-Network $10 copay; 30 visits/year; Out-of-Network 70% UCR after deductible
Emergency Room Visit	No charge in U.S. and while traveling	Anthem pays 20% after deductible within US or traveling
Urgent Care Visit		Anthem pays 20% after deductible
Transportation	12 one-way trips per calendar year; limits apply, advance notice required[1]	Transportation services outside of medically necessary ambulance services is not covered
Home Delivered Meals	Up to 56 meals per year, no charge[1]	Not applicable
Routine Foot Care & Compression Stockings	$0 copay, limits apply	Not applicable
Mental Health (MH)[1]/Chemical Dependency (CD)[1]		
Inpatient	No charge/admission as covered by Medicare; unlimited (MH/CD)	Plan pays Medicare Part A deductible & current per-day deductible from 61st - 90th day (MH/CD)
Outpatient	No charge for Medicare-covered therapy/hospitalization	Anthem pays 20% after deductible

Anthem Blue Cross Life and Health Medicare Supplement Plan: Any portion of your medical expenses that are authorized but not paid for by Medicare will be covered. Medicare pays 80% of most medical services and Anthem pays the remaining 20% after the deductible has been reached.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

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

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Anthem Blue Cross Life & Health Medicare Plan (Medicare Supp.)
Hearing Services		
Hearing Exam	No charge[1]	Covered under your Routine Physical Exam
Medically Necessary Hearing Aid	No deductible; up to $2,000 per ear every 36 months*	No deductible; up to $2,000 per ear every 36 months
Retail Prescription Drugs[3]	Up to 30-day supply	Up to 30-day supply
Generic[4]	$0 copay for select generics, $5 copay generics	$0 copay for select generics, $5 copay generics
Preferred Brand[4]	$25 copay	$25 copay
Non-Preferred Brands/ Non-Formulary[4]	$50 copay	$50 copay
Mail Order Prescription Drugs[2,3]	Up to 90-day supply	Up to 90-day supply
Generic	$0 copay for select generics, $10 copay generics	$0 copay for select generics, $10 copay generics
Preferred Brand	$50 copay	$50 copay
Non-Preferred Brands/ Non-Formulary	$100 copay	$100 copay

* Hearing aids for Anthem Medicare Preferred (PPO) must be ordered through Anthem hearing aid supplier, Hearing Care Solutions.

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. For Anthem diabetic supplies, a different copay may be required. Please see your Evidence of Coverage.

Anthem Blue Cross Life and Health Medicare Supplement Plan: Any portion of your medical expenses that are authorized but not paid for by Medicare will be covered. Medicare pays 80% of most medical services and Anthem pays the remaining 20% after the deductible has been reached.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

SCAN Health Plan and Anthem Medicare Preferred (PPO) Subscribers

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.

Enhanced Social Services Program Benefit	SCAN Independent Living Power (ILP)[1]	Anthem Blue Cross Medicare Preferred (PPO)[2]
Service Areas	Only in Los Angeles, Orange, Riverside, San Diego counties	Throughout the U.S.
Personal Emergency Response System	• Includes installation & monthly monitoring • $0 copay	• One in-home system and monthly monitoring • $0 copay
Transportation to Provider Visits	• Unlimited taxi rides per year • No charge[1]	• 12 one-way trips per year to medical visits, pharmacy, SilverSneakers, etc. within service area; 60 mile limit • Advanced scheduling required • No charge
Caregiver Relief *(Alternative Caregiver Provides Services When The Regular Caregiver Is Not Available)*	• In-home visits when regular caregiver cannot be there • Services include companionship, assistance with bathing, dressing, and light meal preparation • Adult day care – physical, social or intellectual exercises and stimulation for seniors • $15 per visit[1]	• In Home Support; Up to 30 hours per year of assistance with daily living activities *(Benefit halted until vendor is replaced)* • Adult Day Center, up to 8 hours, one day per week at a state-licensed adult day center – Prior plan approval required – Direct member reimbursement, up to $80 per visit
Personal Care and Homemaker Service	• Services include light housekeeping, laundry and meal preparation, grocery shopping, companionship, assistance with bathing and dressing • $15 per visit[1]	• Personal Home Helper, up to 124 hours (4 hours/day, max 31 days) of assistance to include light housekeeping, • help with dressing, eating, bathing/showering, and transferring/mobility help in home – Prior plan approval required – Direct member reimbursement, up to $100 per visit
Home Delivered Meals	• Unlimited; no charge[1]	• Healthy Meals; Up to 56 meals per year, no charge
Bathroom Safety/ Assistive Equipment	• $0 copay	• Up to $200 every year for items allowed by Medicare, order online or through the app
Over the Counter	• Not applicable	• Includes cough and cold, incontinence, and first aid • $30 per quarter, up to $120/year
Health Fitness Tracker	• Not applicable	• Includes one fitness tracking device every 2 years and membership to web-based memory fitness program

1. $850 allowance per month for all ILP services combined.
2. Anthem Medicare Supplement plan enrollees (Anthem Life and Health Medicare plan) are not eligible for these benefits.

LACERS Vision Plans

Kaiser Permanente

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

Medicare Status	Exam Copay
Under age 65 and not enrolled in Medicare	$20
If you have Medicare Part B Only	$15
If you have Medicare Parts A & B	$15

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 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.

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

If enrolled in the **Anthem Medicare Preferred PPO plan**, enrollees have two plans with vision benefits. When you visit your eye doctor, they will have both of your vision plans in their system. If you use all the benefits from your Blue View Vision plan, you can begin using your **Anthem Medicare Preferred PPO** vision benefits. For example, if your frames cost more than the $150 allowance included with your Blue View Vision plan, you can use the frames allowance from your Anthem PPO plan to make up the difference.

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)**	
Exam	Every 12 months[1]		$20 Kaiser Permanente HMO, $15 Kaiser Permanente Senior Advantage
	$20 copay	Up to $49	
Lenses and Options	Every 12 months[1,3]		Every 24 months
Single Vision Bifocal Trifocal Lenticular Tint/photochromic Scratch coating Polycarbonate	Paid in full[2]	Up to $45 Up to $65 Up to $85 Up to $125 Up to $5 Not covered Not covered	Up to $150 for all frames, lenses or contacts
Progressive	$30 additional copay	Up to $85	
Frame Allowance	Every 24 months[1]		
One pair	$150 allowance, then 20% off any remaining balance	Up to $70	
Contact Lenses Allowance	Every 12 months[1,2,4] (Instead of glasses)		
Elective conventional ***or***	Up to $120, then 15% off any remaining balance	Up to $105	
Elective disposable ***or***	Up to $120, no additional discount	Up to $105	
Medically Necessary	Paid in full[5]	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.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

Medical Plan Premiums (Includes Vision Benefits)

	PPO		HMO/Senior Plans				
	U.S.	U.S.	CA			NV	AZ
	Anthem PPO / Anthem Medicare Preferred (PPO) Plan	Anthem PPO / Anthem Life & Health Medicare Plan (Med. Supp.)	Kaiser Permanente HMO/ Sr. Advantage[1]	SCAN Health Plan & Anthem HMO[3]	United-Healthcare HMO & Anthem HMO[3]	UnitedHealthcare HMO	
Retiree/Survivor Only	**Monthly Premiums**						
Under 65 or over 65 w/Medicare Part B only[1]	$1,593.73	$1,593.73	$1,051.78	$1,273.03	$1,273.03	N/A	N/A
65 or older w/Medicare Parts A & B	$435.26	$549.16	$262.47	$226.93	$247.56	$217.27	$322.08
Retiree/Survivor & 1 Dependent	**Monthly Premiums**						
Both under 65 or both 65 or older w/Medicare Part B only	$3,182.43	$3,182.43	$2,103.56	$2,541.03	$2,541.03	N/A	N/A
Retired Member under 65 and Dependent 65 or older w/Medicare Parts A & B	$2,023.96	$2,137.86	$1,288.44	$1,494.93	$1,515.56	N/A	N/A
Retired Member 65 or older w/Medicare Parts A & B and Dependent under 65	$2,023.96	$2,137.86	$1,288.44	$1,494.93	$1,515.56	N/A	N/A
Retired Member & Dependent both 65 or older, both w/Medicare Parts A & B	$865.49	$1,093.29	$524.94	$448.83	$490.08	$429.51	$639.12

Note: Premium rates include Vision benefits. All of the above rates are effective from January 1, 2024 through December 31, 2024.

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 & B of Medicare.
2. Family = 2 or more dependents.
3. Dual Care Households - Person(s) with Medicare Parts A & B would be enrolled in SCAN or UnitedHealthcare while the other person(s) under age 65 or has Medicare Part B Only is enrolled in Anthem Blue Cross HMO.

	PPO		HMO/Senior Plans				
	U.S.	U.S.	CA			NV	AZ
	Anthem PPO / Anthem Medicare Preferred (PPO) Plan	Anthem PPO / Anthem Life & Health Medicare Plan (Med. Supp.)	Kaiser Permanente HMO/ Sr. Advantage[1]	SCAN Health Plan & Anthem HMO[3]	UnitedHealthcare HMO & Anthem HMO[3]	UnitedHealthcare HMO	
Retiree/Survivor & Family[2]	**Monthly Premiums**						
Retired Member & Family under 65 or 65 or older w/Medicare Part B only[1]	$3,747.46	$3,747.46	$2,734.63	$3,309.78	$3,309.78	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	$2,588.99	$2,702.89	$1,919.50	$2,263.68	$2,284.31	N/A	N/A
Retired Member 65 or older w/Medicare Parts A & B and Family w/o Medicare	$2,588.99	$2,702.89	$1,919.50	$2,263.68	$2,284.31	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	$1,430.52	$1,658.32	$1,107.84	$1,217.58	$1,258.83	N/A	N/A

Note: Premium rates include Vision benefits. All of the above rates are effective from January 1, 2024 through December 31, 2024.

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 & B of Medicare.
2. Family = 2 or more dependents.
3. Dual Care Households - Person(s) with Medicare Parts A & B would be enrolled in SCAN or UnitedHealthcare while the other person(s) under age 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 14 for Retired Member medical subsidy eligibility, Page 15 for Retired Member Medical Subsidy charts, and Page 63 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 2024 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	Kaiser	Anthem HMO
Monthly Premiums	**$1,593.73**	**$1,051.78**	**$1,273.03**
Service/Service Credit*	**Monthly Allowance Deduction**		
10	$718.70	$176.75	$398.00
11	$631.19	$89.24	$310.49
12	$543.69	$1.74	$222.99
13	$456.19	$0.00	$135.49
14	$368.69	$0.00	$47.99
15	$281.18	$0.00	$0.00
16	$193.68	$0.00	$0.00
17	$106.18	$0.00	$0.00
18	$18.67	$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 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

Retired Member Only with Medicare Parts A & B

	PPO (U.S.)		HMO Senior Plans				
	Anthem Medicare Preferred (PPO) Plan	Anthem Life & Health Medicare Plan (Med. Supp.)	CA – Kaiser Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	**$435.26**	**$549.16**	**$262.47**	**$226.93**	**$247.56**	**$322.08**	**$217.27**
Service/ Service Credit*	**Monthly Allowance Deduction**						
10 to 14	$108.81	$137.29	$65.62	$56.73	$61.89	$80.52	$54.32
15 to 19	$43.53	$54.92	$26.25	$22.69	$24.76	$32.21	$21.73
20 to 24	$0.00	$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	$0.00

* Refer to Page 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

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

	PPO (U.S.)	HMO (CA)	
	Anthem	Kaiser	Anthem HMO
Monthly Premiums	**$3,182.43**	**$2,103.56**	**$2,541.03**
Service/ Service Credit*	**Monthly Allowance Deduction**		
10	$2,307.40	$1,228.53	$1,666.00
11	$2,219.89	$1,141.02	$1,578.49
12	$2,132.39	$1,053.52	$1,490.99
13	$2,044.89	$966.02	$1,403.49
14	$1,957.39	$878.52	$1,315.99
15	$1,869.88	$791.01	$1,228.48
16	$1,782.38	$703.51	$1,140.98
17	$1,694.88	$616.01	$1,053.48
18	$1,607.37	$528.50	$965.97
19	$1,519.87	$441.00	$878.47
20	$1,432.37	$353.50	$790.97
21	$1,344.86	$265.99	$703.46
22	$1,257.36	$178.49	$615.96
23	$1,169.86	$90.99	$528.46
24	$1,082.35	$3.48	$440.95
25+	$994.85	$0.00	$353.45

* Refer to Page 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

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

	PPO (U.S.)		HMO/Senior Plan (CA)		
	Anthem PPO / Anthem Medicare Preferred (PPO) Plan	Anthem PPO / Anthem Life & Health Medicare Plan (Med. Supp.)	Kaiser HMO / Kaiser Sr. Advantage	Anthem HMO / SCAN Health Plan	Anthem HMO / UnitedHealthcare HMO
Monthly Premiums	**$2,023.96**	**$2,137.86**	**$1,288.44**	**$1,494.93**	**$1,515.56**
Service/ Service Credit*	**Monthly Allowance Deduction**				
10	$1,148.93	$1,262.83	$413.41	$619.90	$640.53
11	$1,061.42	$1,175.32	$325.90	$532.39	$553.02
12	$973.92	$1,087.82	$238.40	$444.89	$465.52
13	$886.42	$1,000.32	$150.90	$357.39	$378.02
14	$798.92	$912.82	$63.40	$269.89	$290.52
15	$711.41	$825.31	$0.00	$182.38	$203.01
16	$623.91	$737.81	$0.00	$94.88	$115.51
17	$536.41	$650.31	$0.00	$7.38	$28.01
18	$448.90	$562.80	$0.00	$0.00	$0.00
19	$361.40	$475.30	$0.00	$0.00	$0.00
20	$273.90	$387.80	$0.00	$0.00	$0.00
21	$186.39	$300.29	$0.00	$0.00	$0.00
22	$98.89	$212.79	$0.00	$0.00	$0.00
23	$11.39	$125.29	$0.00	$0.00	$0.00
24	$0.00	$37.78	$0.00	$0.00	$0.00
25+	$0.00	$0.00	$0.00	$0.00	$0.00

* Refer to Page 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

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

	PPO (U.S.)		Senior Plans (CA) / HMO		
	Anthem Medicare Preferred (PPO) Plan / Anthem PPO	Anthem Life & Health Medicare Plan (Med. Supp.) / Anthem PPO	Kaiser Sr. Advantage / Kaiser HMO	SCAN Health Plan / Anthem HMO	UnitedHealthcare HMO / Anthem HMO
Monthly Premiums	**$2,023.96**	**$2,137.86**	**$1,288.44**	**$1,494.93**	**$1,515.56**
Service/ Service Credit*	**Monthly Allowance Deduction**				
10	$1,697.51	$1,725.99	$1,091.59	$1,324.73	$1,329.89
11	$1,697.51	$1,725.99	$1,091.59	$1,324.73	$1,329.89
12	$1,697.51	$1,725.99	$1,091.59	$1,324.73	$1,329.89
13	$1,697.51	$1,725.99	$1,005.83	$1,324.73	$1,329.89
14	$1,697.51	$1,725.99	$918.33	$1,324.73	$1,329.89
15	$1,632.23	$1,643.62	$791.45	$1,251.17	$1,253.24
16	$1,632.23	$1,643.62	$703.95	$1,163.67	$1,165.74
17	$1,632.23	$1,643.62	$616.45	$1,076.17	$1,078.24
18	$1,632.23	$1,643.62	$528.94	$988.66	$990.73
19	$1,563.40	$1,574.79	$441.44	$901.16	$903.23
20	$1,432.37	$1,432.37	$327.69	$790.97	$790.97
21	$1,344.86	$1,344.86	$240.18	$703.46	$703.46
22	$1,257.36	$1,257.36	$152.68	$615.96	$615.96
23	$1,169.86	$1,169.86	$65.18	$528.46	$528.46
24	$1,082.35	$1,082.35	$0.00	$440.95	$440.95
25+	$994.85	$994.85	$0.00	$353.45	$353.45

* Refer to Page 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

Retired Member and Dependent with Medicare Parts A & B

	PPO (U.S.)		HMO Senior Plans				
	Anthem Medicare Preferred (PPO) Plan	Anthem Life & Health Medicare Plan (Med. Supp.)	CA – Kaiser Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	**$865.49**	**$1,093.29**	**$524.94**	**$448.83**	**$490.08**	**$639.12**	**$429.51**
Service/ Service Credit*	**Monthly Allowance Deduction**						
10	$539.04	$681.42	$328.09	$278.63	$304.41	$397.56	$266.56
11	$539.04	$681.42	$328.09	$278.63	$304.41	$397.56	$266.56
12	$539.04	$681.42	$328.09	$278.63	$304.41	$397.56	$266.56
13	$539.04	$681.42	$242.33	$278.63	$304.41	$397.56	$266.56
14	$539.04	$681.42	$154.83	$278.63	$304.41	$397.56	$266.56
15	$473.76	$599.05	$27.95	$205.07	$227.76	$309.73	$194.45
16	$473.76	$599.05	$26.25	$117.57	$140.26	$222.23	$106.95
17	$473.76	$599.05	$26.25	$30.07	$52.76	$134.73	$21.73
18	$473.76	$599.05	$26.25	$22.69	$24.76	$47.22	$21.73
19	$404.93	$530.22	$26.25	$22.69	$24.76	$32.21	$21.73
20	$273.90	$387.80	$0.00	$0.00	$0.00	$0.00	$0.00
21	$186.39	$300.29	$0.00	$0.00	$0.00	$0.00	$0.00
22	$98.89	$212.79	$0.00	$0.00	$0.00	$0.00	$0.00
23	$11.39	$125.29	$0.00	$0.00	$0.00	$0.00	$0.00
24	$0.00	$37.78	$0.00	$0.00	$0.00	$0.00	$0.00
25+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

* Refer to Page 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

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

	PPO (U.S.)		Senior Plans (CA) / HMO		
	Anthem Medicare Preferred (PPO) Plan / Anthem PPO	Anthem Life & Health Medicare Plan (Med. Supp.) / Anthem PPO	Kaiser Sr. Advantage / Kaiser HMO	SCAN Health Plan / Anthem HMO	United-Healthcare HMO / Anthem HMO
Monthly Premiums	**$2,588.99**	**$2,702.89**	**$1,919.50**	**$2,263.68**	**$2,284.31**
Service/ Service Credit*	**Monthly Allowance Deduction**				
10	$2,262.54	$2,291.02	$1,722.65	$2,093.48	$2,098.64
11	$2,262.54	$2,291.02	$1,722.65	$2,093.48	$2,098.64
12	$2,262.54	$2,291.02	$1,722.65	$2,093.48	$2,098.64
13	$2,262.54	$2,291.02	$1,636.89	$2,093.48	$2,098.64
14	$2,262.54	$2,291.02	$1,549.39	$2,093.48	$2,098.64
15	$2,197.26	$2,208.65	$1,422.51	$2,019.92	$2,021.99
16	$2,197.26	$2,208.65	$1,335.01	$1,932.42	$1,934.49
17	$2,197.26	$2,208.65	$1,247.51	$1,844.92	$1,846.99
18	$2,197.26	$2,208.65	$1,160.00	$1,757.41	$1,759.48
19	$2,128.43	$2,139.82	$1,072.50	$1,669.91	$1,671.98
20	$1,997.40	$1,997.40	$958.75	$1,559.72	$1,559.72
21	$1,909.89	$1,909.89	$871.24	$1,472.21	$1,472.21
22	$1,822.39	$1,822.39	$783.74	$1,384.71	$1,384.71
23	$1,734.89	$1,734.89	$696.24	$1,297.21	$1,297.21
24	$1,647.38	$1,647.38	$608.73	$1,209.70	$1,209.70
25+	$1,559.88	$1,559.88	$521.23	$1,122.20	$1,122.20

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 2024 Health Benefits Guide Supplement for your subsidy information and monthly deduction charts. For more information, contact LACERS.

* Refer to Page 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

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

	PPO (U.S.)	HMO (CA)	
	Anthem	Kaiser**	Anthem HMO
Monthly Premiums	**$3,747.46**	**$2,734.63**	**$3,309.78**
Service/ Service Credit*	**Monthly Allowance Deduction**		
10	$2,872.43	$1,859.60	$2,434.75
11	$2,784.92	$1,772.09	$2,347.24
12	$2,697.42	$1,684.59	$2,259.74
13	$2,609.92	$1,597.09	$2,172.24
14	$2,522.42	$1,509.59	$2,084.74
15	$2,434.91	$1,422.08	$1,997.23
16	$2,347.41	$1,334.58	$1,909.73
17	$2,259.91	$1,247.08	$1,822.23
18	$2,172.40	$1,159.57	$1,734.72
19	$2,084.90	$1,072.07	$1,647.22
20	$1,997.40	$984.57	$1,559.72
21	$1,909.89	$897.06	$1,472.21
22	$1,822.39	$809.56	$1,384.71
23	$1,734.89	$722.06	$1,297.21
24	$1,647.38	$634.55	$1,209.70
25+	$1,559.88	$547.05	$1,122.20

* Refer to Page 14 for Retired Member Medical Subsidy Eligibility and Page 63 for how subsidy is calculated by employment type.

** Kaiser B Only Family plan premium and deductions are not included in this chart.

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 continuance or survivorship allowance. You may find further information on Pages 16, Eligible Survivor Benefits.

Eligible Survivor not in Medicare or with Medicare Part B Only

	PPO (U.S.)	HMO (CA)	
	Anthem	Kaiser	Anthem HMO
Monthly Premiums	**$1,593.73**	**$1,051.78**	**$1,273.03**
Service/ Service Credit*	**Monthly Allowance Deduction**		
10	$1,173.02	$631.07	$852.32
11	$1,130.95	$589.00	$810.25
12	$1,088.88	$546.93	$768.18
13	$1,046.80	$504.85	$726.10
14	$1,004.73	$462.78	$684.03
15	$962.66	$420.71	$641.96
16	$920.59	$378.64	$599.89
17	$878.52	$336.57	$557.82
18	$836.45	$294.50	$515.75
19	$794.38	$252.43	$473.68
20	$752.31	$210.36	$431.61
21	$710.23	$168.28	$389.53
22	$668.16	$126.21	$347.46
23	$626.09	$84.14	$305.39
24	$584.02	$42.07	$263.32
25+	$541.95	$0.00	$221.25

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 16 for Eligible Survivor Medical Subsidy.

* Refer to Retired Member Medical Subsidy Eligibility on Page 15 and Page 63 for how subsidy is calculated by employment type.

Eligible Survivor with Medicare Parts A & B

	PPO (U.S.)		HMO Senior Plans				
	Anthem Medicare Preferred (PPO) Plan	Anthem Life & Health Medicare Plan (Medicare Supp.)	CA – Kaiser Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	**$435.26**	**$549.16**	**$262.47**	**$226.93**	**$247.56**	**$322.08**	**$217.27**
Service/ Service Credit*	**Monthly Allowance Deduction**						
10 to 14	$108.81	$137.29	$65.62	$56.73	$61.89	$80.52	$54.32
15 to 19	$43.53	$54.92	$26.25	$22.69	$24.76	$32.21	$21.73
20+	$0.00	$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 16 for Eligible Survivor Medical Subsidy.

* Refer to Retired Member Medical Subsidy Eligibility on Page 15 and Page 63 for how subsidy is calculated by employment type.

LACERS Dental Plans

LACERS offers two dental plans: Delta Dental PPO℠ and DeltaCare USA® 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 each other's plan.

Dental insurance cards an be viewed and printed online from the Delta Dental website. Dental insurance cards will not be mailed.

Availability	Delta Dental PPO	DeltaCare USA DHMO
U.S. and Its Territories	✓	
California and Nevada	✓	✓[1]
Outside the U.S.	✓	

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

Delta Dental PPO℠

You may visit any licensed dentist, 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® dentist. However, the costs will be higher compared to a PPO dentist. It may or may not be 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® 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).

LACERS Dental Subsidy

Dental Subsidy Eligibility

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

The LACERS 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, Retired Members must:

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

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 dental subsidy because the minimum 10 years of Service or Service Credit has not been met. Please refer to the Glossary on Page 59 for the definitions of Service and Service Credit. See also Page 63 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.

2024 Dental Subsidy

Service/ Service Credit*	% of Maximum	Delta Dental PPO Subsidy Amount	DeltaCare USA DHMO Subsidy Amount
10	40%	$17.17	$6.04
11	44%	$18.89	$6.64
12	48%	$20.61	$7.25
13	52%	$22.32	$7.85
14	56%	$24.04	$8.46
15	60%	$25.76	$9.06
16	64%	$27.48	$9.66
17	68%	$29.19	$10.27
18	72%	$30.91	$10.87
19	76%	$32.63	$11.48
20	80%	$34.34	$12.08
21	84%	$36.06	$12.68
22	88%	$37.78	$13.29
23	92%	$39.50	$13.89
24	96%	$41.21	$14.50
25+	100%	$42.93	$15.10

* Refer to Page 63 for how subsidy is calculated by employment type.

Dental Plan Comparison Chart

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

1. 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.
2. If you use both PPO and Non-PPO dentists, your total annual maximum benefit will never be more than the Annual Maximum Benefit.
3. Services conducted by a Delta Dental PPO℠ contracted provider are reimbursed at the PPO schedule of benefits and subject to the PPO Fee Schedule.
4. Services conducted by a Delta Dental Premier® contracted provider are reimbursed at the Non-PPO schedule, and subject to the Premier Fee Schedule.
5. 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.
6. 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.
7. 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.
8. Plus the cost of precious/semi-precious metal and porcelain.
9. Crowns are considered a Basic service under the Delta Dental PPO plan.
10. DeltaCare USA DHMO children under age 19; Delta Dental PPO children under age 26.
11. Copay covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $25 may apply.
12. Delta Dental PPO: Bite-wing x-rays for adults are once in a calendar year.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. See plan's Evidence of Coverage for limitations and details.

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[1]	$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
Monthly Premiums	**$51.16**	**$15.10**	**$101.45**	**$28.19**	**$146.56**	**$32.59**
Service/ Service Credit*	**Monthly Allowance Deduction**					
10	$33.99	$9.06	$84.28	$22.15	$129.39	$26.55
11	$32.27	$8.46	$82.56	$21.55	$127.67	$25.95
12	$30.55	$7.85	$80.84	$20.94	$125.95	$25.34
13	$28.84	$7.25	$79.13	$20.34	$124.24	$24.74
14	$27.12	$6.64	$77.41	$19.73	$122.52	$24.13
15	$25.40	$6.04	$75.69	$19.13	$120.80	$23.53
16	$23.68	$5.44	$73.97	$18.53	$119.08	$22.93
17	$21.97	$4.83	$72.26	$17.92	$117.37	$22.32
18	$20.25	$4.23	$70.54	$17.32	$115.65	$21.72
19	$18.53	$3.62	$68.82	$16.71	$113.93	$21.11
20	$16.82	$3.02	$67.11	$16.11	$112.22	$20.51
21	$15.10	$2.42	$65.39	$15.51	$110.50	$19.91
22	$13.38	$1.81	$63.67	$14.90	$108.78	$19.30
23	$11.66	$1.21	$61.95	$14.30	$107.06	$18.70
24	$9.95	$0.60	$60.24	$13.69	$105.35	$18.09
25+	$8.23	$0.00	$58.52	$13.09	$103.63	$17.49

* Refer to Dental Subsidy Eligibility on Page 53 and Page 63 for how subsidy is calculated by employment type.

LACERS Well

What is LACERS Well?

LACERS Well is an innovative program designed to help our Members enhance the quality of life and retirement by providing resources and activities that promote optimal health and wellness.

- 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.

For more information: visit lacers.org/lacers-well, contact LACERS at (800) 779-8328, or send an email to 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 from *Well-Being: The Five Essential Elements* by Tom Rath and Jim Carter.

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.

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 Life & Health Medicare Plan (Medicare Supplement), 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

Anthem Blue Cross Life & Health Medicare Plan (Medicare Supplement): A Medicare Supplement PPO plan offered by Anthem Blue Cross and is available to Members with Medicare Parts A & B. Medicare is primary for medical services and Anthem is secondary. Medicare Part D (Rx) is assigned to Anthem. This plan is also known as Assurance Plus 1.

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 & B. Your Medicare Parts A, B, and D (Rx) is assigned to Anthem. All claims go to Anthem.

Carrier: A health insurance organization 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. Annually, CMS publishes Medicare Parts A & B premiums and deductibles, and Part D IRMAA. See also Income-Related Monthly Adjustment Amount (IRMAA) and Social Security Administration (SSA). For questions about CMS, contact CMS using the back of this Guide.

Claim: A request for payment that you or your health care provider submits to your health insurer when you get items or services that may be 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 amounts 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 Allowance: 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, continuance, or survivorship 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. See Page 5 for more details.

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) who has both Medicare Parts A & B and at least one person who does not have Medicare or only has Medicare Part 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 Continuance or Survivorship benefit from LACERS.

Evidence of Coverage (EOC): A document that describes the coverage offered. EOCs for LACERS-sponsored health plans may be found online at lacers.org/evidence-coverage.

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.

Income-Related Monthly Adjustment Amount (IRMAA): A surcharge on top of the basic/standard Medicare Part B and Part D premiums if your modified adjusted gross income of two years prior (i.e., 2024 IRMAA is based on 2022 tax return information) is above annual thresholds determined by Centers for Medicare & Medicaid Services (CMS). Please contact CMS and SSA for more details.

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 CA-HMO or Medicare Advantage 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 37 for Anthem Medicare Preferred (PPO) Enhanced Social Services Program.

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 24 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 & 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.

Social Security Administration (SSA): SSA works, in relation to Centers for Medicare & Medicaid Services (CMS), to process Medicare applications, Medicare replacement cards, and provide general Medicare information. SSA will tell you if you have to pay IRMAA on top of your basic/standard Medicare Part B and D premium. If you have any questions about SSA, contact SSA using the back of this Guide. See also CMS and IRMAA.

Subsidy: A benefit for eligible LACERS Retired Members and eligible Survivors 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 14-17.) Only Retired Members may be eligible for dental subsidy (i.e., neither dependents nor eligible Survivors are eligible for LACERS dental subsidy).

Survivor: See Eligible Surviving Spouse/Domestic Partner.

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

For your convenience, excerpts of the Los Angeles Administrative Code (LAAC) and LACERS Board Manual 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 Board Manual § 4.1 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 Board Manual § 4.1 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 10 Years Minimum = 40% Health Subsidy, 4% for each full year after 10 years
	Age	City Service	Health Service Credit	
Full-time	55+	≥ 10 Years	≥ 10	Service Credit × 4%
Part-time	55+	≥ 10 Years	1-10	40% base subsidy + 4% for each full year of City Service after 10 years

Became LACERS Member After April 22, 1990, including Tier 3 Part-Time effective February 21, 2016

Member Type	Subsidy Eligibility*			Subsidy Calculation 10 Years Minimum = 40% Health Subsidy, 4% for each full year after 10 years
	Age	City Service	Health Service Credit	
Full-time	55+	≥ 10 Years	≥ 10	Service Credit × 4%
Part-time	55+	≥ 10 Years	1-10	40% base subsidy + 4% for each full year of City Service after 10 years

*** 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 (e.g., 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	2024 Subsidy Amount
10		40%	See medical subsidy chart on Page 15; See dental subsidy chart on Page 53
11 to 25+	*On/before 04/22/1990: based on Service	4% for each full additional year	
	*After 04/22/1990: based on Service Credit		

Appendix: Official Health Plan Names

Carriers	Plans	Member/Survivor's Residence	Official Name according to Plan's Evidence of Coverage
Anthem Blue Cross	HMO – under age 65 or 65+ with only Medicare Part B and no Part D	CA	Your Anthem Blue Cross HMO Plan
	HMO – age 65+ with only Medicare Parts B and D		
	PPO – under age 65	CA	Prudent Buyer®
	PPO – age 65+ with Medicare Parts B and D		
	PPO – under age 65	Non-CA state	PPO (non-California resident)
	PPO – age 65+ with Medicare Parts B and D		
	Medicare Preferred (PPO) with Senior Rx Plus – Medicare Parts A and B MAPD	U.S. and its territories	Anthem Medicare Preferred (PPO) with Senior Rx Plus
	MedicareRx (PDP) with Senior Rx Plus – Part B PDP	U.S. and its territories	Blue Cross MedicareRx (PDP) with Senior Rx Plus
	Life and Health Medicare Plan (Medicare Supplement)	U.S. and its territories	Assurance Plus 1
	Out-of-Country	Outside of U.S. and its territories	Fee-for-Service Medical
Kaiser Permanente	Traditional HMO (non-Medicare)	SoCal / NorCal	Kaiser Permanente Traditional HMO
	Senior Advantage HMO with Part D	SoCal / NorCal	Kaiser Permanente Senior Advantage (HMO) with Part D
SCAN Health Plan	SCAN Medicare Advantage Plan (HMO)	CA	SCAN Medicare Advantage Plan
UnitedHealthcare	UnitedHealthcare Medicare Advantage (HMO)	SoCal / NorCal / AZ / NV	UnitedHealthcare® Group Medicare Advantage (HMO)
Anthem Blue Cross	Blue View Vision	U.S. and its territories	Blue View Vision
Delta	DeltaCare USA HMO	CA / NV	Dental Health Care Plan
	Delta Dental PPO	U.S. and its territories	Delta Dental PPO

Notes

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

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