Anthem®

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

MEDICARE
Group Plan

Your Medicare Advantage Enrollment Guide

LACERS - Part A and B MAPD
Anthem Medicare Preferred (PPO) with Senior Rx Plus
1/1/2022 - 12/31/2022

Look inside!

SilverSneakers® fitness program
Healthy meal delivery
Healthy pantry
Non-emergency transportation
LiveHealth Online

Plan benefits, tools, and resources

The page with this icon lists the steps to take to enroll. It appears after the Benefits Charts.

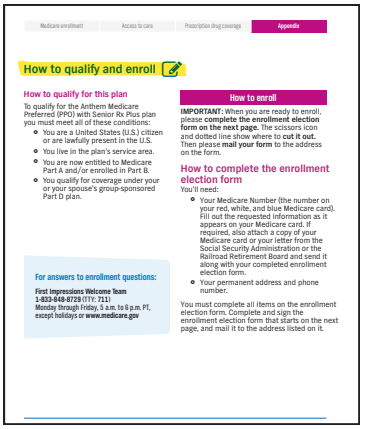
Plan highlights and enrollment

LACERS offers you this Anthem Medicare Preferred (PPO) with Senior Rx Plus plan. It is both a **Medicare Advantage** plan and a **PPO*** plan from Anthem BC Health Insurance Company. This Anthem plan gives you benefits Original Medicare covers and beyond, including:

- **Medical Benefits**
  - **A $0 copay for an Annual Wellness visit when you see a doctor in the plan**
  - **National Access Plus, which allows you to see any doctor who accepts both Medicare and the plan. You don't need to see in-network doctors to pay the lower in-network price. See page 11 for more details.**
- **Prescription drug benefits**
  - **Coverage on commonly prescribed drugs, plus Extra Covered Drugs**
  - **$0 copays on Select Generics**
  - **Plan pharmacies nationwide**
- **Additional benefits**
  - **SilverSneakers®**
  - **LiveHealth® Online**
  - **Discounted rates on health products and services**

For enrollment assistance from a live person here in the United States, you can call our **First Impressions Welcome Team**. This team can answer your questions, review plan details, and check drug coverage and costs.

If you are ready to enroll, please see the page titled "How to qualify and enroll" that looks like this. It comes after the Benefits Charts.


Medicare enrollment | Access to care | Prescription drug coverage | Appendix

How to qualify and enroll

How to qualify for this plan

To qualify for the Anthem Medicare Preferred (PPO) with Senior Rx Plus plan you must meet all of these conditions:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and/or enrolled in Part B.
- You qualify for coverage under your or your spouse's group-sponsored Part D plan.

For answers to enrollment questions:

First Impressions Welcome Team
1-833-848-8729 (TTY: 711)
Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays or www.medicare.gov

How to enroll

IMPORTANT: When you are ready to enroll, please **complete the enrollment election form on the next page.** The scissors icon and dotted line show where to **cut it out.** Then please **mail your form** to the address on the form.

How to complete the enrollment election form

You'll need:

- Your Medicare Number (the number on your red, white, and blue Medicare card). Fill out the requested information as it appears on your Medicare card. If required, also attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board and send it along with your completed enrollment election form.
- Your permanent address and phone number.

You must complete all items on the enrollment election form. Complete and sign the enrollment election form that starts on the next page, and mail it to the address listed on it.

For a smooth enrollment, please make sure that both the Social Security Administration and LACERS have your most current information and that their records match.

First Impressions Welcome Team
1-833-848-8729 (TTY: **711**) Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays

* PPO stands for preferred provider organization. PPOs use a network of hospitals and doctors.

The ABCDs of Medicare

This is a Medicare Advantage plan with Part D.

Medicare is a federal government health insurance program available to people:

- Over age 65.
- Under age 65 with certain disabilities.
- With end-stage renal disease (ESRD).
- With amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

Medicare comes in parts, known as A, B, C, and D

Part A (hospital insurance) comes from the government.

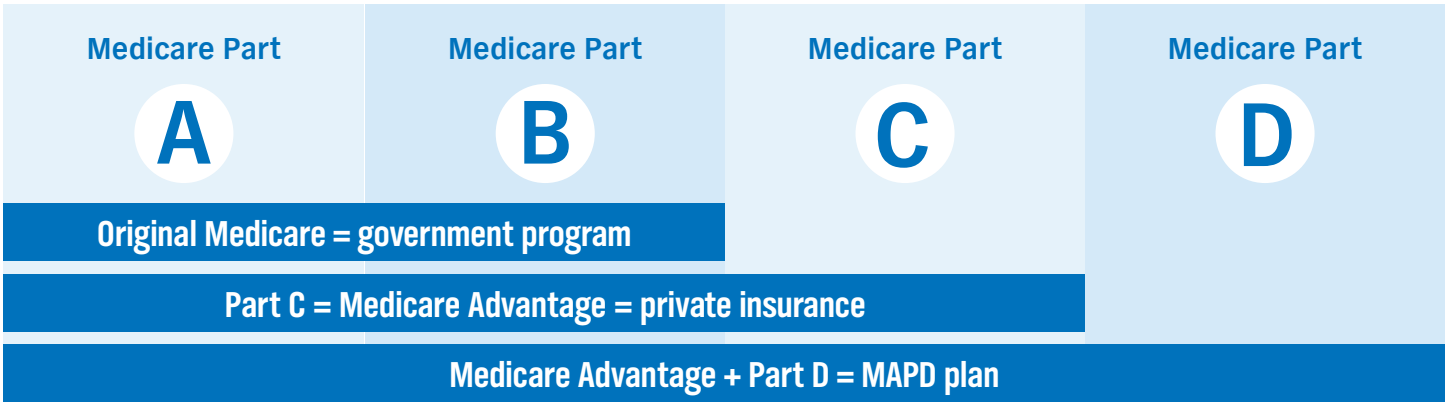
Part B (medical insurance) comes from the government.

Together they are called **Original Medicare**, the government program.

Part C (Medicare Advantage) covers Parts A and B, plus offers additional benefits. It only comes from private insurance companies like ours.

Part D (prescription drug coverage) covers drugs and only comes from private insurance companies like ours. When combined with Part C, it is known as a Medicare Advantage plan with prescription drug coverage (MAPD).

You can learn more about Medicare at **www.medicare.gov** or **1-800-MEDICARE** (**1-800-633-4227**), TTY: **1-877-486-2048**, 24/7.



Safeguards and savings with Medicare Advantage

For medical care, drugs, and the unexpected, Medicare Advantage plans offer you an advantage compared to Original Medicare.

As a Medicare Advantage member, there is a limit set on how much you'll spend out of pocket each year on medical expenses. Medicare Advantage plans also often use fixed prices that help you anticipate costs.

If something unexpected happens while traveling outside of the United States, Medicare Advantage members have emergency care coverage.

Medicare Advantage prescription drug coverage is something Original Medicare doesn't offer. Whether or not you take prescription drugs, you'll have the coverage in place if you need it.

You can secure these additional benefits when you enroll in a Medicare Advantage plan like this one.

Original Medicare	Medicare Advantage
No limit to medical costs members pay annually — no annual out-of-pocket maximum	**Plan pays 100%** of covered medical costs for rest of plan year after max out-of-pocket met*
Members pay **percentages of costs** (20% coinsurance for common services like outpatient surgery and doctor visits)	Members often pay copays (**fixed dollar amounts**) for more transparency
No emergency care coverage outside of U.S.	**Emergency care** is covered outside of U.S.
No Part D prescription drug coverage	Many plans include **drug coverage**

For answers to Medicare Advantage questions:

First Impressions Welcome Team
1-833-848-8729 (TTY: **711**) Monday through Friday, 5 a.m. to 6 p.m. PT, except

* You can view the full details of covered services in the Benefits Charts in the back of this guide. Not all medical costs are included in or are subject to the annual out-of-pocket maximum.

Plan definitions

These frequently used terms may appear in your Benefits Charts and this guide.

Care

Facility A location for receiving care. Examples: hospital, skilled nursing facility (SNF), imaging center.

Inpatient care Medical treatment for someone formally admitted to a facility with a doctor's order. Without a doctor's order, it may be considered outpatient care, even if you stay overnight.

Outpatient care Medical treatment for someone not admitted to a facility. May take place in a doctor's office, clinic, or hospital outpatient department.

Preventive care Services and treatment to prevent illness or injury. Examples: Annual Wellness Visit, screenings, diet or exercise counseling.

Primary care provider (PCP) A general practice doctor who treats basic medical conditions and is often the first doctor patients see for health concerns.

PCPs provide checkups, vaccinations, and screenings. They help diagnose conditions and refer to specialists when needed.

You are not required to select a PCP.

Provider A medical professional who provides care. Examples: doctor, specialist, physician assistant, nurse practitioner, nurse.

Cost

Allowed amount The maximum amount the plan pays for each covered service.

Annual out-of-pocket maximum (or max OOP) Maximum amount you pay for medical costs each plan year. After paying the max OOP, you pay nothing for covered services until the next plan year. Copays, coinsurance, and deductibles count toward the max OOP, but not all costs do.

Benefits Charts The complete list of medical care and drugs the plan covers. They appear in the back of this guide.

Coinsurance* A percentage you pay for covered services or drugs after paying your deductible. The plan pays the rest.

Copay* A fixed dollar amount you pay for covered services or drugs after paying your deductible. The plan pays the rest.

Cost share* (also called "cost-sharing amount" or "your share of the costs") Usually a copay or coinsurance, this is the amount you pay for covered services or drugs, while the plan pays the rest.

Covered services and drugs Medical care and drugs your plan pays for under the plan terms.

Deductible* The fixed dollar amount you pay for medical care or drugs before the plan begins to pay.

This plan does not have a deductible. You pay only your cost share once your membership starts.

* These terms may not apply to your plan. Please see the Benefits Charts for the full plan details.

Medical benefit highlights

You have coverage for these health services.

Health and wellness

- Preventive care services
- Flu and pneumonia vaccines and most health screenings
- Inpatient hospital care and ambulance services
- Emergency and urgent care
- Skilled nursing facility benefits
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Lab services and outpatient X-rays
- Home health agency care
- Tobacco-cessation counseling
- Non-emergency transportation

Nutrition

- Diabetes services and supplies
- Healthy Meals
- Healthy Pantry

Devices

- Durable medical equipment and related supplies
- Prosthetic devices
- Personal emergency response system (PERS)
- Wearable health and fitness tracker
- Assistive devices

Programs and services

- 24/7 NurseLine
- Outpatient surgery and rehabilitation
- SilverSneakers® fitness program
- Medicare Community Resource Support
- Doctors available anytime, anywhere with LiveHealth Online
- Foreign travel emergency and urgently needed services
- Adult Day Center

For answers to benefit questions:

First Impressions Welcome Team
1-833-848-8729 (TTY: **711**) Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays

The full details appear in the Benefits Charts, starting on page 20.

A closer look at popular benefits

Annual health exams and preventive care

The plan offers the following and more with no additional cost, as long as you see a doctor who accepts Medicare:

- Annual Wellness Visit
- Preventive care services
- Flu and pneumonia shots
- Tobacco-cessation counseling

House Call program[1]

The House Call program offers a personalized visit in your home that can lead to a care plan tailored just for you. The House Call program is offered at no additional cost to members who qualify, based on their healthcare needs.

Adult Day Center

This program reimburses you for one eight-hour day each week (up to $80) at a care center of your choice. You qualify if you rely on a caregiver for support with at least two activities of daily living, such as bathing, dressing, or eating.[2] The program benefits both you and the caregiver who supports you. While at the care center, you'll receive support and the opportunity to socialize with others if you choose. Your caregiver can take time for themselves to return refreshed. Since there is no network, you can select the best state-licensed care center for you.

Healthy Pantry

Once approved, you receive monthly nutritional counseling sessions via phone and a monthly delivery of nonperishable healthy pantry items that may help you change long-term eating habits to promote healthy eating.

1 House Call program is administered by an independent contracted vendor.
2 Provider will need to attest support is needed for at least two activities.

More popular benefits

LiveHealth® Online[1]

Using LiveHealth Online, you can visit with a doctor, therapist, or psychologist through live video on your smartphone, tablet, or computer with a camera. It's a great way to:

- Access a board-certified doctor in the comfort of your home, 24/7.
- Find help with common conditions like the flu, colds, sinus infections, pink eye, and skin rashes – this even includes having prescriptions sent to the pharmacy,[2] if needed.
- Set up a 45-minute counseling session with a licensed therapist or psychologist to find help when you feel depressed, anxious, or stressed.[3]

With the Anthem plan, video visits using LiveHealth Online are $0.

Healthy Meals

After discharge from the hospital or when diagnosed as diabetic or overweight, you may qualify to receive nutritionally balanced meals delivered to your home at no cost.

MyHealth Advantage

This program sends regular reminders about needed care, tests, or preventive health steps to keep you healthy. It also offers access to health specialists who can answer your questions.

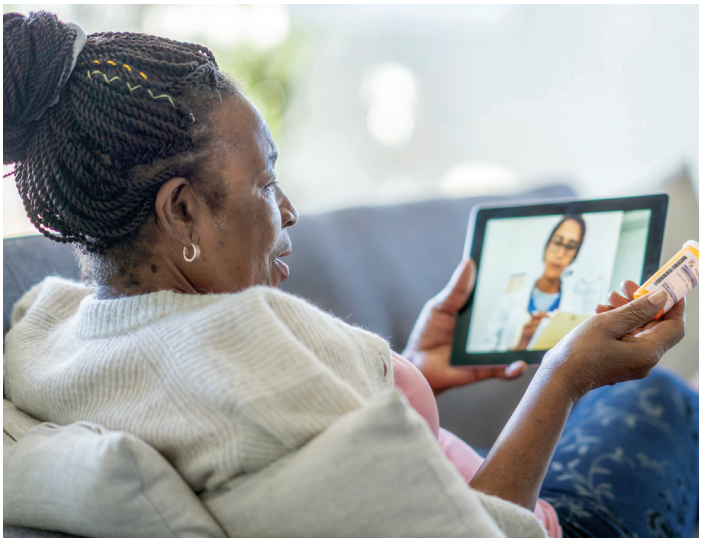
Wearable health and fitness tracker

You can request your no-cost wearable fitness device (a health and wellness tracker designed to promote an active lifestyle) to monitor your physical activity and progress toward healthy behaviors. For better brain health, you will have access to an online program with exercises that work out your attention span, brain speed, memory fitness, people and navigation skills, and intelligence. Access this program on your own schedule through any computer, tablet, or smart device with an internet connection.

1 LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of this plan.

2 Prescription availability is defined by physician judgment.

3 Appointments subject to availability of a therapist. Therapists using LiveHealth Online cannot prescribe medications. The information contained in this program is for general guidelines only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.



Care and support with Aspire Health[1]

Aspire Health is a community-based program that specializes in providing an extra layer of support to patients facing serious illness and their families. This support is provided by a team of doctors, nurse practitioners, nurses, and social workers who work closely with a patient's primary care provider and other providers to coordinate care and improve communication. Aspire's clinical team is available 24/7 to provide extra care and attention, as well as education about illness, the plan of care, and medications. Aspire's services are provided through a combination of home-based visits and telehealth support.

SilverSneakers®

SilverSneakers is a fitness and lifestyle benefit that gives you the opportunity to connect with your community, make friends, and stay active. Your membership gives you:[2]

- Memberships to thousands of participating locations with use of basic amenities,[3] plus group exercise classes[4] for all levels at select locations.
- The SilverSneakers GO™ app with adjustable workout programs tailored to individual fitness levels, schedule reminders for favorite activities, the option to find convenient locations, and more.
- Access to SilverSneakers LIVE virtual classes and hundreds of On-Demand online videos for at-home workouts.

To find a location near you or join virtual classes, visit **www.SilverSneakers.com** or call **1-855-741-4985**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.

These resources are available at no additional cost to you.

1 Aspire Health is a separate company providing coordination of care through home-based visits and telehealth services on behalf of this plan.

2 Always talk with your doctor before starting an exercise program. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is a separate company providing a fitness program on behalf of this plan.

3 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

4 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

More popular benefits

Personal emergency response system (PERS)

Coverage of one personal emergency response system and monthly monitoring in your home. This benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall).

24/7 NurseLine*

When health issues arise after hours and the doctor's office is closed, you can still find the answers you need. The 24/7 NurseLine puts you in touch with a registered nurse anytime of the day or night. Just call **1-800-700-9184** (TTY: **711**) to have your questions answered and access recorded messages on more than 300 health-related topics.

Nonemergency transportation

Covers one-way trips to and from locations within the local service area. Trips may be covered for traveling to and from medical visits, SilverSneakers locations, and visits to a pharmacy to pick up prescriptions.

* The information contained in this program is for general guidance only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.

Your doctor, your choice — nationwide

How National Access Plus works

- **Convenience** — see any doctor, provider, or specialist who participates in Medicare and accepts the plan either as an in-network or out-of-network provider.
- **Any copay or coinsurance remains the same** — whether in or out of this plan's provider network, your cost share doesn't change.
- **Your benefits and coverage won't change**, locally or nationwide, in- or out-of-network, giving you added value.

What if a doctor or other provider says they don't accept this plan?

If your doctor has any questions about your eligibility or coverage, have them call the provider phone number on the back of your plan membership card. We'll explain how your plan works and how they can submit a claim for your visit.

Health and savings with SpecialOffers

Our members receive discounts on these products and services.

Fitness and healthy living

The ChooseHealthy® program*

- Discounts on services such as acupuncture, chiropractic care, therapeutic massage, and more from a nationwide network of healthcare providers.
- Discounts on fitness and wellness products such as activity trackers, equipment, and more. Obtain access to online health and wellness classes at no additional cost.

Fitbit

Save up to 22% on select Fitbit trackers and smartwatches.

Garmin

20% off select Garmin wellness devices

GlobalFit™

Discounts on gym memberships, fitness equipment, coaching, and more

Jenny Craig®

Free three-month program (food not included), plus $120 in food savings (purchase required) or save 50% off our premium programs (food costs separate)

Puritan's Pride

10% off vitamins, supplements, and minerals

SelfHelpWorks

Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or face an alcohol problem.

Dental

ProClear™ Aligners

Improving your smile shouldn't cost a fortune. You can save 50% off the cost of a beautiful, professional smile in the comfort of your own home. There are no metal braces, no time-consuming dentist visits, and no hidden fees. When you order, you can receive a free whitening kit, along with a great-looking smile.

* The ChooseHealthy program is provided by ChooseHealthy, Inc. ChooseHealthy, Inc. is a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a trademark of ASH and used with permission herein. The ChooseHealthy program is a discount program; it is not insurance. You can access services from any ChooseHealthy participating provider; referral from a primary care physician is not required. You are responsible for paying the discounted fee directly to the contracted provider.

Family and home offerings

Allergy Control and National Allergy

Save up to 25% on select products. Free shipping on all orders over $59 when shipping ground within the contiguous United States.

23andMe

- $40 off each Health + Ancestry Service kit
- 20% off one 23andMe kit — learn about your wellness, ancestry, and more

Vision

1-800 CONTACTS® or Glasses.com™

- $20 off orders of $100 or more for the latest contact lenses or brand name frames
- Free shipping

Premier LASIK

- Save $800 on LASIK when you choose any featured Premier LASIK Network provider.
- Save 15% with all other in-network providers.

TruVision

- Save up to 40% on LASIK eye surgery at over 1,000+ locations
- Over 6.5 million procedures performed in the network

SpecialOffers is a discount program that is not part of your health plan coverage. It is a value-added online service we provide to give our Medicare Advantage members access to discounts offered by different vendors. Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services, or information provided by SpecialOffers vendors. Arrangements and discounts were negotiated between vendors and Anthem for the benefit of our members. The products and services described are not part of our contract with Medicare. They are not subject to the Medicare appeals process. Any disputes about these products or services may be subject to the Anthem grievance process.

IMPORTANT: SpecialOffers vendors and discounts are subject to change without notice.

Plan onboarding after you join

After you enroll, you will receive:

- **Proof of your enrollment request**, with your membership start date listed.
- **Your plan membership card.** Begin using this card on your membership start date.
- **A health survey** (we'll call you within 90 days) to help us understand and address your needs.

You'll also receive a **plan welcome guide** with ways to:

- Make the most of your benefits.
- Find plan doctors and facilities.
- Access information online.

Perks of our website and app

As a member, you can find information online without needing to call or sort through papers.

Once you receive your plan membership card, you can register at www.anthem.com/ca to:

- **Access plan and health resources.** You can check the status of claims and review plan documents. If you need to, you can request a replacement plan membership card or print a temporary one. There is also an online library of medical articles and videos. If you choose, you can opt in to receive paperless communications.
- **Search** covered doctors, drugs, and facilities.
- **Use mail order** for prescription drugs.
- **Message us** securely.

With the Sydney Health app, you can do all that, plus:

- **View your plan membership card** — wherever you are.
- **Use your device's GPS** to find nearby doctors, hospitals, and urgent care centers.
- **Check the status** of recent medical claims.
- **Use the chat feature** to quickly find answers to your questions.
- **Set health reminders** and wellness goals.
- **Store and share health records** with My Family Health Record (myFHR), which gives you the ability to share your health information with doctors, family members, and caregivers.

Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.

Drug highlights and savings

Using covered medications and plan pharmacies can save you money.

Covered medications

We cover generic, brand name, and specialty drugs that Medicare Part D allows us to cover, plus even more than Medicare lets us. These additional drugs are called our Extra Covered Drugs. You can call our **First Impressions Welcome Team** to receive a full list of covered drugs and plan pharmacies. We can also check coverage of specific drugs and pharmacies over the phone.

Choosing covered generic drugs may save you money without sacrificing effectiveness. Generics have the same active ingredients and effects as brand name drugs, generally without the higher cost share. Generic drugs on our Select Generics list have a $0 copay.

Plan pharmacies

You have options and savings with our pharmacy network and mail-order pharmacy.

You'll save by filling prescriptions at any of our 65,000 plan pharmacies. Most national chains and many local pharmacies are in our National Discount Network.

Our mail-order pharmacy service can save you both time and money by mailing supplies of up to 90 days, often for less than if you were to fill a 90-day supply from a retail pharmacy.

For a complete list of covered drugs and plan pharmacies:

First Impressions Welcome Team
1-833-848-8729 (TTY: **711**)
Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays

Please see the Benefits Charts in this guide for the complete details.

Top 50 most commonly prescribed drugs we cover

If you don't see one of your drugs here, you can call us to check the full drug list for you.[1]

atorvastatin calcium	*allopurinol*
amlodipine besylate	*sertraline hydrochloride*
levothyroxine sodium	*escitalopram oxalate*
lisinopril	*fluticasone propionate*
losartan potassium	*tramadol hydrochloride*
metoprolol succinate	*meloxicam*
metformin hydrochloride[2]	*atenolol*
rosuvastatin calcium	*trazodone hydrochloride*
omeprazole	*famotidine*
hydrochlorothiazide	*latanoprost*
simvastatin[2]	*alprazolam*
tamsulosin hydrochloride	*finasteride*
pantoprazole sodium	*potassium chloride*[2]
gabapentin	*ezetimibe*
furosemide	*cephalexin*
ELIQUIS[2]	*duloxetine hydrochloride*
metoprolol tartrate	SHINGRIX
carvedilol[2]	*azithromycin*
pravastatin sodium	*triamcinolone acetonide*
hydrocodone/acetaminophen	*spironolactone*
clopidogrel bisulfate	XARELTO
montelukast sodium	*bupropion hydrochloride*
albuterol sulfate	*lisinopril/hydrochlorothiazide*
amoxicillin	*zolpidem tartrate*
prednisone	*alendronate sodium*

Generic drugs appear in lowercase italics (*lisinopril*, for example), while brand name drugs are in uppercase (ELIQUIS, for example).

1 This list is current as of April 2021 and is subject to change. It is not a complete list of covered drugs.

2 Not all dosages are covered at the generic cost share.

$0 copay for Select Generics

These generic drugs have the same active ingredients and effects as brand name drugs for a $0 copay. If you don't see one of your drugs here, you can call us to check the full drug list for you.[1]

Use	Name	
Cardiovascular	Atenolol tablet	Irbesartan tablet
	Atenolol/chlorthalidone tablet	Irbesartan/hydrochlorothiazide tablet
	Benazepril tablet	Lisinopril tablet
	Benazepril/hydrochlorothiazide tablet	Lisinopril/hydrochlorothiazide tablet
	Bisoprolol fumarate tablet	Losartan potassium tablet
	Bisoprolol/hydrochlorothiazide tablet	Losartan potassium/ hydrochlorothiazide tablet
	Carvedilol tablet	Metoprolol tartrate tablet
	Chlorthalidone tablet	Quinapril tablet
	Enalapril maleate tablet	Ramipril tablet
	Enalapril/hydrochlorothiazide tablet	Trandolapril tablet
	Fosinopril tablet	Valsartan tablet
	Furosemide tablet	Valsartan/hydrochlorothiazide tablet
	Hydrochlorothiazide capsule/tablet	
Cholesterol	Atorvastatin tablet	Rosuvastatin tablet
	Lovastatin tablet	Simvastatin tablet[2]
	Pravastatin sodium tablet	
Diabetes	Glimepiride tablet	Glipizide/metformin hcl tablet
	Glipizide ER tablet	Metformin ER tablet[2]
	Glipizide tablet	Metformin tablet
Osteoporosis	Alendronate sodium tablet	

1 This list is current as of May 2021 and is subject to change. It is not a complete list of covered drugs.

2 Not all dosages are covered at the Select Generics cost share.

Prescription drug coverage with Part D

This plan includes prescription drug coverage, also called Medicare Part D. All of our covered drugs appear on a drug list, called the *Part D Formulary*. This plan also covers drugs beyond those that Medicare allows, which appear on a separate list called *Extra Covered Drugs.*

If you take a drug that is not covered, you have three options. You can:

1. Ask your doctor to switch you to a covered drug.
2. Request an exception.
3. Request a temporary supply while discussing other drug options with your doctor.

Our **First Impressions Welcome Team** is available to check the drug list and estimate costs.

Covered drugs are divided into levels, or tiers. Drugs on the **lowest-numbered tier generally cost less**, while drugs on the **highest-numbered tier generally cost the most**. All of the tiers contain drugs that we cover based on their safety and effectiveness. This chart provides an overview of how the tiers and pricing generally work.

Drug type	Description	Possible tier coverage[2]	Cost
Generic[1]	Same active ingredients and effects as brand name drug without the brand name	Tier 1	$
Preferred brand name	Safe and effective brand name drugs that may not have a generic alternative	Tier 2	$ $
Nonpreferred brand name	Less commonly used brand name drugs that usually have a generic alternative	Tier 3	$ $ $
Specialty	Cost over $830 for 30 days. May require special handling.	Highest tier	$ $ $ $

1 High-cost generic medications may also appear on the same tiers as brand name medications. Please consult the formulary for specific tier details.

2 Some drug lists divide generic drugs into two tiers. For those lists, the tier number increases by one for all tiers after the first. For example, Tier 1 becomes Tier 1 and Tier 2, and the numbering continues up the tiers.

Complete Benefits Charts

These describe the plan's medical and prescription drug benefits, including:

- What we cover.
- Any copay or coinsurance amounts.
- Any out-of-pocket costs.

Look for the apple

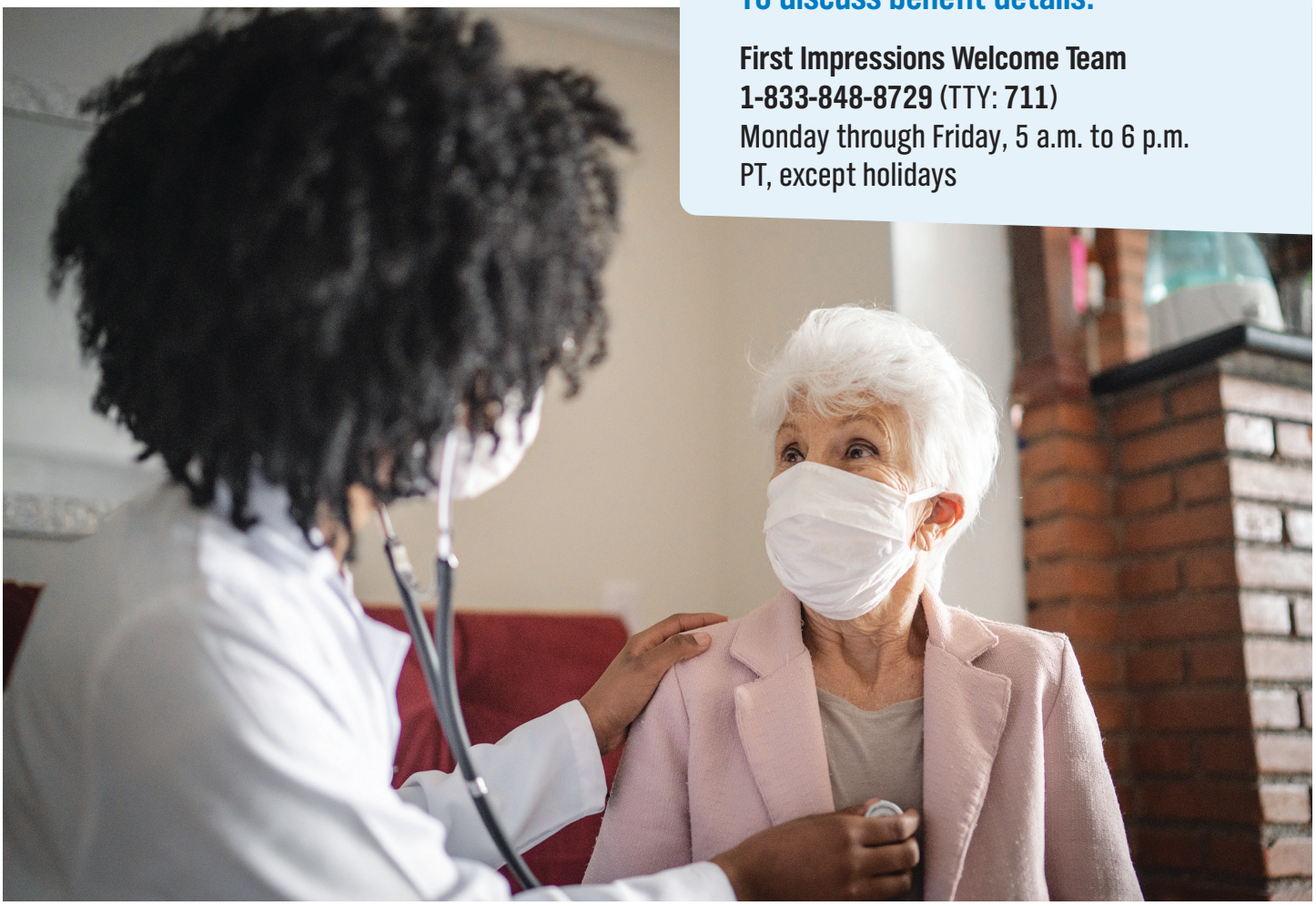
It appears next to **preventive services we cover at no cost** if you see a doctor who accepts Medicare and the plan.

Medical benefits start on page Med-1.

Prescription drug benefits start on page Rx-1.

To discuss benefit details:

First Impressions Welcome Team
1-833-848-8729 (TTY: **711**)
Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays



We are happy to review your benefits with you. Call our First Impressions Welcome Team.

Your 2022 Medical Benefits Chart
PPO Plan 0PH
LACERS

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.		
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$0 Combined in-network and out-of-network	
Inpatient services		
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines.		If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient mental health care* Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital. In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.	$0 copay for days 1-100 per benefit period	$0 copay for days 1-100 per benefit period
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech language therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services	No prior hospital stay required.	No prior hospital stay required.
Generally, you will receive your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (con't) • A SNF where your spouse is living at the time you leave the hospital In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.		
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or a skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetic and orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back and neck braces, trusses and artificial legs, arms, and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy, and speech language therapy	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the cost share amounts indicated.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech language therapy • Medical and social services • Medical equipment and supplies	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be an in-network provider or an out-of-network provider. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than this plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Medicare for the services that Original Medicare pays for. Services covered by Original Medicare include: • Drugs for symptom control and pain relief • Short-term respite care • Home care Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, nonurgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from an in-network provider, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $0 copay for the one time only hospice consultation	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $0 copay for the one time only hospice consultation

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care (con't) For services that are covered by this plan but are not covered by Medicare Part A or B: This plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits*	$0 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services	$0 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services
Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Retail health clinics • Basic hearing and balance exams performed by your Primary Care Physician or specialist, if your doctor orders it to see if you need medical treatment • Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video doctor visits • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	$0 copay per visit to an in-network specialist for Medicare-covered services $0 copay per visit to an in-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.	$0 copay per visit to an out-of-network specialist for Medicare-covered services $0 copay per visit to an out-of-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network

Physician services, including doctor's office visits (con't)
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  o You're not a new patient **and**
  o The evaluation isn't related to an office visit in the past 7 days **and**
  o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion by another in-network provider prior to surgery
• Physician services rendered in the home
• Outpatient hospital services
• Non–routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)
• Allergy testing and allergy injections		

Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain*	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit
Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • Not associated with surgery; and • Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistances (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United Sates, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs) in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit
Outpatient mental health care, including partial hospitalization services* Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Facilities where surgical procedures are performed and the patient is released the same day. **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient hospital observation, non-surgical* Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit	$0 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit
Ambulance services • Covered ambulance services include fixed wing, rotary wing, water, and ground ambulance services, to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for Medicare-covered ambulance services	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.	$0 copay for each Medicare-covered emergency room visit	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Urgently needed services • Urgently needed services are available on a worldwide basis. If you are outside of the service area for your plan, your plan covers urgently needed services, including urgently required renal dialysis. Urgently needed services are services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from an in-network provider.	$0 copay for each Medicare-covered urgently needed care visit	
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copay for Medicare-covered cardiac rehabilitation therapy visits	$0 copay for Medicare-covered cardiac rehabilitation therapy visits

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	$0 copay for Medicare-covered pulmonary rehabilitation therapy visits	$0 copay for Medicare-covered pulmonary rehabilitation therapy visits
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay for Medicare-covered supervised exercise therapy visits	$0 copay for Medicare-covered supervised exercise therapy visits

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Durable medical equipment (DME) and related supplies* Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, continuous blood glucose monitors, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. Coverage is limited to 2 sensors per month and one receiver every 2 years. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). For new prescriptions, we will not cover other brands unless your provider tells us it is medically necessary. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.	$0 copay for Medicare-covered DME $0 copay for Medicare-covered CGMs and related supplies See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	$0 copay for Medicare-covered DME $0 copay for Medicare-covered CGMs and related supplies See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
Prosthetic devices and related supplies* Devices (other than dental) that replace all or a body part or function. These include, but are not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery. See "Vision care" later in this section for more detail.	$0 copay for Medicare-covered prosthetics and orthotics	$0 copay for Medicare-covered prosthetics and orthotics

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home infusion therapy*	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home
Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Separately from the home infusion therapy professional services, home infusion requires a durable medical equipment component: • Durable medical equipment – the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	$0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)	$0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users) Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors • Blood glucose monitors are limited to one every year • Up to 200 blood glucose test strips and lancets for a 30-day supply • One pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Diabetes self-management training is covered under certain conditions	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors $0 copay for Medicare-covered blood glucose monitor $0 copay for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors $0 copay for Medicare-covered blood glucose monitor $0 copay for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies*	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test
Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease $0 copay for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease $0 copay for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$0 copay per visit for Medicare-covered opioid treatment program services	$0 copay per visit for Medicare-covered opioid treatment program services

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Vision care (non-routine) Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic-Americans who are age 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	$0 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $0 copay for glasses/contacts following Medicare-covered cataract surgery	$0 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $0 copay for glasses/contacts following Medicare-covered cataract surgery

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Preventive services care and screening tests  You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition care or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.		
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months, or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules **If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.**	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Cervical and vaginal cancer screening Covered services include: • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: 1 Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
"Welcome to Medicare" preventive visit The plan covers a one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit.
Annual wellness visit If you've had Medicare Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible enrollees are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Smoking and tobacco use cessation (counseling to quit smoking) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) • Home dialysis or certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home and outpatient dialysis equipment and supplies Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section below, "Medicare Part B prescription drugs."	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $0 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $0 copay for Medicare-covered self-dialysis training $0 copay for Medicare-covered home dialysis equipment and supplies $0 copay for Medicare-covered outpatient dialysis equipment and supplies	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $0 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $0 copay for Medicare-covered self-dialysis training $0 copay for Medicare-covered home dialysis equipment and supplies $0 copay for Medicare-covered outpatient dialysis equipment and supplies

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs)*	$0 copay for Medicare-covered Part B drugs	$0 copay for Medicare-covered Part B drugs
These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.	$0 copay for Medicare-covered Part B drug administration	$0 copay for Medicare-covered Part B drug administration
Covered drugs include: • "Drugs" include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents such as Erythropoietin (Epogen®), Procrit® or Epoetin Alfa and Darboetin Alfa (Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	$0 copay for Medicare-covered Part B chemotherapy drugs	$0 copay for Medicare-covered Part B chemotherapy drugs
	$0 copay for Medicare-covered Part B chemotherapy drug administration	$0 copay for Medicare-covered Part B chemotherapy drug administration
We also cover some vaccines under our Part B prescription drug benefit.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs) (con't) Some of Part B covered drugs listed above may be subject to step therapy. You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Additional supplemental benefits, services, and discounts		
Routine hearing services • Routine hearing exams Routine hearing exams are limited to 1 every 12 months. Routine hearing exams are limited to a $70 maximum benefit every 12 months combined in-network and out-of-network. • Hearing aid fitting evaluations are limited to 1 per covered hearing aid • Hearing aids Hearing aids are limited to a $2,000 maximum benefit per ear every 36 months combined in-network and out-of-network. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. The hearing aid benefit does not provide coverage for amplifiers, internet purchases, assistive listening devices (ALDs), earmolds or accessories. We have partnered with Hearing Care Solutions to bring you these discounts and services. For your hearing aid to be covered, you must select a device from the list available through our participating hearing aid supplier. This supplier must be used for both in-network and out-of-network benefits. Our supplier will send the device directly to your provider. Your plan does not reimburse for devices received from other vendors or providers. For more information on your benefit, covered devices or to locate a Hearing Care Solutions provider please contact Member Services. Hearing benefit management administered by Hearing Care Solutions, an independent company.	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.	$0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids through our hearing aid supplier Hearing aid must be selected from the list of available devices. Our supplier will send the device directly to your provider. Members receive a free battery supply during the first 3 years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine vision services • Routine vision exams Routine vision exams are limited to 1 every calendar year. The routine vision exam is limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. • Eyewear Eyewear is limited to a $100 maximum benefit* every 2 calendar years combined in-network and out-of-network. Covered eyewear includes prescription glasses, lenses, frames and contacts. This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. This information is intended to be a brief outline of coverage. For additional benefit information, including exclusions and limitations or to locate a participating Blue View Vision provider, please contact Member Services. You will be directed to the dedicated Blue View Vision Member Services line. If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. In-network benefits and discounts will not apply. * Any remaining unused eyewear benefit amount must be used in the same calendar year of the first eyewear purchase. Unused amounts cannot carry over to the following calendar year or benefit period.	Must use a Blue View Vision provider. $0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost.	$0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine foot care • Up to 12 covered visits per year combined in-network and out-of-network Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails, and other hygienic and preventive maintenance care.	$0 copay for each visit to an in-network primary care physician for routine foot care $0 copay for each visit to an in-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for any remaining cost.	$0 copay for each visit to an out-of-network primary care physician for routine foot care $0 copay for each visit to an out-of-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for any remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered "Welcome to Medicare" or “Annual Wellness Visit.”	$0 copay for an annual physical exam	$0 copay for an annual physical exam

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Video doctor visits LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists and psychiatrists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your Membership Card ready – you'll need it to answer some questions. **Sign up for Free:** • You must enter your health insurance information during enrollment, so have your Membership Card ready when you sign up. **Benefits of a video doctor visit:** • The visit is just like seeing your regular doctor face-to-face, but just by web camera. • It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.[1] • If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan. 1. Prescription is prescribed based on physician recommendations and state regulations (rules). 2. Appointments are typically scheduled within 14 days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 14 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	$0 copay for video doctor visits using LiveHealth Online	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE™, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-855-741-4985 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers LIVE, SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved.	$0 copay for the SilverSneakers fitness benefit	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
24/7 NurseLine Also, as a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the nurse line at 1-800-700-9184. TTY users should call 711. Only 24/7 NurseLine is included in our plan. All other nurse access programs are excluded.	$0 copay for 24/7 NurseLine	
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. • Emergency outpatient care • Urgently needed services • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at 800-810 BLUE or collect at 804-673-1177. Representatives are available 24 hours a day, 7 days a week, 365 days a year to assist you. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a Supplemental Benefit and not a benefit covered under the Federal Medicare program. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.	$0 copay for emergency care $0 copay for urgently needed services $0 copay per admission for emergency inpatient care	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Community Resource Support Need help with a specific issue? Your plan benefits are designed to cover what Medicare covers, as well as some additional supplemental benefits as described in this benefits chart, but we know that you might need additional help. As a member, your plan provides a Medicare Community Resource Support benefit to help bridge the gap between your medical benefits and your optimal health, by connecting you to resources available to you in your community. The Medicare Education and Outreach team can help you locate helpful resources within your community, such as food pantries, home maintenance programs, utility assistance programs, social activities, and much more. If you need assistance or have questions about this benefit, call Member Services at the number listed on the back of your Membership Card.	$0 copay for Medicare Community Resource Support	
Healthy Meals* • Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home or when you have a Body Mass Index (BMI) of 18.5 or under, you have a BMI of 25 or higher or an A1C level more than 9.0 as determined by your provider. For fastest qualification, your provider or case manager is best suited to request this on your behalf. Alternatively, you can contact Member Services and a representative will initiate the process to validate your eligibility. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements.	$0 copay for Healthy Meals	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Healthy Pantry*	$0 copay for Healthy Pantry	
Special Supplemental Benefits for the Chronically Ill Maintaining a healthy diet to support a chronic medical condition can help you maintain or improve your overall health. As a Special Supplemental Benefit for the Chronically Ill, you must: • Meet the CMS mandated criteria. This criteria can be found in the Chapter “Medical benefits (what is covered and what you pay)" in your Evidence of Coverage. • Provide supporting documentation from your physician identifying you, as having a condition that can be made worse by not having or would benefit from having nutritional counseling and help with obtaining appropriate pantry items. We can help you obtain this information. We are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone. Upon approval you are eligible for: • Monthly nutritional counseling sessions via phone. • A monthly delivery of non-perishable pantry items sent directly to your home. Your monthly box of staples will consist of a variety of non-perishable foods that can vary each month. • Your nutritional consultations will help you utilize these items and provide you with information on how to supplement them with additional food resources. You can contact Member Services on the back of your Membership Card to begin the process to validate your eligibility.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Adult day center* • Coverage is available for up to one (1) day per week (up to 8 hours per day) for adult day center services. • The center must be licensed by the state to provide adult day center services. • We will reimburse up to $80 for each covered visit. You are responsible for any remaining costs. A visit is defined as less than or equal to eight (8) hours. It cannot be split over multiple days. Any portion of a day used is considered one day. To qualify, you must: • Get prior approval from the plan. • Need help with at least two (2) activities of daily living (ADLs) as determined and recommended by your health care provider. • Adult day center covered days is a direct member reimbursed benefit. Claims for reimbursement must be submitted by the member to the plan with appropriate documentation. Please contact Member Services for further information.	$0 copay for each adult day center visit After the plan pays benefits for adult day center you are responsible for any remaining cost.	
Assistive devices Covered items allowed by Medicare include, but are not limited to: ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair ramps and much more. Approximately 14 business days after enrollment, you will receive a Welcome Kit containing your benefit card, catalog and how to access online, so you can start shopping for covered products. There are three ways to access your benefit through our vendor: 1. Place orders online through the web. You can select in-store pick up or home delivery. 2. Shop in stores using your assistive device benefit card at Walmart stores. 3. Call to place an order. Pick items by shopping online or from the assistive device catalog. Have your product name(s) and assistive device benefit card number ready. You can select in-store pick up or home delivery.	This plan covers approved assistive devices, up to $200 every year. Unused assistive device amounts do not roll over to the next year. After the plan pays benefits for assistive devices, you are responsible for any remaining cost.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Assistive devices (con't) • Any repair or replacement of items selected is limited to the manufacturer's warranty. • Items must be primarily for your use only. • Items are limited to those offered within the catalog and subject to availability. • Quantity limits may apply. Please contact Member Services if you have questions about this benefit.		
Health and fitness tracker for your body & mind health Coverage includes a fitness tracking device to track your physical activity and a member engagement website designed to provide guidance, encouragement, and motivation. Limit is one device every two years provided through our contracted vendor. Additionally, this benefit provides access to a web based memory fitness program designed to help maintain or improve your focus, attention, reaction time, brain speed, and memory. Please contact Member Services for more information.	$0 copay for health and fitness tracker	
In-home support • This benefit provides up to 30 hours per year of assistance with activities of daily living to support member independence, such as helping with home-based chores, meal preparation, help with pets, use of electronics/communications, and fitness activities to encourage overall health. • In-home support can work in conjunction with other benefits or care plans to promote independent living, aid in reducing a member's feeling of social isolation and improve their overall mental outlook. • You must use a plan approved provider. For more information please contact Member Services.	$0 copay for in-home support After the plan pays benefits for in-home support you are responsible for any remaining cost.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Personal emergency response system (PERS) Coverage of one personal emergency response system and monthly monitoring in the member's home when arranged by the Plan with our contracted vendor. The personal emergency response system benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall). Please call Member Services for more information or to request the unit.	$0 copay for personal emergency response system	
Personal home helper* • This benefit provides services from a personal care attendant for assistance with home based chores and activities of daily living (ADL) due to health issues not otherwise covered under any other Medicare benefit. • Covers up to 124 hours of care per year (up to four (4) hours per day for a maximum of 31 days in the year). Use of less than 4 hours is still considered a day. • We will reimburse up to a maximum benefit of $100 per day. • Caregiver must meet all applicable state licensing/certification requirements to be eligible for reimbursement. To qualify, you must: • Get prior approval from the plan. • Need help with at least two (2) activities of daily living (ADLs) as determined and recommended by your health care provider. • Personal home helper is a direct member reimbursed benefit. Claims for reimbursement must be submitted by the member to the plan with appropriate documentation. Personal home helper services include: • Help with bathing and showering • Help with dressing • Transferring or mobility help in the home • Light housekeeping (cleaning, laundry, dishes, etc.)	$0 copay for personal home helper services After the plan pays benefits for personal home helper services you are responsible for any remaining cost.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Personal home helper* (con't) • Meal preparation • Help with medication adherence Please contact Member Services for further information.		
Routine transportation • Routine transportation covers up to 12 one-way trips each year. A trip is defined as a ride from one destination to another. A trip is limited to 60 miles. • Trips are covered within your local service area for plan covered services, such as medical visits, visits to SilverSneakers locations and visits to a pharmacy to pick up prescriptions. A stop at a pharmacy after a doctor's appointment to pick up prescriptions will not count as a separate trip. When you schedule a pick-up from the visit, tell the vendor that you need to go to the pharmacy. Ask the provider/facility to call in the prescription so you have a shorter wait. • You must schedule trips 2 business days in advance. When scheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. • Trips will not be covered for non-health related services such as going to buy groceries, personal errands or other reasons when accessing non-covered services. We have partnered with Access2Care to bring you these discounts and services. For more information about this benefit, please contact Member Services. Access2Care, an independent company is providing routine transportation on behalf of our plan.	$0 copay for routine transportation	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Additional acupuncture services Coverage includes acupuncture services, not covered by Medicare, rendered by a licensed acupuncturist to treat a disease, illness or injury. Benefits include: • Initial patient exam, as well as acupuncture treatment, re-examinations and other services in various combinations Medicare non-covered acupuncture services are limited to 30 visits per year combined in-network and out-of-network. For additional benefit information, please contact Member Services.	$0 copay per visit After the plan pays benefits for Medicare non-covered acupuncture services, you are responsible for any remaining cost.	$0 copay per visit After the plan pays benefits for Medicare non-covered acupuncture services, you are responsible for any remaining cost.
Additional chiropractic services Coverage includes chiropractic services, not covered by Medicare, rendered by a physician to treat a disease, illness or injury. Benefits include: • Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination; • Adjustments; • Radiological x-rays and laboratory tests; and • Medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment. Medicare non-covered chiropractic services are limited to 30 visits per year combined in-network and out-of-network. For additional benefit information, please contact Member Services.	$0 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services, you are responsible for any remaining cost.	$0 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services, you are responsible for any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost-sharing for like services. Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services and routine vision services. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$0 Combined in-network and out-of-network	

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Chart.

Your 2022 Prescription Drug Benefits Chart
Premier 5/25/50 (with Senior Rx Plus)
LACERS – Parts A & B Members

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	Premier
Deductible	None
Supplemental Gap Coverage	Generic and Brand

Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and your retiree drug plan for covered Part D prescriptions reaches your Initial Coverage Limit of $4,430.	
Retail Pharmacy	per 30-day supply
• Select Generics	$0 copay
• Generics	$5 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$50 copay
Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.	
Mail-Order Pharmacy	per 90-day supply
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	$50 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$100 copay

Covered Services	What you pay
Part D Gap Coverage	
Your payment responsibility changes once you reach your Initial Coverage Limit of $4,430. Below is your payment responsibility during the period after you meet your Initial Coverage Limit and until you meet your True Out of Pocket limit.	
Retail Pharmacy	per 30-day supply
• Select Generics	$0 copay
• Generics	$5 copay
• Preferred Brands	$12.50 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$25 copay
Mail-Order Pharmacy	per 90-day supply
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$50 copay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $3,600.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply
• Select Generics	$0 copay
• Generic Drugs	5% coinsurance with a minimum of $2.00 and a maximum of $5
• Brand-Name Drugs	5% coinsurance with a minimum of $5.00 and a maximum of $25

- **Coverage Gap Discount Program:** If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2022, once the cost paid by you and your retiree drug plan reaches $4,430 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $7,050. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever, and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to pay its share of the cost. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

- **Dispense as Written:** When a member's physician has specified "dispense as written (DAW)" for non-preferred brand-name drugs or non-formulary drugs, the copay for preferred brand-name formulary drugs will apply. When a member's physician has not specified DAW for non-preferred brand-name drugs or non-formulary drugs, the Tier 3 copay will apply. The lower formulary brand copay will not apply to single source drugs even if the physician denotes "dispense as written".

Your 2022 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
These are drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These drugs are covered by your Senior Rx Plus benefits. Some of these drugs may be required on your retiree drug plan by state regulations. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.	
Retail Pharmacy	per 30-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$5 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs	$50 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$5 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs	$50 copay
• Contraceptive Devices	Limit 1 per year; $25 copay per Covered Device

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$10 copay
• Preferred Brands	$50 copay
• Non-Preferred Drugs	$100 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Brands	$50 copay
• Non-Preferred Drugs	$100 copay
Other Non-Part D Coverage	Copay or coinsurance
• Contraceptive Devices	Limit 1 per year; $25 copay per Covered Device

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

How to qualify and enroll

How to qualify for this plan

To qualify for the Anthem Medicare Preferred (PPO) with Senior Rx Plus plan you must meet all of these conditions:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's group-sponsored health plan.

For answers to enrollment questions:

First Impressions Welcome Team
1-833-848-8729 (TTY: **711**)
Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays or **www.medicare.gov**

How to enroll

IMPORTANT: When you are ready to enroll, please **complete the enrollment election form on the next page.** The scissors icon and dotted line show where to **cut it out.** Then please **mail your form** to the address on the form.

How to complete the enrollment election form

You'll need:

- Your Medicare Number (the number on your red, white, and blue Medicare card). Fill out the requested information as it appears on your Medicare card. If required, also attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board and send it along with your completed enrollment election form.
- Your permanent address and phone number.

You must complete all items on the enrollment election form. Complete and sign the enrollment election form that starts on the next page, and mail it to the address listed on it.

Anthem

Anthem BC Health Insurance Company Group Sponsored Health Plan Enrollment Election Form

All fields on this form are required		
Group sponsor name: **LACERS**		Group #: **CA039GRS**
Plan you will join: ☑ **Anthem Medicare Preferred (PPO) with Senior Rx Plus**		Requested effective date of coverage: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.
FIRST name:	LAST name:	Middle initial:
Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other
Permanent residence street address (Do not enter a P.O. Box):		
City:	State:	ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed):		
Street address:	City:	State: ZIP code:

Email address:_____

Your email address will be used for communications only from Anthem BC Health Insurance Company. We will not share your email address.

Your Medicare information:

Medicare Number: _____

Note: The Medicare Number is required to complete your enrollment. If you do not provide your Medicare Beneficiary ID from your Medicare ID Card, your enrollment into the plan may be delayed.

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If "yes," retirement date (month/date/year): _____

If "no," name of retiree:_____ Retiree Medicare ID #:_____

2. Do you have other medical insurance? ☐ Yes ☐ No

If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____

What are the effective dates of coverage? _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of institution:_____

Address (number and street) and phone number of institution:_____

_____

4. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-833-848-8729**, TTY: **711**, Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays, for additional information or questions you may have.

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this Medicare Advantage Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem BC Health Insurance Company will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Anthem Medicare Preferred (PPO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Anthem BC Health Insurance Company. Benefits and services authorized by Anthem BC Health Insurance Company and contained in my Anthem Medicare Preferred (PPO) with Senior Rx Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem BC Health Insurance Company will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment election form, and
    2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Anthem

Please return this enrollment election form to:
Los Angeles City Employees' Retirement System (LACERS)
Attn: Health Benefits Administration Division
P.O. Box 512218
Los Angeles, CA 90051-0218

Please refer to the Anthem BC Health Insurance Company *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

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Required information for this plan year

Your rights, protections, and Medicare options

As a Medicare beneficiary, you have many rights and options put in place to protect you as a consumer. You have choices. As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan.
- A Medicare health plan like the one offered in this guide.

You may have other options

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may affect other retiree benefits your group sponsor offers. No matter what you decide, you may still be eligible for the Original Medicare program.

Geographic service areas covered by this plan

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

Your Medicare protections

The plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. The plan provider can decide each year whether to keep offering Medicare Advantage plans, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract.

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with this plan, please contact our **First Impressions Welcome Team** and ask for a copy of the *Evidence of Coverage (EOC)*.

Extra Help from Medicare

You may be able to find help to pay for your prescription drugs and other Medicare costs. If you qualify for Medicare's Extra Help and are enrolled in a Part D plan like this one, Medicare can pay up to 100% of your prescribed drugs. This can help offset your drug plan's monthly premium, plus coinsurance and copays for covered prescription drugs.

Extra Help can also close any drug coverage gaps and stop late enrollment penalties (LEPs). For more information, visit **www.medicare.gov** or **www.ssa.gov**, or call:

- **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.
- **The Social Security Administration** at **1-800-772-1213**, Monday to Friday, 7 a.m. to 7 p.m. ET. TTY users should call **1-800-325-0778**.
- **Your state Medicaid office.**

Required information for this plan year

Information about Medicare

To help you make more informed healthcare decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, please contact our **First Impressions Welcome Team**.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must still pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late enrollment penalty if you decide to reenroll.

Enrolling in other plans

If you decide to enroll in other plans, you will be disenrolled from your current plan.

Notifying your group sponsor

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

What to know about a drug list

A drug list is a list of drugs covered by the plan. We choose our list to provide good prescription coverage and a good value to you, as well.

Your full Benefits Charts will tell you if you have an open or closed drug list plan. Open plans cover almost all Medicare Part D eligible drugs, while closed plans cover most.

When new drugs come to market, we conduct a clinical and cost review and may add them to the drug list. To keep plans affordable, every year we may also remove drugs or change the cost you pay for them the following year. But don't worry; we'll notify you first and send you a new drug list when we make these changes.

Important: Check to see if your drug is on the drug list before you go to the pharmacy.

If the drug you take is not on our drug list, you will have to pay the full price of the drug. If that's the case, or if your drug comes with additional requirements or limits, you may be able to receive a temporary supply. We will notify you once the temporary supply is dispensed. You will have to contact your doctor and ask if you can switch to a different drug listed on our drug list.

About IRMAA and your income level

If your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit, you must pay an income-related monthly adjustment amount (IRMAA) in addition to your monthly plan premium.

The Social Security Administration will contact you if you have to pay an IRMAA, which you must pay to them, not us.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B or Part D premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Required information for this plan year

Information about Medicare

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the **First Impressions Welcome Team** at the number listed in this guide to request interpreter services.

Out-of-network/noncontracted providers are under no obligation to treat Anthem BC Health Insurance Company members, except in emergency situations. Please call our **First Impressions Welcome Team** at **1-833-848-8729**, TTY: **711**, Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays, for more information.

This information is not a complete description of benefits. Contact the plan for more information. Every year, Medicare evaluates plans based on a five-star rating system.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Benefits Charts and *Evidence of Coverage (EOC)*, which is received upon enrollment. In the event of a conflict between the Benefits Charts/*EOC* and this guide, the terms of the Benefits Charts and *EOC* will prevail.

Coordination of Benefits (COB) letter

If we receive Coordination of Benefits (COB) information from CMS, we are required to send a letter to you requesting verification of the other coverage information. The benefit verification letter we send will include information from CMS, including any other coverage that needs to be verified. Separately, we could receive COB information from other reporting sources in addition to CMS.

If the information is not correct in the letter, you can call Member Services or you can fill in the correct information on the letter and return it to the plan for processing.

If a response is not received within 21 days, the information on the letter is considered to be accurate.

If the previous carrier does not notify CMS of the previous plan termination prior to the plan enrollment process, a COB letter could be triggered for the plan that was just terminated.

Required information for this plan year

Information about Medicare

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

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Anthem BC Health Insurance Company – H4036

2021 Medicare Star Ratings

Every year, Medicare evaluates plans based on a 5-star rating system. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Ratings that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2021, Anthem BC Health Insurance Company received the following Overall Star Rating from Medicare:

★★★★
4 Stars

We received the following Summary Star Ratings for Anthem BC Health Insurance Company's health/drug plan services:

Health Plan Services: ★★★★
4 Stars

Drug Plan Services: ★★★½
3.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars – excellent
★★★★	4 stars – above average
★★★	3 stars – average
★★	2 stars – below average
★	1 star – poor

Learn more about our plan and how we are different from other plans at **www.medicare.gov**.

You may also contact us Monday to Friday, 8 a.m. to 9 p.m. ET, at **1-833-848-8729** (toll-free) or **711** (TTY).

Current members please call **1-833-848-8730** (toll-free) or **711** (TTY).

Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

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